CONSULTATION ON HUMAN RESOURCES FOR HEALTH FOR HIGH INCOME COUNTRIES

Preparatory meeting for the Third Global Forum on HRH

Meeting report

4-5 September 2013, Oslo

Acknowledgements

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Table of Contents

Executive Summary

The Directorate of Health of Norway, the Norwegian Agency for Development Cooperation, the World Health Organization and the Global Health Workforce Alliance convened a consultation on human resources for health (HRH) in High Income Countries (HICs) on 4-5 September 2013 to enhance a common understanding of HRH challenges and increase HICs engagement in advancing global HRH solutions. The meeting will feed into the 3rd Global Forum on HRH in Brazil in November 2013.

In the mid-2000s a critical shortage of health workers in the global south, often exacerbated by international migration, was identified as a key challenge in achieving the Millennium Development Goals and universal health coverage. It is now increasingly recognized that the issue is more multi-faceted than an exclusive focus on shortages would imply: It is a global problem, affecting all the countries in the world, and its dimensions start from governance and management of HRH, affecting, beyond availability, also accessibility, quality and performance of health services.

The experiences in addressing HRH challenges in HICs in the context of a limited resources and recession, and broader trends such as demographic changes, evolving patterns of migration, and a rising burden of non-communicable (NCDs,) present valuable lessons to be shared with the global HRH community, and provide a basis for articulating commitments to further improve access to health workers at all levels. The implementation of the WHO Code of Practice on International Recruitment of Health Personnel (COP) represents a key framework for action to ensure ethical approaches to health worker migration and recruitment. The actions taken to implement the COP contribute not only to the global health workforce but also directly to strengthening the domestic health landscape.

HIC face the dual challenge of developing better long-term planning capacity, while at the same time trying to alleviate pressures to contain health budgets in the short term. As health workforce trends are driven by long-term fundamentals, such as demography and population health transitions leading to a growing burden of non-communicable diseases and long-terms care, countries need to focus today's decisions on estimates for 10-20 years in the future, taking into consideration not only numbers of health workers but also ensuring they have the right skills mix, competencies, quality and geographical distribution. Such forecasting and planning exercises should harness the potential of innovative technologies, HRH governance structures and service delivery models. Federal countries like the USA and supra-national entities like the European Union are confronted with the challenge of how to promote coherent policy implementation among their constituent States. In the European Union, intraregional collaboration in forecasting and planning is critical.

The health worker roles and norms need rethinking, including: a possible move away from rigid hierarchical structures; more emphasis to preventive strategies; a new understanding of the role of health workers as change agents in their communities and societies; new models for providing care more cost-effectively outside of hospitals, addressing the needs of aging population and long-term care; the role of technology. The profile of health professionals, their competencies and their

education paths need to be redesigned according to these trends and to the goal of universal health coverage.

Collaboration between the different ministries and stakeholders, including trade unions and professional associations, among others, can enhance the effectiveness of health workforce planning and management. Similarly, there are opportunities in strengthening collaboration with the private sector and civil society. A joint approach for analyzing the needs, both in the short and long term, of different health care actors should be developed.

Health workforce planning has to continue moving from simplistic and static models to the understanding of the complex and evolving nature of HRH. The planning for the future must start now, aligning the activities on the WHO Code with others: WHO should lead the rethinking of the health workforce agenda looking 20 years ahead.

The absolute numbers of health workers is likely to continue growing: in future forecasting models, however, there should be a move beyond planning only for the numbers of health personnel to be educated, taking into consideration the broader labour market dynamics, and ensuring health workforce planning undergoes continuous monitoring and adaption.

Countries, development partners, international agencies, and all national and international actors with a stake in health workforce development are invited to make new HRH commitments at the 3rd Global Forum for HRH to advance the health workforce agenda. The template for commitments is intended to assist countries and other stakeholders to identify relevant HRH commitments to be brought to the Forum; it does so by mapping out the most effective interventions and their interrelatedness to improve the situation of HRH. It draws on the WHO COP, and a solid policy and evidence base in support of Member States efforts.

Preliminary examples of commitments and actions shared at the consultation by some HIC (e.g. France, Ireland, Norway, USA) indicate the potential to design and seek greater synergy and integration between the domestic and international dimensions of HRH development: preparing commitments to be announced at 3rd Global Forum provides a unique opportunity for high income countries to develop a clear vision on how their national HRH efforts contribute to the wider global agenda.

There is a growing appreciation of the inherent complexities in the HRH field, providing fresh opportunities to identify key entry points for policy intervention at system level. In future, technological advances, demographic trends, the relative growth of non-communicable diseases and the impact of long-term care need to inform the planning and development of a fit for purpose health workforce.

It is critical to have new political commitments to bring HRH at the forefront of the UHC discourse, and high-income countries need to be an integral part of that discussion. The template for commitments provides a framework for action and innovation. Commitments could also be made that relate to:

- Promotion of HRH on the global agenda through a strong investment case
- The Code of Practice as a convening instrument
- Strengthening national governance and management for HRH leadership and regulation
- Supporting the normative role of WHO and the facilitation role of GHWA
- Strengthening the evidence base, learning from success and failures
- Developing national mechanisms for HRH reporting and accountability
- Moving towards a more responsive and accurate HRH benchmarking system

The Third Global Forum on HRH, and the political document that will be adopted by it, provide an opportunity to make a strong commitment to this agenda, and to ensure that health workforce challenges are recognized as a global issue, and not just one affecting 57 developing countries.

1. Introduction and objectives of the consultation

Dr Bjorn Guldvig (Directorate of Health, Norway), Ms Villa Kulild (Norad, Norway), Dr Rüdiger Krech (WHO/HQ, GHWA), Dr Hans Kluge (WHO/EURO)

On 4 and 5 September 2013, the World Health Organization (WHO) and the Global Health Workforce Alliance (GHWA), in collaboration with the Directorate of Health of Norway as well as The Norwegian Agency for Development Cooperation (Norad), organized a consultation on Human Resources for Health in High Income Countries, hosted by the Directorate of Health in Oslo. The consultation brought together Government officials and representatives from other constituencies in high income countries (HIC) to create momentum and to bring visibility on the health workforce global development agenda.

The event was part of the preparations for the3rd Global Forum on HRH, which will take place in Recife, Brazil on 10-13 November 2013: the Forum is organized under the theme "Human Resources for Health: foundation for Universal Health Coverage and the post-2015 development agenda.

Shortages, maldistribution and uneven quality and performance of human resources for health (HRH) are challenges that affect countries at all levels of development, including HIC. The experiences in addressing them through adequate planning and forecasting of the health workforce in the context of limited resources, and broader trends such as demographic changes, migration, the rising burden of non-communicable diseases (NCDs) and other emerging diseases present valuable lessons to be shared with the global HRH community, and may provide a basis for articulating commitments to further improve access to health workers at regional, national and local levels. The implementation of the WHO Code of Practice on the International Recruitment of Health Personnel represents a key framework for actions to ensure ethical approaches to health workers migration and recruitment in countries and globally. Furthermore, collaboration among high and low income countries in improving access to health workers is a pre-requisite for achieving UHC and development goals globally.

The overall objective of the Oslo consultation was to develop a common understanding of HRH challenges in HIC and foster their engagement towards solutions. Specific expected results included:

1. Illustrate the framework and process to obtain HRH commitments, instrumental to attaining universal health coverage, to be announced at the 3rd Global Forum;
2. Greater understanding of possible solutions to common HRH challenges in HIC, through sharing of experiences and lessons learned, both in relation to the national and international HRH agendas.

This report reflects the broad range of views by different constituencies, and the interconnectedness of the various elements of health workforce development.

2. Global HRH challenges: an unfinished agenda - HRH situation in High Income Countries: overview of HRH trends in HIC since Kampala Declaration and new challenges for and beyond 2015

Dr Bjorn Guldvog, Director General, the Directorate of Health, Norway Prof. James Buchan (Queen Margaret University, UK), Mr Michael Schoenstein (OECD), Dr Matthias Wismar (European Observatory on Health Systems and Policies) Prof. Shinjiro Nozaki (Nagasaki University/ GHWA), Prof. Stefan Lindgren (World Federation for Medical Education) Ms Leslie Bell (International Council of Nurses), Mr Martin Ratz (Paragona Group)

2.1. Overview

The critical shortage of health workers across the world, exacerbated in some low-income countries by migration to advanced economies, had been identified by the World Health Report 2006 as one of the most significant constraints to the achievement of health and development goals. While progress has been made to increase the number of health workers in some of the countries with the greatest need, it is increasingly recognized that the issue is more complicated than an exclusive focus on shortages would imply; it is a global problem, affecting all the countries in the world, including the high income countries, rather than just a development issue affecting poor countries.

A revamped global HRH agenda will be critical for moving towards, attaining and sustaining universal health coverage. This new agenda must provide answers to and address, besides shortages of health workers, a range of other issues, such as:

- An inclusive definition of "workforce": what skills mix is best to achieve the expected results in the most efficient way? What is the health workforce, whom does it include, in addition to health professionals? What is the role of front line health workers and back office staff? What is the relation between paid and informal workforce? Will lay carers also be included, as well as patients themselves and/or relatives?
- More intelligent use of data.
- Important to understand labour markets' dynamics for the health workforce.
- Different relevant stakeholders need to be involved in planning and projections: the planning needs to be flexible and adaptive
- The scenarios for HRH plans need to be costed, to indicate the boundaries of what is possible to do within the budget available.
- Need to go beyond pre-service education, and to integrate in HRH planning and management policy lessons learnt from initiatives on retention, upgrading of staff, distribution.
- Maintain quality assurance capacity through effective human resource management
- Ensure sustained political buy-in.

The recent financial crisis has had an impact on HRH and on the health workforce: for instance there is evidence that many health workers postponed their retirement for financial reasons, a trend which cannot continue. The patterns of migration of health workers into EU have also changed in the recent years: during 2001-2006, for example there was a massive inflow of nurses to

UK, mostly from non-EU countries. However, during the last few years the migration of nurses takes place more from other EU countries, due to the free movement of labour within the EU. Forecasting alternative scenarios of health workforce production, inflows and outflows allows identifying suitable policy options tailored to the needs and context of individual countries.

2.2.Financial crisis and its impact on the health workforce

The impact of the financial crisis on labour markets across OECD countries has been deep and long-lasting, heavily affecting employment. In the health sector, however, employment has held up relatively well compared to other sectors: there are more doctors and nurses in almost all OECD countries in 2012 than there were in 2008. Sources of growth in absolute numbers are instructive in highlighting crisis impact, for example:

- in a number of countries, doctors increased their effective retirement age;
- nurse retention improved, with nurses returning to work from inactivity or other jobs and/or deciding to work longer, like doctors.

However, it is difficult to ascertain whether this is a more cyclical (market-driven) or rather structural change (population and policy-driven). Current Human Resource policies in the OECD bloc may reflect these developments, with more emphasis on using existing Human Resources better and longer, e.g. through better retention, and longer working life spans.

There has been a change in HRH policy focus of governments since 2010. Up to 2008-2010, the main issue perceived as a policy concern was sufficient staffing, i.e. growing the overall number of health workers. Since then, countries signal that the main HRH policy concerns now are:

1. the geographic distribution of doctors;
2. the specialty choice of doctors, especially general medicine gaps;
3. better task sharing between profession and better team delivery of services.

Health workforce policy making in HIC should use the triggers for reform originating from the crisis to continue developing better long-term planning capacity, while at the same time trying to alleviate pressures to reduce budgets for healthcare in the short term. As health workforce trends are driven by long-term fundamentals, such as demography and population health, including long term care for elderly, and characterized by long time lags (especially for doctors), countries need to focus today's decisions on estimates for 10-20 years in the future, taking into consideration not only numbers of health workers but also ensuring they have the right skills mix, right training, quality and geographical distribution. Therefore investment in dealing with uncertainties in the future is necessary.

The devolution to quasi-public agencies of some government responsibilities relating to health workforce planning and management (as has been observed in the UK, the Netherlands, Australia) can be a model of interest to other countries. Potential advantages of such initiatives may include:

- Better integrating technical know-how into the policy process.
- Shifting from one-off "plans" to continuous monitoring and constant evolution of plans.

- Wider inclusion of stakeholders across different sectors (health, education, treasury).

2.3.Health professionals mobility in the European Union

Health professionals have always moved to, from and within Europe for work and other reasons. However, concerns about the scale of movement are increasing. New patterns of disease, new technology and increasingly global markets have multiplied pressures in countries and on health systems. Professional mobility is a civil right for EU, EFTA (Norway, Iceland, Liechtenstein) and Switzerland citizens. There is a mutual recognition scheme in which some professions (medical doctors, nurses, dentists, pharmacists) are regulated and accredited.

The patterns of health workforce migration have changed: brain drain in its traditional sense from the resource poor countries to the developed world is no longer the largest source of migration, as the intraregional mobility in EU has become as important as interregional one. There is no-longer a clear division between receiving and sending countries. Moreover the situation is changing rapidly, and the flows of migration may change depending on the need and preferences, as well as the financial situation. On the other hand, in many countries health worker positions remain unfilled; and the education pipeline is not preparing qualified health workers with the right skills mix for the positions needed.

Domestic HRH planning policies do not address regional concerns, or take into account regional market dynamics: countries that are doing better in attracting doctors and health workers have their needs fulfilled, while others may see the benefits of their investment in training accrue to other countries in the region. Within Europe, the health workforce mobility remains an issue which causes political concern, but no political consensus on what measures should be taken for the region has been reached.

2.4.Demographic change and impact on HRH in a "super ageing" society (Japan)

Japan, with a population 65 years and above representing 23.7% of the total, is the first "super aged" society in the world. In this demographic scenario, the working population is reduced and medical expenditures increase due to growing health care needs of the aged, in particular to treat non communicable diseases which often require costly long-term care.

The reduction of the working population has caused a shortage of care-givers and nurses, as well as bigger gaps between urban and local areas. The problem is aggravated by the fact that the young people are not interested in working in health care jobs, as the training takes long and the salaries are not attractive compared to the time taken by education and the long hours of work. The government is addressing the shortage of health workers through importing nurses and care givers from Philippines, Vietnam, Thailand and China under Economic Partnership Agreement scheme since 2008.

However, the countries where Japan is importing health workers from are themselves likely to face problems due to ageing populations. Asian countries, where the ageing populations are likely to

become an issue, will need to learn from lessons from Japan and other countries that have already had to address the consequences of aging populations to the demand of health workers.

2.5.Challenges in medical education

While the education of health professionals continues throughout their careers to ensure that they can integrate the advancements in medicine into their work to continue providing quality health care, there is a need for changes in the role of medical doctors. Their function should focus more on health promotion as a member of the society and on long-term management of chronic diseases, not only on making diagnosis and prescribing treatments. In today's education there is emphasis on specialization and treatment, but the training should also focus more on competencies and dialogue with patients and on their role as leaders or members of health teams.

The education of medical doctors should be planned and implemented with the expected future needs of patients and societies in mind, and not on the needs of specific health care professional categories. Technology provides opportunities to enhance training and medical care. The role of medical professionals is important also in assessing and responding to the needs of societies and patients. As a consequence of increased international mobility of doctors and patients, medical schools need to include an international / global health dimension.

2.6.Challenges in nursing shortages

In an economic downturn, the nurses tend to get targeted first for a downsizing of both their training and employment numbers. The financial crisis, which has caused many nurses to continue working longer than before and delay their retirement, has meant that the nursing workforce is aging.

Nursing has for a long time been seen as undervalued women's work. To make the profession more attractive, especially in HIC, changes are warranted to how health care is delivered. Recruitment and retention policies are also critical in making nursing an attractive career choice, and require strong political will to make the changes needed, including improving the skills mix, having more flexible working environments and working hours. Reforms must be implemented to increase productivity in the health care team and to implement positive practice environments. Also technological advances impact on delivery of care, and need to be integrated into the education.

In Europe and North America demographic trends characterized by fewer people employed and more retired raise questions on how these societies will be able to finance the employment of the number of nurses that will be required for long term care of the elderly. More emphasis needs to be given to preventive strategies, and corresponding changes in the roles and responsibilities of the health care delivery team. New models need to be developed for providing care more cost-effectively outside of hospitals, addressing the needs of aging population and long-term care.

Different settings have different needs and roles for nursing professionals. These must be evaluated, and in particular the definition and education requirements of nurse practitioners need to be developed and agreed on. It is important to reach a consensus on how the different roles will be

rolled out in different settings: for example, nurses can be given more responsibilities in the organization of hospital workflows and hierarchies. However, attention needs to be paid that the new tasks are matched with a new set of skills, and to avoidance of value clashes.

2.7.Private sector recruitment agency experiences

Findings from an analysis conducted by a private for-profit recruitment company working on cross-border recruitment and training of 1000 senior healthcare professionals across 18 EU states during 2003-2013 show that its activities are strictly demand-driven: requests for staff are received from hospitals within Europe, and the contracts of employment that are established are conditional upon completion of a training course and satisfactorily meeting accreditation requirements in the destination country. Success factors underpinning the business model of private recruiters include a very close interaction with key stakeholders (employers, healthcare professionals and training organization) in searching and planning the employment path, and tailor-made training designed to bridge linguistic, cultural and practice differences.

Effects on healthcare migration within the EU as a result of the economic crisis have been very dynamic, making forecasting exercises more difficult. In the EU there has been a general shift in migration from "East to West" to "South to North". Recruitment agency mechanisms can be adapted to a broader or different context, to bridge gaps in the shortage or skill mix of health workers, while at the same maintaining close collaboration between the HRH planning globally and recruitment agency activities to avoid situations where staff is recruited from one service to another, and merely shifting the shortage from one locus of the health system to another. In areas where there is an extraordinary high level of unemployment, it is possible to develop training programmes for the unemployed.

An ethical Code of Practice for private sector recruiters should also be developed to enhance recruitment standards, for instance recommending against recruiting from other hospitals or health care facilities which might as a result face a staffing shortage themselves.

3. Actions in HICs to address HRH challenges and country experiences in implementing the WHO Global Code of Practice

Dr Nils Daulaire (Global Affairs, HHS, USA), Mr Michel Van Hoegaerden (EU Joint Action), Dr Daniel Reynders (International Relations, Federal Public Service Health, Food Chain Safety and Environment, Belgium), Ms Ulla-Maija Laiho (Ministry of Employment and Economy, Finland), Mr Tjitte Alkema (European Hospital and Healthcare Employers' Association), Ms Linda Mans (Wemos Foundation), Ms Katie Drasser (Aspen Institute)

3.1.United Sates experiences in implementing the WHO Code of Practice

The United States Government is utilizing aspects of the Code for strengthening the Health Systems, especially in relation to nursing and midwifery. A system to track data domestically and internationally has been established. For the implementation of the Code, the US Government is working both domestically and internationally with the purpose of strengthening the health system

through training of health workers in sending countries and of reducing the pull factor in the US: collaboration with different stakeholders is a key element. The Code has provided a new push to pay attention to health workforce issues, and emphasized the fact that it is a global issue and not only a national one.

Related to its development assistance, the US government is building HR capacities in countries to strengthen health systems. PEPFAR has an explicit target for training and retention of more than 140,000 new health care workers to strengthen health systems in highly AIDS affected countries. This will continue to be done through 3 initiatives that were established for the purpose: International AIDS Education and Training Center (I-TECH) for doctors, Medical Education Partnership Initiative (MEPI) and Nursing Education Partnership Initiative (NEPI). In 2013 the Global Health Service Partnership (GHSP), a program that aims to improve clinical education, expand the base of physician and nursing educators and build healthcare capacity in countries that face critical shortages of healthcare providers, has sent the first cohort of American medical and nursing educators to resource-limited countries.

Domestically the Health Resources and Services Administration (HRSA) and the Office of Global Affairs (OGA) at the U.S. Department of Health and Human Services have been designated as the joint National Authority, and they guide the implementation of the Code. The United States is a complex environment to work in due to different federal agencies, and health care governance is at state level. Therefore the Code implementation needs customized and specific approaches to work with different partners. As part of the efforts to strengthen health systems domestically, the government is aiming to train more health workers and provide access to services for those with no insurance. These efforts have had the following results: 30% Increase in enrollment in medical school; 24% more nurses registered; 69% medical assistants increase. The National Health Service Corps seek to expand coverage to 10.4 million people in underserved areas.

It is foreseen that if the new insurance coverage moves to implementation phase, the demand for health care and accordingly for health workers will increase. The Code implementation becomes critical, and the right to move will need to be set against not trying to attract only the best health workers globally, but to build the existing workforce and production of the workforce domestically as well.

3.2.EU joint action on health workforce planning

The "EU joint action" is a mechanism for EU countries to collaborate on HRH issues. Its objective is collaboration and exchange among member states in Europe and to improve planning of HRH. It aims to involve the participating countries for sharing experiences and practices on methods and implementation, for developing common processes, mechanisms, and guidelines for planning and forecasting HRH, as well as for collecting data and conducting studies to inform planning. Currently only some European countries are doing planning and forecasting systematically. The Joint action will have a shared objective to implement the Code within Europe and internationally. Its importance is in making politicians know what effects their decisions may have and to turn political discussions into real actions.

In the EU regional context it is easier to manage change and migration than globally because there are existing mechanisms for such intraregional collaboration.

3.3.Health workforce planning in Belgium

In Belgium there is in general a good access to health workers, aided by its health insurance system and concerted efforts to retain health workers. National authorities, insurance companies and professional associations discuss together every year the needs for the following year. Even with these efforts, there are still challenges in planning and forecasting the numbers of needed health workers, including nurses, general practitioners, specialists. However, the landscape is changing with aging of the population, migration, and globalization forces. Therefore it is important to start thinking now 10 years ahead, and not to limit planning to annual cycles: in planning for the future it is critical to assess whether the need for health workers is real or as perceived by professional associations. There might be tendency towards a proliferation of specialties and sub specialties, which may distort the real need for health workers and not serve all those in need.

3.4.Inter-ministerial collaboration for health workforce planning in Finland

In Finland the top priority for the Government is welfare and social services, and concerted efforts are made to improve them. The Government started in 2009 a programme (HYVA) that encourages public and private actors to work together to provide social and welfare services, aiming at empowering citizens through the right to choose between alternative providers.

The potential efficiency and workers' motivation gains possible by privatizing the health services should be balanced with the principles of preserving equity and people's access to health care, especially in a period of financial crisis and austerity measures.

For workforce planning an inter-ministerial collaboration has been set up, which includes ministries of finance, education, social and health representing 90% of public expenditures. In planning for health workforce, the issues that are looked at are: the demand and supply of health workforce, forecasting, attractiveness of the industry, among others. A model has been developed on how to analyze the needs of different industries, and based on these both short and long term forecasting is made. This is supported by collaboration with the trade unions. However, further developments for health workforce governance are needed, for example an ethical model for international recruitment, which represents a priority for the future.

3.5.Code of Conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector

The European Hospital and Healthcare Employers' Association (HOSPEEM) and the European Public Services Union (EPSU) signed in 2008 a Code of Conduct on Ethical Cross-border Recruitment and Retention, which has been implemented in HOSPEEM member countries.

An issue that has risen in its implementation is that stakeholders do not always know what others are doing. In ensuring a sustainable health workforce, while understanding that health care

availability is becoming health care consumption, it is critical to engage employers, professional associations, governments. The discussions between stakeholders should include discussion on cost-effectiveness consideration. More social dialogue is called for to develop a sustainable workforce, taking into consideration labour productivity and good working conditions for the health workforce, in search for solutions for the future.

3.6.Civil society action for health workforce

Sustainability globally in health care and health workforce should start at home – at national level and in Europe. Public health objectives and health workforce development and management have political dimensions, and choices are made often based on political priorities, for example, in terms of creating or maintaining jobs. As health inequities are increasing, one of the main questions European CSOs are looking at is how to ensure that everyone continues to have access to a qualified health provider despite the conditions triggered by the current economic cycle. The migration and mobility of health personnel in Europe are impacting on the availability of qualified health providers for European citizens. According to CSOs, this calls for fundamental debates about the future of welfare and health care, focusing on the need for solidarity and equal access to care. Crucially, it will also require a coherent approach by the European Commission and EU, and the national ministries of Health, Welfare and Sport, Economic Affairs, and Foreign Affairs.

CSOs' efforts in eight EU-countries within the Health Workers for All project include translation of the COP and HOSPEEM code and the facilitation of dialogue at national and European level between the actors involved in training, recruiting, retaining and deploying health care workers. By working together to identify opportunities and avenues for promoting a sustainable and fair national health personnel policy, this multi-stakeholder approach has been enabling to join forces and pool professional expertise to stimulate policy and activities geared to this objective.

3.7.Summing up: planning for future HRH

Health workforce planning has to continue moving from simplistic and static models to the understanding of the complex nature of HRH. The planning for the future must start now, and not to be limited to the implementation of the WHO Code: WHO should lead the rethinking of the health workforce agenda looking 20 years ahead.

Effective planning will require a long-term horizon, and an evidence-informed scanning of present and future anticipated challenges. The absolute number of health workers is likely to continue growing: in future forecasting models, however, there should be a move away from planning only for the numbers of health personnel to be educated, taking into consideration labour market dynamics, of which education is an important dimension, but not the only one. Health workforce planning, rather, needs continuous monitoring and adaption according to the changing environment and the evolving demand and supply conditions.

Different systems and work environments require different health workers, and more importantly the requirements are for different sets of skills. The health worker roles and norms need rethinking. There needs to be space for task shifting and new responsibilities, new ways for health workforce

to carry out their responsibilities. Lessons can be learnt from other countries and regions: for example in Africa nurses prescribe medicines, whereas in some HIC they are not allowed to. There is need to put more emphasis on preventive medicine, and the profile of health professionals need to be redesigned according to what is expected from health care systems in achieving Universal Health Coverage.

The planning of health service delivery must be from a system point of view, looking at the different competencies that are required and not only from the point of view of different professions. Another common theme and lesson learned emerging from a review of past and ongoing planning and policy experiences relates to the need to engage different sectors and levels within government and other priority stakeholders in society, so as to guarantee broad ownership and enhance implementation and sustainability of health workforce development strategies.

4. **HRH challenges in achieving UHC and in post 2015 agenda - preparing commitments for the 3rd Global Forum and beyond**

Giorgio Cometto (Global Health Workforce Alliance), Mr Emmanuel Lebrun-Damiens (France), Dr David Weakliam (Ireland), Dr Otto Christian Ro (Norway), Mr Bjarne Garden (Norway) Dr Rüdiger Krech (WHO).

For the 3rd Global Forum for HRH countries, development partners, international agencies, and all national and international actors with a stake in health workforce development are invited to make new HRH commitments to advance the health workforce agenda. Effective strategies that address in a sustainable manner deep-seated challenges require a long-term perspective, with multi-stakeholder and multi-constituency collaboration.

Commitments made are expected to follow certain pathways where the most effective intervention and their interrelatedness to improve the situation of HRH have been proven. A template has been developed for the partners and stakeholders to assist them to identify the relevant pathways which their planned commitments can follow to ensure the maximum impact for improving the health workforce in their countries or constituencies. The template draws on the WHO Code, and the different policy documents that Member States have endorsed that call for action on HRH.

The commitments will be shown throughout the 3rd Global Forum and will be reflected in the outcome document of the Forum. The country specific commitments will be added as an annex to the outcome document.

4.1.France's commitment to HRH within MNCH (Muskoka Initiative)

France will use the template for engaging different ministries to develop domestic commitments for HRH. The template might help in convincing decision makers that HRH is an important topic, and how the issues related to HRH and migration are dealt with has consequences.

One of the most significant examples of the commitment by the French Government to international efforts at health workforce development is a multi-agency (WHO, GHWA, UNFPA, UNICEF,

UNWomen), multi-country (11 Sub-Saharan countries) programme, focused on reproductive, maternal, newborn and child health in the context of the G8 Muskoka Initiative. Within this programme, the focus on HRH is concentrated on midwives, aiming to build synergy among partners and working with local government to improve quality of midwifery schools.

France welcomes a systems thinking for HRH planning to be brought to 3rd Global Forum. Current MDGs are vertical, and there needs to be more focus on systems thinking. The 3rd Global Forum should send a clear message that HRH must be in the post 2015 development agenda, including through one indicator on HRH in the post-MDG framework.

4.2.Ireland's roadmap to commitments on HRH

The HRH situation in Ireland was in the past characterized by a widening gap between demand and supply, and hence Ireland resorted to recruitment from overseas. Challenges include a lack of coherence between domestic policies and policies for development collaboration – the latter awarded a high priority to HRH as part of its bilateral and multilateral programmes, whereas the former became reliant on recruitment from low income countries due to weak human resources planning.

Drivers of change have included the economic downturn, which provided impetus to link the global and domestic agendas and improve service and HRH planning. The WHO COP was helpful as an instrument in defining how to respond to global responsibilities. Irish Aid and HSE signed a Memorandum of Understanding and started joint activities to strengthen HRH in low income countries. Domestic HRH planning was better aligned to service delivery (clinical programmes, task shifting) and production was increased to meet workforce service needs. An important component in the new planning was stakeholder collaboration, and the promotion of a - more integrated and coordinated approach among different government departments.

Domestic HRH commitments in Ireland will relate to strengthening clinical programmes, medical workforce planning, including a more efficient skills mix, and to enhancing nurse training and retention; on the international agenda, Ireland will strengthen its bilateral and multilateral institutional partnerships for postgraduate medical training, technical assistance, advocacy – including GHWA – and research.

4.3.Norway's plans for commitments

Norway, building on its very active role in negotiations leading to adoption of the COP, is now implementing its recommendations domestically and internationally. Long term domestic planning for HRH is done by forecast modeling every 3 years, balancing supply and demand. The forecast has been updated every 3 years with a time line of 20 years ahead. In the future (8 years) it is foreseen that there will be shortage of nurses, but a sufficient number of physicians. Overall, policy commitments for HRH are reflected in many relevant white papers referring to the domestic policy environment. The priority is to take care of domestic issues first before addressing the global needs. Currently there are plans to improve hospital care with better and more efficient skills mix and opportunities for task shifting.

Tentative international commitments by Norway may include: contributing to the compliance with the COP internationally (including in partnership with Aspen, WHO, GHWA), supporting efforts to alleviate HRH challenges in developing countries through education, retention efforts and innovative strategies, HRH advocacy through Norway's health diplomacy, supporting WHOs normative role, including in the HRH domain, supporting multi stakeholder coordination and mechanisms (such as GHWA)to provide a global leadership to the HRH agenda.

4.4.Other potential commitments

Other countries and institutions are considering their commitments to the HRH agenda:

- For instance Germany has restricted recruitment from the 57 countries deemed to have a critical shortage according to the World Health Report 2006, and is implementing initiatives to improve availability of health workers through mobilization of domestic labour force and by raising the retirement age
- The 1 Million Community Health Workers Campaign will strive to ensure the CHW plans it is supporting are mainstreamed in national plans and mechanisms.
- The health workforce migration policy council will continue advocating on the implementation of the Code, and can help in ensuring accountability of commitments.
- The United States reconfirmed their existing commitments and will continue ongoing efforts. In the future they are looking to expanding the evidence base on effective HRH approaches, and will focus on change management and decision making.

4.5.Summing up: committing to HRH change domestically and internationally

Preparing commitments to be announced at Recife provides a unique opportunity for high income countries to develop a clear vision on how their domestic contributions fit in the global HRH agenda. For example, Ireland's shift from international recruitment to domestic self-sufficiency represents a development that can represent a contribution to the global HRH agenda.

This is a unique opportunity for high income countries to bring their HRH challenges and solutions within a global discourse. It is important for the high income countries to make domestic commitments, but their role in the global solidarity mechanisms will require international commitments from them as well. The commitments may be based on the commitments framework, but also respond to the demands for the implementation of the Code of Practice. The commitments can also couple international development with domestic issues.

5. Conclusions

Prof James Buchan (Queen Margaret University, United Kingdom)

There is a growing understanding of the inherent complexities in the HRH field, providing fresh opportunities to identify key entry points for policy intervention at system level. In future, technological advances, demographic trends, the relative growth of non-communicable diseases,

the impact of long-term care need to inform the planning and development of a fit for purpose health workforce.

Even though we know more about HRH, the political commitment for HRH can be further strengthened. It is critical to have new political commitments to bring HRH at the forefront of the UHC discourse, and high-income countries need to be an integral part of that discussion. The template for commitments provides a framework for action and innovation. At national level a coherent, coordinated "joined up" government approach (including health, education, finance, trade, aid sectors etc.) is needed, together with collaboration with other stakeholders for a coordinated response to HRH challenges.

Commitments could also be made that relate to:

- Promotion of HRH on the global agenda through a strong investment case.
- The Code of Practice as a convening instrument.
- Strengthening national governance and management for HRH leadership and regulation.
- Supporting the normative role of WHO
- Strengthening the evidence base, learning from success and failures.
- Developing national mechanisms for HRH reporting and accountability.
- Moving towards a more sophisticated HRH benchmarking system.

Health workforce challenges represent a global issue and not just one affecting 57 developing countries anymore. A different approach is called for to ensure that this challenge is truly understood and managed as a shared global priority. Partnerships and collaboration are key for making the case for HRH and finding solutions. The global outcome document from the 3rd Global Forum will need to express this.

The Global Health Workforce Alliance is hosted and administered by the World Health Organization

Consultation on Human Resources for Health in High Income Countries
Preparatory meeting for the 3rd Global Forum on HRH

The Directorate of Health, Universitetsgaten 2, Oslo, Norway
4 September 2013

Hotel Scandic KNA, Parkveien 68, 0202 Oslo, Norway
5 September 2013

Agenda

OBJECTIVES OF THE MEETING

Enhance common understanding of HRH challenges by the High Income Countries and increase their engagement in advancing global HRH solutions

Specific expected results:

1. Outline for commitments to be articulated around the actions required to overcome HRH barriers, improve coverage and attain UHC, to be announced at the 3rd Global Forum, bearing in mind the Kampala Declaration (2008) and the WHO Global Code on Practice of International Health Personnel Recruitment (2010).
2. Greater understanding of joint and complementary actions available for high and low income countries through contributions from HICs into the global HRH agenda on:
    a. shared experiences on HIC dilemmas and solutions in HRH and
    b. models among HIC on tackling issues related to equitable distribution of health workforce – at national and global levels.

Timetable

DAY 1, Wednesday, 4 September 2013 The Directorate of Health, Universitetsgaten 2, Oslo		
17:00-17:30	Opening plenary: Welcome and Introductions Overview and expected outcomes	**Dr Bjorn Guldvig** (Directorate of Health, Norway) **Ms Villa Kulild** (Norad, Norway) **Dr Rüdiger Krech** (WHO/HQ, GHWA)
17:30-18:00	HRH in achieving UHC, 3rd Global Forum on HRH	**Dr Rüdiger Krech** (WHO/HQ, GHWA)
18:00-18:30	Approaches to HRH in EURO	**Dr Hans Kluge** (WHO/EURO)
20:00	Dinner at Hotel Scandic KNA	Hosted by the Directorate of Health, Norway

DAY 2, Thursday, 5 September 2013 Hotel Scandic KNA, Parkveien 68, Oslo		
08:30-08:45	Keynote: **Global HRH challenges: An unfinished agenda**	**Prof. James Buchan**
08:45-10:15	Panel discussion: **HRH situation in HICs**: overview of HRH trends in HICs since Kampala and new challenges for HRH now and beyond 2015	Health workforce priorities and trends in OECD countries after the financial crisis, **Mr Michael Schoenstein** (OECD). Findings of the PROMeTHEUS Project, **Dr Matthias Wismar** (European Observatory on Health Systems and Policies). Demographic change and impact on HRH in super aging society, **Prof. Shinjiro Nozaki** (Nagasaki University/GHWA) Challenges in medical education, **Prof. Stefan Lindgren** (World Federation for Medical Education) Challenges in nursing shortages, **Ms Leslie Bell** (International Council of Nurses) Recruitment Organization experiences from the field, **Mr Martin Ratz** (Paragona Group) Moderation: **Dr Bjorn Guldvog**, Director General, the Directorate of Health, Norway
10:15 - 10:45	**COFFEE BREAK**	
10:45 - 11:00	Keynote: **US experiences in implementing the WHO Code of Practice**	**Dr Nils Daulaire** (Global Affairs, HHS, USA)
11:00-12:30	Panel discussion: **Actions in HICs to address HRH challenges and country experiences** in implementing the WHO	Response of EU countries to HRH challenges, EU Joint Action on health workforce planning and forecasting,

	Global Code of Practice	**Mr Michel Van Hoegaerden** (EU Joint Action) Reflections on the profile of health professions in the 21th century, **Dr Daniel Reynders** (International Relations, Federal Public Service Health, Food Chain Safety and Environment, Belgium) Inter-ministerial cooperation in health workforce planning, **Ms Ulla-Maija Laiho** (Ministry of Employment and Economy, Finland) Code of Conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector, **Mr Tjitte Alkema** (European Hospital and Healthcare Employers' Association) Civil Society engagement, **Ms Linda Mans** (Wemos Foundation) Moderation: **Ms Peggy Clark**, Vice President of Policy Programs, Executive Director of Aspen Global Health and Development, Health Worker Migration Global Policy Advisory Council, Aspen Institute
12:30 - 13:30	**LUNCH**	
13:30-16:00	HRH challenges in achieving UHC and in post 2015 agenda - preparing **commitments for 3rd Global Forum** and beyond Introduction to 3rd Global Forum Commitments framework	Introduction to the Commitments framework by **Dr Giorgio Cometto** (GHWA) Country examples of commitments: **Mr Emmanuel Lebrun-Damiens** (France) **Dr David Weakliam** (Ireland) **Dr Otto Christian Ro** (Norway) **Mr Bjarne Garden** (Norway) Moderation: **Dr Rüdiger Krech** (WHO/HQ, GHWA)
16:00 - 16:30	**COFFEE BREAK**	
16:30-17:00	**Conclusions and recommendations** **Closure**	Moderation: **Prof. James Buchan**

List of participants

Oslo consultation on HRH

4-5 September 2013

Countries

Austria
Ms Ludmilla Gasser
Deputy Head
General Legal Affairs and Health Professions
Federal Ministry of Health
Vienna

Belgium
Dr Daniel Reynders
Head of Service
International Relations
Federal Public Service Health, Food Chain Safety and Environment
Brussels

Mr Michael Van Hoegaerden
Programme Manager
Joint Action Health Workforce Planning & Forecasting
Federal Public Service Health, Food Chain Safety & Environment
Brussels

Denmark
Dr Birte Obel
Head of Division
Education and Registration, National Board of Health, Department of Education & Registration
Copenhagen

Finland
Ms Ulla-Maija Laiho
Director of Development
Ministry of Employment and Labour
Helsinki

France
Mr Emmanuel Lebrun-Damiens
Head of Department for Health, Food Security and Human Development
Ministry of Foreign Affairs
Paris

Germany
Ms Natalia Melkoserov
HRH – GIZ
Bonn

Dr Angelika Schrettenbrunner
Senior Advisor Health Systems
GIZ
Bonn

Ireland
Dr David Weakliam
Consultant in Public Health Medicine
Department of Public Health, HSE-Area Office
Tullamore, Co.Offaly

Norway
Dr Bjørn Guldvog
Director General
Directorate of Health
Oslo

Ms Villa Kulild
Director General
Norad
Oslo

Ms Tonje Borch
Director
Department of Global Health
Directorate of Health
Oslo

Mr Bjarne Garden
Director
Department for Global Health, Education and Research
Norad
Oslo

Dr Jon Espelid
Adviser
Ministry of Health and Care Services
Oslo

Dr Otto Christian Ro
Project Director
Department of Global Health
Directorate of Health
Oslo

Mr Kristian Roksvaag
Senior Advisor
Department of Education and Health Personnel
Directorate of Health
Oslo

Dr Hilde C Sundrehagen
Director
Ministry of Health and Care Services
Oslo

Dr Anders L Tysse
Senior Adviser
Ministry of Health and Care Services
Oslo

Spain
Mrs Pilar Carbajo Arias
Deputy Director for Professional Regulation
Ministry of Health, Social Services and Equality
Madrid

Sweden
Mrs Eva Wallin
Head of Unit, NDO for COP Human Resources for Health
National Board of Health and Welfare
Stockholm

Switzerland
Ms Delphine Sordat Fornerod
Deputy Head - NDO for COP HRH
Division of International Affairs, Federal Office of Public Health
Bern

United Kingdom
Dr Nick Tomlinson
Head of EU and Global Affairs
Department of Health
London

United States of America
Dr Nils Daulaire
Assistant Secretary for Global Affairs
Department of Health and Human Services
Washington D.C.

Dr James Heiby
Medical Officer
HCI Chief Technical Officer
USAID
Washington D.C.

International Organizations and partners

The Aspen Institute
Ms Katie Drasser
Deputy Director
Aspen Global Health and Development
Washington D.C., USA

Earth Institute, Columbia University
Dr Joanna Rubinstein
Assistant Director, The Earth Institute for International Programs
Special Advisor to Prof. Jeffrey D. Sachs
New York, USA

European Hospital and Healthcare Employers' Association
Mr Tjitte Alkema
Secretary General
Brussels, Belgium

International Council of Nurses
Ms Lesley Bell
Consultant, Nursing and Health Policy
Geneva, Switzerland

International Labour Organization
Ms Christiane Wiskow
Health Services Specialist
Sectoral Activities Department
Geneva, Switzerland

Norwegian Knowledge Centre for the Health Services
Dr Sigrun Mogedal
Special Advisor
Global Health Unit
Oslo, Norway

OECD
Mr Michael Schoenstein
Economist
Health Division
Paris, France

Paragona
Mr Martin Ratz
Group CEO
Stockholm, Sweden

Wemos
Ms Linda Mans
Health Advocate
Amsterdam, The Netherlands

World Federation for Medical Education
Prof Stefan Lindgren
President
Copenhagen, Denmark

World Health Organization

Headquarters
Dr Rüdiger Krech
Director, Ethics and Social Determinants of Health
Responsible, 3rd Global Forum on HRH, GHWA

Dr Giorgio Cometto
Adviser to Executive Director
GHWA
Ms Taina Nakari
Programme Officer
GHWA

Prof Shinjiro Nozaki
Nagasaki University, Japan
External relations, GHWA

Dr Amani Siyam
Technical Officer
Human Resources for Health

Regional Office for Europe
Dr Hans Kluge
Director
Health Systems and Public Health

Dr Galina Perfilieva
Programme Manager
Human Resources for Health

Dr Matthias Wismar
Senior Health Policy Analyst
European Observatory on Health Systems and Policies

Independent expert
Professor James Buchan
The United Kingdom

Observers
Mr Kim Terje Loraas
Senior advocacy advisor
Save the Children, Norway