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Dear Jim,

Technical Working Group Consultation Papers 1 to 8

Thank you for the opportunity to comment on the initial papers which we feel provide an important mechanism for updating and adding momentum to the global human resources for health agenda.

There is an enormous amount of material to be commended and we wish to thank all those involved in the preparation of these papers for their hard work. Set out below are comments where we see either gaps or opportunities for the future. These comments should not be viewed as a criticism but rather an opportunity to push and shape thinking.

Approach

In our comments we have particularly focused on two aspects:

1. The implications for nursing based on the fact that the nursing scope of practice has been shown, time and time again, to be amenable to change based on population and patient health needs and due to the fact that nursing has been particularly successful in delivering services to the most vulnerable and hard to reach populations. We see nursing as central to any future HRH strategy designed to address universal health coverage and the post-2015 development goals.

2. Systems level comments that we feel need to be addressed so as to bring coherence, efficiency, effectiveness and sustainability to any future strategy.

General

Clearly, due to the nature of the development of the eight working papers, there are some overlaps and some gaps. As we understand it, a single coherent document will be produced in the coming months and we welcome this approach.

It will be important that a single set of explicitly stated assumptions are extracted from the various working papers as these will help frame a future orientated approach and offer a sound foundation for informed and coordinated action.
Care should be taken to identify added value interventions or work-streams that will address multiple agendas. It is clear that some common problems are repeatedly identified across the eight papers and these need concerted effort.

- Lack of agreement on new models of care delivery, holistic in their approach, targeted towards population health needs and based on geographic distribution.
- Lack of workforce and education capacity data that is valid, reliable and comprehensive.
- Models of education that are clinically rooted in centralized facilities with high-technology specialist care delivery and that fail to address a prevention, patient centered, community based approach.

Economic, Demographic and Epidemiological Transitions

- The paper raises a number of important issues but, in terms of the epidemiological transitions, fails to acknowledge the major shift in the burden of disease towards non-communicable disease. This will require a community orientated, prevention focused approach. This has implications for the health care delivery model.
- The changing nature of generational cohort-values is not addressed and, since employment values and career patterns have shifted away from a model of careers for life to one of multiple careers, this needs to be addressed as part of a comprehensive workforce plan.
- We welcome the recognition that a wider group of actors need to be involved in workforce planning.
  - New professional regulatory models are needed to address patient protection, contribute to the availability of real time data on workforce competence and capacity, as well as optimised data transfer that facilitates mobility (Benton et al. 2013a).
  - In addition to the comments on ASEAN, we would also highlight that there are some interesting shared jurisdictional developments within the CARICOM area and also, due to the different constitutional arrangements, some of the development lead by the National Council of State Boards of Nursing (www.ncsbn.org) with regards the ‘compact’ arrangements and work on advanced nursing practice.
  - Developments such as ‘The Professional Card’ arrangements amongst regulatory authorities within the EU also provide the potential for further collaboration and access to valuable tracking data. In the fullness of time this may lead to shared services and/or common or at least aligned systems.
- A stronger connection to the education sector is needed since one of the major limiting factors is the availability of faculty. Little is known about faculty migration and, with the globalisation of the education market, this
needs to be seen as an area for priority work (Benton et al. 2013b). For the future, faculty need to work differently, be prepared to support learner-centred and team-based approaches to programme delivery and equipped to optimise technology as a means of initial and ongoing educational content delivery.

- The behaviour of high-income countries with regard to educational investment during times of recession adds to the boom and bust cycle of global migratory demand. The counter cyclical impact in high income countries, where established nurses seek additional hours or delay retirement during economic downturns, results in newly qualified students being unable to enter the employment market. Failure to consolidate their experience can result in them being lost to health care but further data on this is also needed.

- Educational institutions need to be facilitated to play to their strengths so as to avoid the development of boutique programmes that have limited uptake and questionable sustainability. Examples such as collaboration across institutions in some African countries and development such as the University of the Highland and Islands in Scotland are models worthy of closer examination.

- We concur with the comments that the WHO code remains unfinished business.
  - We believe that data from commercial companies on recruitment patterns could prove valuable in deciding on both pre-registration and post-registration educational investment needs – what are the specific roles and competence gaps that employers are seeking to ‘import’.
  - We note the comment on the lack of information on non-doctor or non-nurse cohorts but we wish to point out that, globally, the model of nurse-midwife is the commonest model. There is certainly a high demand for midwifery faculty and this is a point that we would wish to link to our previous comments on faculty migration.

Transformative Education

- We note that the format of this paper offers a range of bullet points that, whilst intuitively correct, are not accompanied by the same level of research evidence as was presented in TWG1. Since significant financial investment will be needed to bring about the changes highlighted a stronger set of evidence-based arguments needs to be made.

- There is a dissonance between the current educational model - which tends to be focused on centres of excellence usually in large cities where educational experience relating to a fragmented specialist approach to care is the norm - and the holistic burden of health needs found in
communities. We welcome the fact that this is hinted at in several statements but needs to be explicitly confronted if sustainable access to both education and health services are to be assured for the future.

- We are surprised that there is no explicit reference to the ‘theory-practice gap’. This has received considerable attention in both the professional and scholarly press but, as yet, has not been systematically examined so as to enable an informed and comprehensive set of solutions to be identified and applied. We believe that this is essential in terms of optimising investment and securing best outcomes. ICN is working on such a review at this time and although specifically focused on nursing we believe will have wider application for other practice-based disciplines (Pérez-Raya, F., Benton, D., González-Jurado, MA. - A systematic review of the theory practice gap).

Data and Measurement of HRH
While it is difficult to comment in the absence of a substantive paper, we do have a number of comments on the basis of the summary page that may or may not be addressed in the more comprehensive document.

- From a nursing perspective the current ILO classifications are increasingly less helpful in a practical sense and often lead to confusion. A more up-to-date set of definitions based on competencies rather than tasks are required. The ICN (2008) Continuum of Nursing Practice offers a good starting point to address this. We are currently in the process of updating this document to include articulation with educational level descriptors.

- ICN has developed an International Classification of Nursing Practice (ICNP) – which is acknowledged as part of the WHO classifications and has been fully implemented in a number of systems. The government of Portugal has mandated the inclusion of this in the patient record and, as a result, it is possible to track the most frequently performed nursing interventions. This also provides useful data in helping to align curricula on continuing competence requirements. Such data systems need to be considered as part of any real-time, comprehensive approach.

- With the advancement of technology and the emphasis on UHC it will be important that data systems are able to support sub-national HRH data mapping and tracking. Approaches such as that used by the Brazilian government to map access to health care teams across their country’s geography has an important accountability as well as practical application. We would encourage wide-scale use of such techniques.

- We also wish to comment that the recent development of a number of HRH observatories seems to be facilitating a culture of trans-national collaboration and learning and we would encourage this development.
Accountability and Alignment with Post2015 Goals
We were unable to obtain access to this paper so we cannot offer comments but stand ready to do so should we receive a copy.

Leadership and Governance
Health systems are facing fast paced, dynamic change and are ever-increasingly more complex. We do not disagree with the points made in the working paper but feel there are several major omissions.

- The paper seems to be written from a top down perspective and fails to recognise the need for leadership and governance throughout the system. Resource decisions and opportunities for efficiency, effectiveness and quality improvement are system wide and therefore leadership is needed at all levels.

- Whilst we fully support the proposal that the very highest levels of political support are needed to secure the right level of investment we would also argue that a grounded, patient orientated approach to investment decision-making is essential for optimum outcome and efficient resource use. Those with the detailed knowledge of what is needed and what it will take to fix it must be included in the prioritization and allocation processes.

- In most countries nursing consists the major contributor to the HRH resource up to 80% of care and accounting for 50% of financial spend yet nurses are rarely involved in leadership and governance processes. Army’s throughout the world have recognised that in fluid environments leadership is needed at all levels and these leaders are empowered to act. Unfortunately in this paper there is no real focus on workforce empowerment and this, in our view, is a major omission. Lessons from such work as the Magnet hospital movement can offer many insights (Buchan, 1994).

- We agree with the five workforce imbalances and would add a sixth. Investments have often been disease focused and as a result workers have been subject to internal-country competition. A holistic (patient centred) approach to health care delivery rather than a competing parallel programme model is needed. The patient has health needs and as such the pregnant woman with HIV and TB that is overweight and suffering from diabetes needs to have all her needs met in a single one-stop system rather than as a series of fragmented encounters. This has major implications for the competencies required, educational preparation needed, resources deployed and the configuration of teams.
Fragile States
We concur with the need to respond to the specific circumstances of the state concerned and to move away from a one-size-fits-all approach. We also would like to reinforce and expand one recommendation and offer one additional perspective.

- Having worked extensively with our member associations’ in-country we are acutely aware of the pressures that uncoordinated responses can have. Multiple assessment missions all requesting similar information in differing reporting templates can place additional burdens on local capacity. Similarly overlapping and at times competing rebuilding initiatives need to be avoided. With a commitment to open and transparent approach greater focus on the use of shared data repositories that different stakeholders can both contribute to and draw information from need to be considered.
- We have seen the power and commitment of the diaspora who after a period of conflict may not wish to return to their country but may wish to provide support in other ways. Mobilisation of diaspora should be considered as part of at least the medium and longer term redevelopment planning.

Productivity and Performance
We had provided the references to the secretariat but these do not seem to have made it into the consultation draft so for completeness the references are as follows:


We have one additional comment with regard the paper and offer this for consideration.
- In relation to quality improvement both within the developed and developing world the use of technologies including mHealth-based apps should be evaluated as a means of capturing as a byproduct of clinical intervention data that not only supports clinical practice but also offers near-real-time quality improvement benchmark feedback.

Beyond the Health Sector
There are several points that we would ask you to consider in relations to both societal change and actions that can bring benefits to HRH demands.
• There is a need to explicitly address the role that the design environment can play in maintaining independence and minimising demands on health services. Housing that is designed to facilitate self-care will play an increasing role as societies age. The use of colour to enable individuals with failing eyesight to navigate their home or the location of power sockets at a level that is easy to access can help avoid trips and falls and facilitate independent living. The health sector needs to work with architects and builders to effect these changes.

• Similarly, good transport systems can not only improve access to well placed health facilities but also can play a role in facilitating the elderly to remain integral members of society.

• We also need to be aware that the structures of societies are changing. In some countries the young need to migrate away to find employment leaving the elderly behind. In such conditions a new conceptualization of community and family is required to facilitate care and support in communities.

• In other locations, such as in four African countries where we are working, initiatives such as the Girl Child Education Fund which supports the orphaned girl children of nurses to attend school, profound results can be achieved, such as far higher levels of girls going to tertiary education; massive reductions in teenage pregnancy; and the mobilisation of local communities to develop their own initiatives for boy children.

• We would therefore encourage the working group to think more radically about the nature and range of relationships that could help to have a positive impact both on the provision of HRH but also on reducing demand.

We hope that these comments are helpful and we very much look forward to seeing the next stage of the consultative document.

Yours sincerely

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Chief Executive Officer

References


