Human Resources for Health
Options analysis for Global HRH Governance post 2015

Summary of Phase 1 consultations
By Sigrun Møgedal

Introduction to Phase 1

The preliminary summary of Phase 1 consultations represents work in progress in response to the request by the Global Health Workforce Alliance (GHWA) Board to develop options forward for global multi-sector governance of actions on health workforce after the termination of the current GHWA mandate in its current form, hosted by World Health Organization (WHO).

Part 1 presents observations and reflections, captured during the consultations, on the status of HRH today, with a mixture of progress, opportunities and challenges.

Part 2 presents proposed HRH Actions in a table with national, regional and global actions, with the inputs received as a response to six clusters of "missed opportunities" in the HRH response so far. The tables are not meant to be exhaustive, but serve to highlight needs for action. Inputs to the tables have been received from GHWA partners and HRH stakeholders that have responded to the Phase 1 consultations, either through written inputs or in personal discussions.

Part 3 of the summary presents comments received in the consultation process which did not easily fit into the particular table format.

There is broad agreement that country action is "front and center" in building robust solutions. Countries that have been in dealing with access to health workers, have found different ways to respond. What they have in common is the capacity, creativity and determination to make use of domestic strength - and at the same time engage with international networks and international support in ways that contribute to the agreed national agenda.

Phase 2 of consultations will seek to further explore priority global HRH actions in order to overcome some of the current fragmentation and gaps in the global response. This will be the basis for discussing different options for collaborative action and alignment, including the option of a next generation global multi-sectoral/multi-stakeholder anchoring platform for human resources for health and social care. Written comments, questions and further inputs to these documents are very welcome (to ghwa@who.int), as well as inputs to consider in the Phase 2 process.

Sigrun Møgedal
(in collaboration with the GHWA Secretariat)
22.10.2014
1. REFLECTION NOTE ON STATUS FOR HRH WITH INPUTS FROM PHASE 1 CONSULTATIONS

After a decade of calls for action, three Global Forums on Human Resources for Health (Recife 2013, Bangkok 2011, Kampala 2008) one World Health Report (2006) and a Joint Learning Initiative (2004), we have seen definite progress in building understanding of the essential role of HRH and building capacity within countries to integrate HRH strategies into health policies and plans. Even so, some very basic unresolved issues remain.

The Ebola outbreak is a new reminder that health security for all depends on health workers on the ground. Critical gaps and missed opportunities have long been ignored at all levels - local, national, regional and global. This has left the most vulnerable without access and systems still unable to respond to crises.

Old challenges and new opportunities now exist side by side as we enter the path to Universal Health Coverage which cannot be achieved without health and social care workers, who stand at the interface between the provider systems, people and communities.

Country action must be at the core of the response. Rwanda, Ethiopia, Bangladesh and Thailand offer robust examples. Global action must enable and support, in ways that do not make national action harder. This note is to invite reflection on concrete action at the global level to enable sustainable solutions in countries.

Some observations on status after a decade of advocacy, convening, knowledge development and support include:

1. **Definite progress and new opportunities**
   - New momentum and urgency is building to address health workforce related barriers to access (MDG, NCD, UHC, Health Security), both at national and global levels.
   - Countries and partners in HRH made fresh commitments in Recife 2013 that will be monitored, and the Recife Declaration was confirmed by the World health Assembly.
   - Country examples demonstrate that it is doable to make significant improvement in access, even in the context of constrained economy and capacity
   - Evidence shows that investment in the health workforce (and particularly female health workers) is good for employment and good for the economy
   - Evidence has also increased, and continues to improve In quality, connecting investments in health workers to improvements in service delivery – and community health.
   - The significant impact of community volunteers and CHWs toward expanding health promotion and widening access to services has brought more attention to the broad possibilities that community-focused primary care can offer as an integral part of a new service delivery construct.

2. **Trends and projections - a differentiated picture.**
   - The demographic and epidemiological transition indicates additional and changing demand for the health and social care workforce (size, skill-mix, care models, public/private), calling for new service delivery models.
   - The financing of health care is becoming more complex, with a wider range of national and international, public and private actors, but also with new solutions through various measures for health and social protection.
• New technologies and treatment opportunities increase the expectations on the health and social care system and offer hope to a growing number of people who will seek services and more affordable care.
• Private sector sees opportunities in health business and have brought solutions to challenges at a more rapid pace, such as for supply chain and information management in support of health workers on the ground.
• There is a risk of increasing inequity and access gaps for the poorest segment of the population in all countries, and that countries with the lowest capacity can be left behind in managing transition.

3. Normative work
• A body of normative work exists, including professional standards and competencies, guidelines and policy frameworks, but needs to also cover social care workers.
• Evidence on the effects of different health workforce options and strategies are increasingly available and there is a growing acknowledgement that this evidence base should be used to inform decisions and policies.
• The knowledge base on best practice and tools is strengthened, but needs updating to match the new realities.
• Several efforts have been made to improve workforce data, including definitions. There is still a need to reconcile different data sets across agencies and partners. Further, competencies for applying and using data consistently at national and sub-national levels needs more attention.

4. "Stubborn" issues remain for countries to manage health workforce challenges
• Data registration on population and the health workforce, inclusive of numerous cadres, in countries and by partners is uneven and poorly supported, it does not match the need to inform policy and planning, manage access gaps and measure results.
• National mechanisms for stewardship and leadership across different sectors for policy, regulation and coordination/integration do not exist or have limited power/capacity, except for a few countries, such as Thailand.
• The health sector has limited policy space and capacity for managing employment and employment conditions in order to deal with remote and rural access gaps and in the context of broader labor market realities.
• Data, systems and impact measurement for HRH need to be implemented that are interoperable and frequently (quarterly) updated. The connection between HRH performance and service quality needs to be addressed.
• Absolute shortages of some cadres persist, different in different settings, along with training deficits; weak systems for payment of salaries and incentives; poor provider-service user relations and disrespect towards both service users and frontline providers in many settings.
• Failure to provide supportive supervision and active management for frontline workers across many settings, with frontline workers feeling isolated; unrealistic expectations of frontline workers with minimal training (such as lay health workers).
• Focus on vertical programs without systems strengthening and integration; donor dependency; weak position of national level policymakers in the context of changing public-private mix in healthcare and the way international actors engage.
5. **Fragmented partner action limits country opportunities**
   - There is no overview available about the overall partner contributions to health workforce development. The current membership platform of GHWA is not fully utilized by members.
   - Many partners contribute to meet the access gap, but largely limited to the need for results in their own priority programs through selective, vertical interventions.
   - Even within same agency, such as in the UN system, there is very limited bridging between action on HRH through different departments, sections or programs, as illustrated in each of the H4+ agencies (WHO, WB, UNICEF, UNFPA and UNAIDS).
   - Different UN agencies also outside the H4+ are engaged in policy development and work that relates to or impacts on the health workforce, yet the collaboration across agencies remains fragmented. Member states participating in the governance and support of these agencies do not use their "power" to drive coherent solutions.
   - Efforts need to be directed toward fostering integrated health care systems—rather than continuing fragmented, vertical, specialized care—in order to move towards UHC.
   - Financial incentives and insurance schemes must be assessed and discussed with national leaders in terms of how they contribute to effective and efficient quality health service delivery.
   - There is a need to bridge the gap between public and private health providers to foster access and equity.
   - National leaders require support as they develop private sector arrangements that are fair, and transparent, do not distort the HRH labor market and increase access to affordable care services.
   - The incentives for alignment and coherence across global partners, including the donor agencies, the professional organizations, the academic sector, the NGOs and private sector actors are not strong enough as a base for mutual accountability.
   - No mechanism exist that can align or pool funding from multiple sources for the health and social care workforce. Multilateral funding follow special health initiatives which contributes to fragmentation.
   - The WHO Global Code of Practice on International recruitment of Health Personnel have elements that could serve as a basis for coherence, but is voluntary and has not been fully utilized including through reporting.

6. **Need to agree on the result framework for HRH. Accountability**
   - The A-A-A-Q framework was used for preparing the commitments of the Recife Forum on Human resources for Health in 2013. There is still an open discussion about how the result framework for action on health and social cares workers can be established to fit in with the new health goal for sustainable development.
   - Indicators to measure HRH access gaps and performance need to be agreed and specified in the result framework for UHC.
   - There has been a lack of accountability at all levels including country governments, global agencies and initiatives, donors, private and academic sectors, implementers and health workers on their contribution to a sustainable health workforce, calling for clear contracts and accountability procedures.
   - Although efforts have been made to monitor the Kampala Declaration and Agenda for Global Action, the necessary inclusive national platforms for monitoring and assessment has not been functional and GHWA has had limited capacity and entry-points to engage.
7. **No consistent global voice for break through global action on HRH**

- There is no consistent and strong message from global leaders on the need to take urgent action on health and social care workforce in the context of the new post2015 development agenda, although essential for ensuring healthy lives and promoting well-being for all at all ages.

- The long-standing weak and uneven capacity in some countries, including in fragile states and states in conflict, are not addressed at the level of global policy and decision making for health. Access gaps put both national and global health security at risk.

- Regional and global voice is needed to foster collaboration in transformative medical education, including collaboration among Medical/Dental/Pharmaceutical councils of different countries to build agreement on mutual accreditation of each others courses and work together, such as through South-South collaboration.

- Countries have the opportunity to step into the space where there is no global voice, show country leadership and collectively build the case for investing in the health workforce when dealing with partners at national and global level.
## 2. HRH ACTIONS - SUMMARY OF INPUT

<table>
<thead>
<tr>
<th>Essential action</th>
<th>National level</th>
<th>Regional level</th>
<th>Global level</th>
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<tbody>
<tr>
<td>INFORMATION</td>
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<tr>
<td>Collect, collate, analyze and share data, inclusive of all providers</td>
<td>Making HIS for HRH operational. Identify access gaps. Capacity to apply data to inform decisions</td>
<td>HRH Observatories “African Information Highway”</td>
<td>Align HIS requirements across key actors for their HRH component of H. system support Presenting global data</td>
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<td>Info for evidence and feed back loops (two-way) for monitoring impact.</td>
<td>Knowledge hubs for evidence based practice and feed back to HW and communities</td>
<td>Regional networks of evidence based practice</td>
<td>Synthesize, disseminate and apply evidence in global action</td>
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<td>Monitoring progress</td>
<td>National platform, linked to National Health System monitoring to confirm effective interventions</td>
<td>Regional mechanisms that bring HRH monitoring and tracking to regional and sub-regional institutions, UN commissions etc</td>
<td>Agree on monitoring performance, HRH in UHC + investment tracking (WHO + ILO + WB + OECD ++ ). Mutual accountability across actors. Need independent monitoring</td>
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<td>Tracking investments, including ODA</td>
<td>Domestic and external Public + Private</td>
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<td>INSTITUTIONS</td>
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<tr>
<td>Inclusive, multi-sector and multi stakeholder mechanisms for leadership and stewardship</td>
<td>Most important in countries: National inter-ministerial platforms – to align policies and ensure collaborative implementation Many models being tried (Thailand, China)</td>
<td>Regional networks and platforms that bridge gaps between academic, public and private action – will be different in different regions. Building on and activating what is there</td>
<td>Different options for convening key actors at global level - need to be more multi-sectoral and have enough strength to ensure clarity in deliverables from each partner + mutual accountability</td>
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<td>Institutional capacity for HRH responsive budgeting of domestic and external funding</td>
<td>Making domestic all external funding for health make predictable contribution to HRH</td>
<td>Making the case for shared responsibility and collective action</td>
<td>Funding mechanisms dedicated for external support to national plans must have a funding window for HRH and HRH Capacity</td>
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<tr>
<td>Dedicated institutional capacity for overall management of HRH as part of UHC</td>
<td>MOH or other national institutions with explicit responsibility as the hub for HRH access and quality</td>
<td>Shared learning within and across regions</td>
<td>Shared global learning and knowledge exchange, with contributions from all actors</td>
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<td>Essential action</td>
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<tr>
<td><strong>INTEGRATION</strong></td>
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<td>More responsive Inter-agency collaboration with greater clarity of roles and relationships to other partners</td>
<td>WHO, other UN agencies (including ILO, UNDP and UNESCO) together with World Bank need to activate national collaboration for HRH</td>
<td>Mechanisms of accountability that reward effective collaboration. Institutional accountability for the inter-agency response and regulation. Activate the strength of ILO tripartite process and reporting to ECOSOC?</td>
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| Tools and frameworks for planning and management used by countries and partners are different and difficult to reconcile | Capacity to set out a national policy & planning framework that deals with workforce as part of UHC and drives aligned partner action. Supervision and support for FLHWs | Supportive technical inputs and engagement with stakeholders at regional level in support of integrated delivery and coherent multi-sector action | Align technical assistance and programming tools for HSS and HRH support across agencies and partners and foster capacity in countries for leadership and stewardship |

| Support for health workers with single focus on selective interventions must be re-oriented towards client orientation, integrated delivery and sustainable solutions | Fit single focus support to National HRH plans and address the misfit between health needs and effective health coverage and demand, purchasing power and organizational capacity | Forge agreement on alignment and responsiveness to integrated delivery across agencies and partners. Consolidate and align actions on HRH within each agency | |

<p>| Private - public sector arrangements that are fair, transparent and do not distort sustainable access to affordable care services. | Enabling policies and regulation of private sector in ways that optimize collaboration for health worker education, career development and access for un-served and marginalized populations | Regional opportunities for collaboration with private sector in emerging economies | Dialogue and guiding principles for commercial actors in medical education and private commercial health markets. Links to broader shared action on political health equity determinants |</p>
<table>
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<tr>
<th>INVESTMENT</th>
<th>Engagement Activities</th>
<th>Funding Mechanisms</th>
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<tr>
<td>Underinvestment - un-attractive because recurrent expenditure + long term investment with largely long term yields. Setting out a priority menu for HSS funding with line item resources for HRH with realistic costing.</td>
<td>Engage national level decision-makers outside the health sector to build shared understanding of the employment and labor market challenges, appropriately based in a social contract framework for rights to health and social protection.</td>
<td>Regional multi-sector and multi-partner engagement to better link health financing and health account discussions to HRH. Support countries to raise the perceived priority for the health workforce, including education and employment conditions.</td>
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<tr>
<td>No available, dedicated funding mechanism for key investments in HRH (Education, Institutional Capacity, Technical Assistance and Knowledge etc)</td>
<td>Make all external health sector support respond to health workforce access gaps and serve sustainable health workforce solutions, with predictable, long-term investment.</td>
<td>Investment in regional collaboration to promote /reward health professional schools that graduate health workers working in under-served communities.</td>
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<tr>
<td>Financial incentives and insurance schemes that will inform quality, effective and efficient health service delivery.</td>
<td>The role and potential of performance based funding as a contribution to systemic /sustainable health workforce investment.</td>
<td>Mechanisms to align or pool funding - how an existing multilateral or pooled funding mechanisms contribute?</td>
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<td>Align approaches to social protection and health financing. Cross agency issues of salary support and incentives.</td>
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3. A SELECTION OF COMMENTS RECEIVED

1. Each country carries the responsibility for health and social care for its own population, with the necessary policies, budgets, regulation and employment conditions for health and social services workforce, including the workforce for public health measures and fulfilling the obligations of International Health Regulations.

2. No country is able to deal with their health workforce independent from other countries. Education and employment opportunities across borders and the challenges of health security, require collaboration among clusters of countries, regional groups and at global level.

3. The importance of HRH and the critical need for more and appropriately distributed health workers is widely accepted. Even so, critical gaps in access to health workers on the ground persist and demonstrate health security threats for local populations, nations and the world, such as demonstrated by the Ebola epidemic out of control.

4. The early response will always be local. Health workers on the ground are essential for achieving Universal Health Coverage, but also for preparedness and protection when epidemics threaten or disasters strike.

5. Particularly in a time of global unrest and pandemic threats that are heightened with the increasing mobility of populations, the social worker workforce and the mental health workers are in great demand. This is a workforce that needs greater attention and needs to be more effectively integrated into the PHC framework.

6. The economic growth potential of investment in health workers education and employment has not been recognized and acted on. The employment effects of the health sector, both public and private, in particular in times of crises should be understood as a stabilizing factor for the economy that is accompanied by better health of the population in working age and thus higher economic growth.

7. Many discussions, meetings, decision and conversations on health financing and health accounts are carried on completely divorced of health workforce development considerations. This separation creates false expectations of funding capacity and funding needs and leads to HRH and HSS plans that are not costed and are unrealistic.

8. The large investments in global health through global funds, partnerships and initiatives have systematically failed to respond to systemic workforce issues and to bring health workforce issues into the dialogue with countries, assuming a workforce in place.

9. Lack of data is a big problem and WHO's data base is still very rudimentary. New methods are needed to assess, track, monitor and evaluate the HRH situation and compare distribution of workers. A framework is needed for using the data well and measure if a country situation has become better or worse.

10. Regional observatories can assist national efforts and help augment roll up of country data to global data sets. An nimble entity on implementation and data validation needs to be assigned and empowered to work with national leaders; charged with oversight and equipped with resources.
11. The need for a HRH Community of Scholars-Policy makers-Practitioners that can move forward the collection of improved data, undertake analysis, develop key tools for tracking progress. Successful innovations needs to be documented, validated and disseminated

12. The availability of health workers must be explicitly linked to the work on Universal health coverage. Health workforce constitutes the core of UHC. The density of health workers at national level, but also in rural and urban areas, must be included as indicator for assessing the extent of health coverage and related access to health services.

13. Working conditions, wages and career perspectives must be better reflected, with a focus on employment conditions and opportunities. At the center should be modern job profiles attractive for health workers that realize synergies with other social protection areas, services and workforces e.g. social workers, teachers and others.

14. Health sector innovation has generally been more focused on technologies, drugs and commodities and missing out on health workforce solutions fit for the current context of remaining and new unmet needs.

15. Academic networks have received too little attention and support, would engage the most relevant and powerful stakeholders. Medical education leaders are essential for reforms to succeed

16. Potential exists in the results-based financing of health professional schools that rewards schools that graduate health workers who work in under-served communities. This will incentivize schools to restructure their admissions, curriculum, and educational process.
The Global Health Workforce Alliance (GHWA) was established in 2006 to bring together the forces of country leadership and global solidarity, serving as a common platform and a catalyst for an effective response to the health workforce crisis at global, regional and country level. GHWA was assigned the role of ensuring successful implementation of a 10-year plan of action set out in the WHO World Health Report 2006 – Working Together for Health.

Hosted by WHO as a partnership up to May 2016, an expressed role for GHWA was also to assist WHO in the fulfillment of its normative and standard setting mandates (applicable to the health workforce), and to enhance the performance of other partners by promoting cohesion and synergy across all actors. While GHWA has a broad based membership, cohesion and synergy across actors remain an unfinished agenda.

With less than 2 years of the 10-year mandate remaining, the GHWA Board has asked for an options analysis for multi-sectoral HRH governance beyond 2016 to be considered at the 18th Board Meeting in February 2015.

This note is to introduce this work, which will require broad consultation with all stakeholders, GHWA membership and Board members.

The main questions that will be addressed in the consultation process include:

1. to what extent there is a continued need for a global multi-sectoral and multi-stakeholder stewardship and anchoring platform for human resources for health and social care beyond the current mandate
2. what the characteristics of such a platform should be to make it fit for purpose within the new post 2015 sustainable health and development framework
3. how a global platform could foster collaboration across different existing and new targeted programs, instruments, agencies and partnership, in support of sustainable workforce solutions on the ground

These three main questions are similar to the questions raised in the lead up to the establishment of GHWA in 2005-2006. We now have experience with the choices made at that time, which can inform the choices we make for the future.

At the same time, the context in which we work has changed, in terms of new needs, new actors, new technologies and new solutions. The evolving disease burden of non-communicable diseases will, along with aging of the global population, call for new models of care and most likely bring new multi-stakeholder platforms. Labor market issues are coming to the forefront. The roles of the public, non-governmental and private sector are changing and so are the roles of professional associations. Possible options for a multi-stakeholder global platform for HRH going forward therefore need to be relevant to these changes and bring out the best, both in terms of the experience with the GHWA model as well as the new opportunities.

The first step in the consultation process is to assess and review the case for a global multi-sectoral and multi-stakeholder platform for HRH governance and stewardship. Convening, advocating and monitoring performance are core functions for GHWA in the current set up. The need for new functions should also be explored, along with the continued relevance of
the current functions that GHWA has been mandated to perform (as expressed in the MoU with WHO and reflected in the current GHWA strategy).

To the extent there is sufficient convergence on the need for a multi-stakeholder platform, various options will be developed and explored as the next step, in consultation with stakeholders that express interest.

**Guidance from the 2013 Recife Declaration**

The consultation process will make use of the guidance provided by the Recife Forum and the subsequent resolution of the World Health Assembly.

The Declaration makes renewed HRH Commitments from Governments towards universal coverage, promoting an integrated agenda for national and global collective action on HRH and with full involvement of health providers at all levels of health services provision.

It recognizes progress made over the last decade, but also takes note of persisting challenges, stating that: “investment in HRH remains low; fundamental discrepancies exist between health worker supply and demand; HRH planning is often weakened by uncoordinated interventions on single issues, focusing on an individual cadre or illness and not on prevention; and the adoption and implementation of effective policies remains uneven. As a consequence, severe shortages, deficiencies in distribution and performance, gender imbalances and poor working environments for health workers remain matters of major concern”.

There is full agreement that the country level is the primary focus for collaboration to the achieve health workforce development that is required for universal health coverage and the leading role and primary responsibility of governments, particularly as stewards and regulators of the health labor market and HRH education is recognized. The Declaration also points out the need for country level multi-stakeholder and multi-sector collaboration.

In the Recife Declaration commitments are made to "addressing transnational issues and work towards strengthening health systems, including HRH governance and mechanisms by i) disseminating good practices and evidence; ii) strengthening data collection from countries; iii) promoting multidisciplinary, multi-country research and knowledge exchange; iv) providing and mobilizing technical assistance where needed; v) strengthening accountability to identify existing gaps; and vi) promoting and supporting implementation of the WHO Global Code of Practice on the international Recruitment of Health Personnel."

The World Health Assembly, endorsing the Declaration with its call to action, requested the Director-General to develop and submit a new global strategy for human resources for health by the Sixty-ninth World Health Assembly.

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