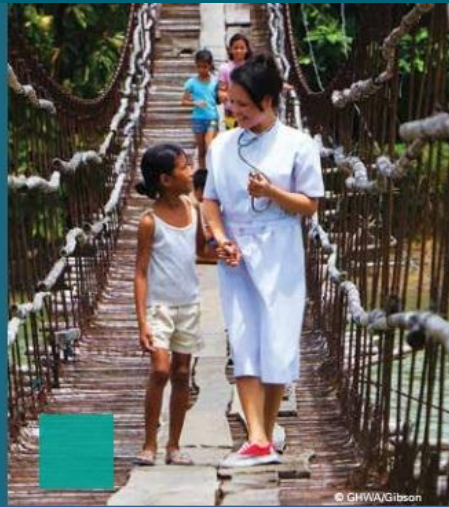


HEALTH WORKFORCE 2030



Tackling health workforce challenges to universal health coverage: setting targets and measuring progress

Dr Giorgio Cometto

Global Health Workforce Alliance
World Health Organization

Joint Action Health
Workforce Planning and
Forecasting Conference

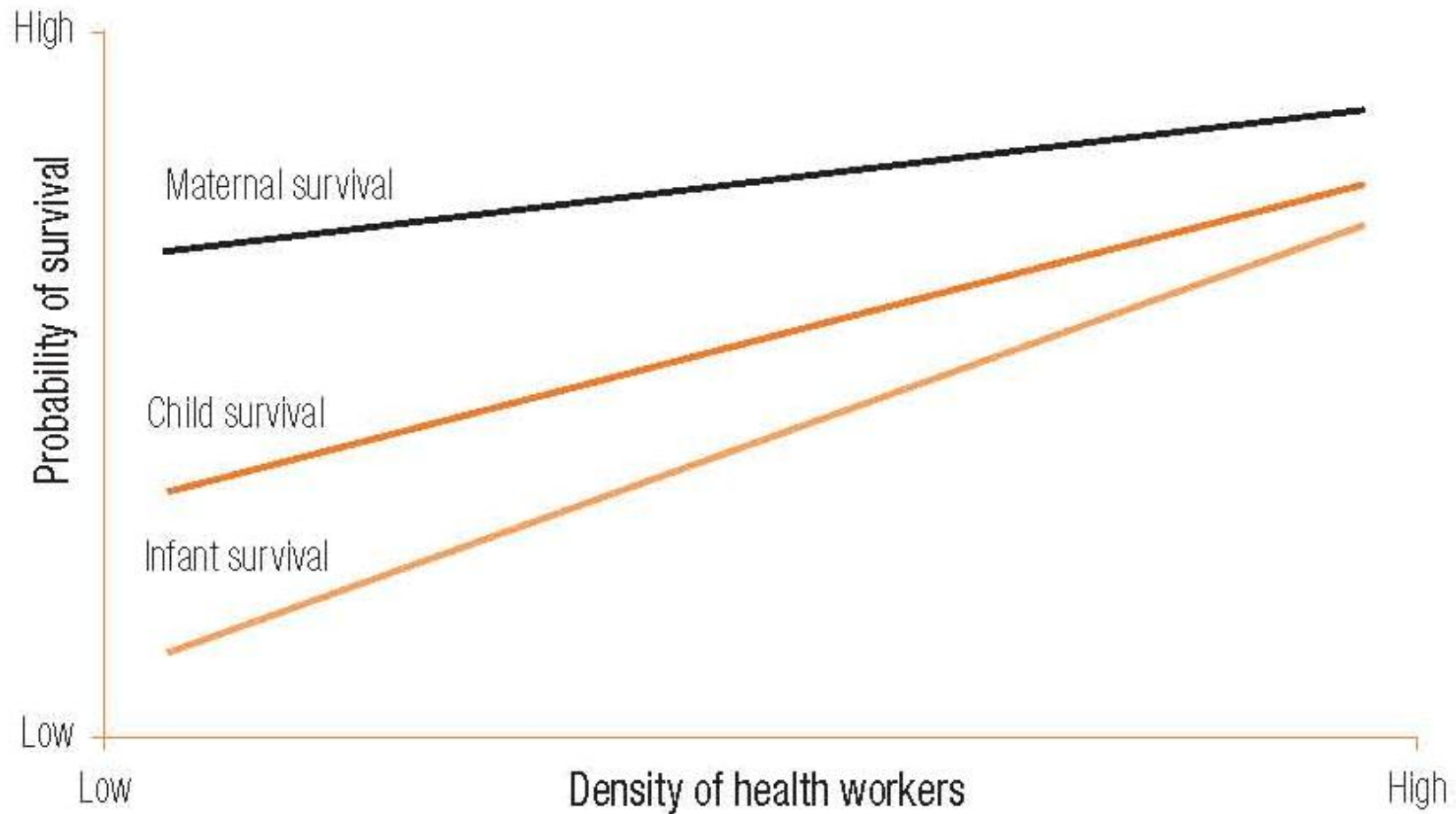
Rome
4 December 2014

Outline

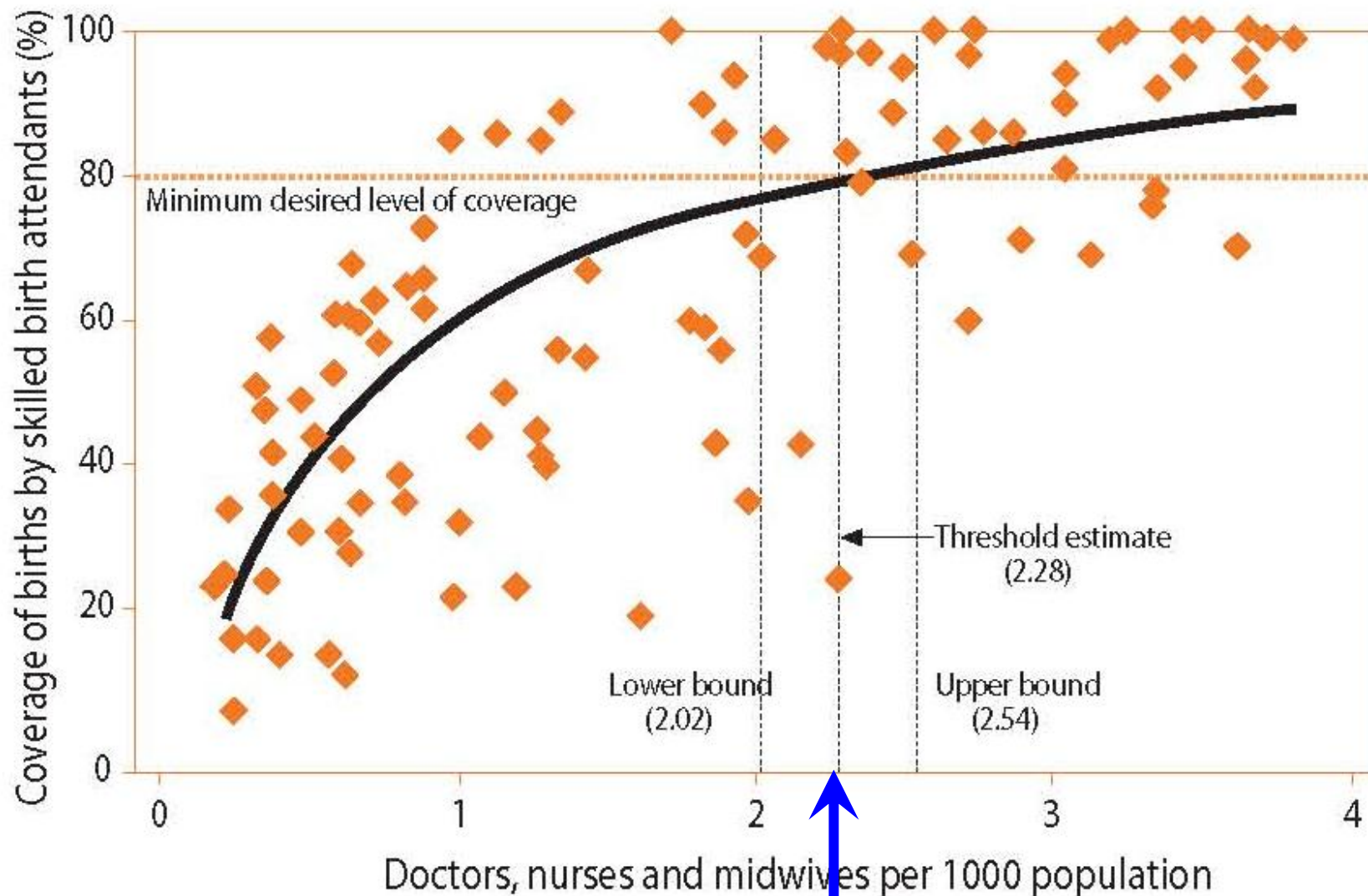
1. Health workforce benchmarks during the Millennium Development Goals era (2000-2015)
2. Health workforce for universal health coverage: a new discourse
3. Sustainable Development Goals (2016-2030): the health workforce implications
4. Requirements for tracking health workforce development at national level
5. The Global Strategy on Human Resources for Health

1. Health workforce benchmarks during the Millennium Development Goals era (2000-2015)

Health worker availability and survival

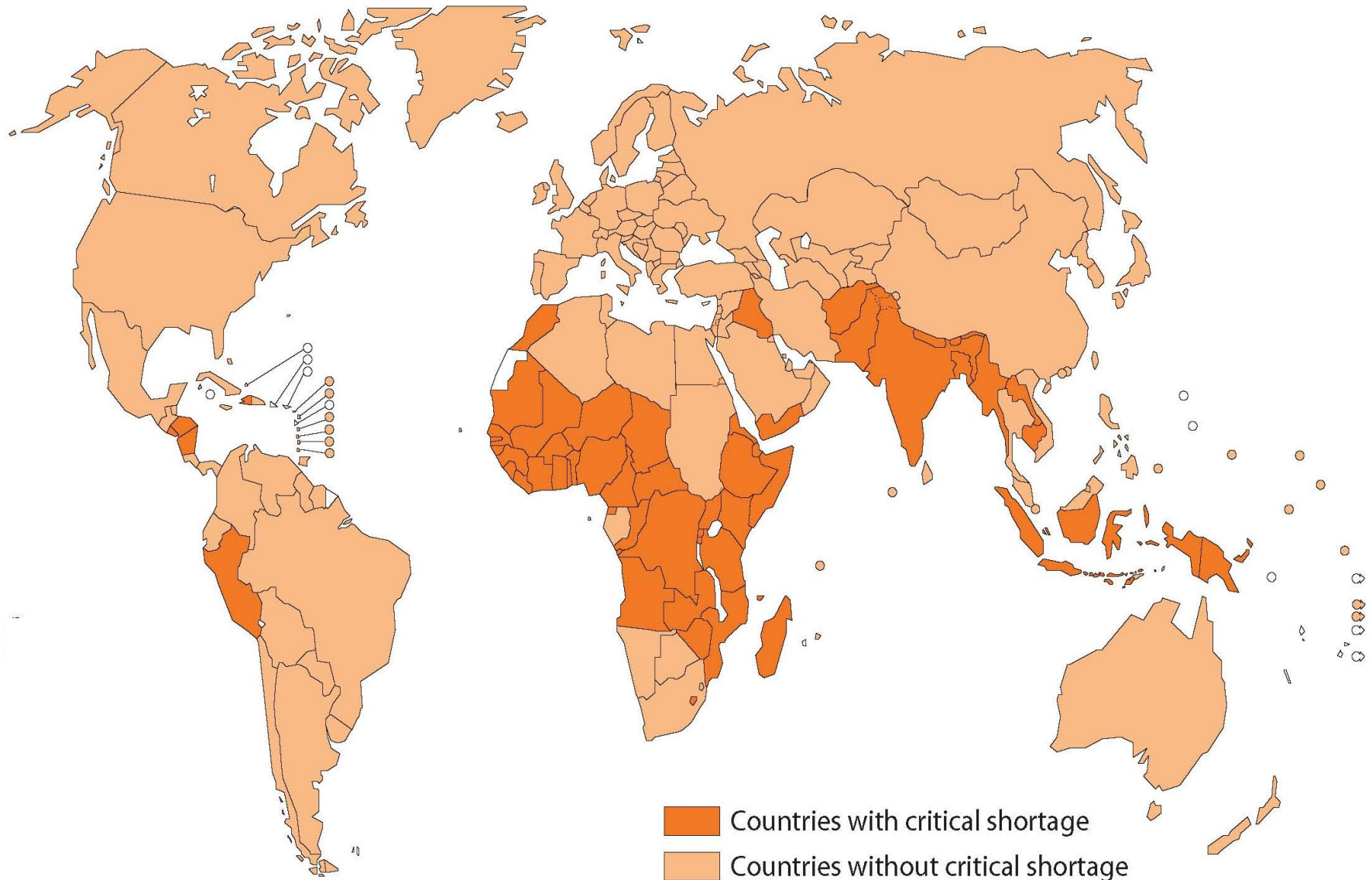


HWs density and health services

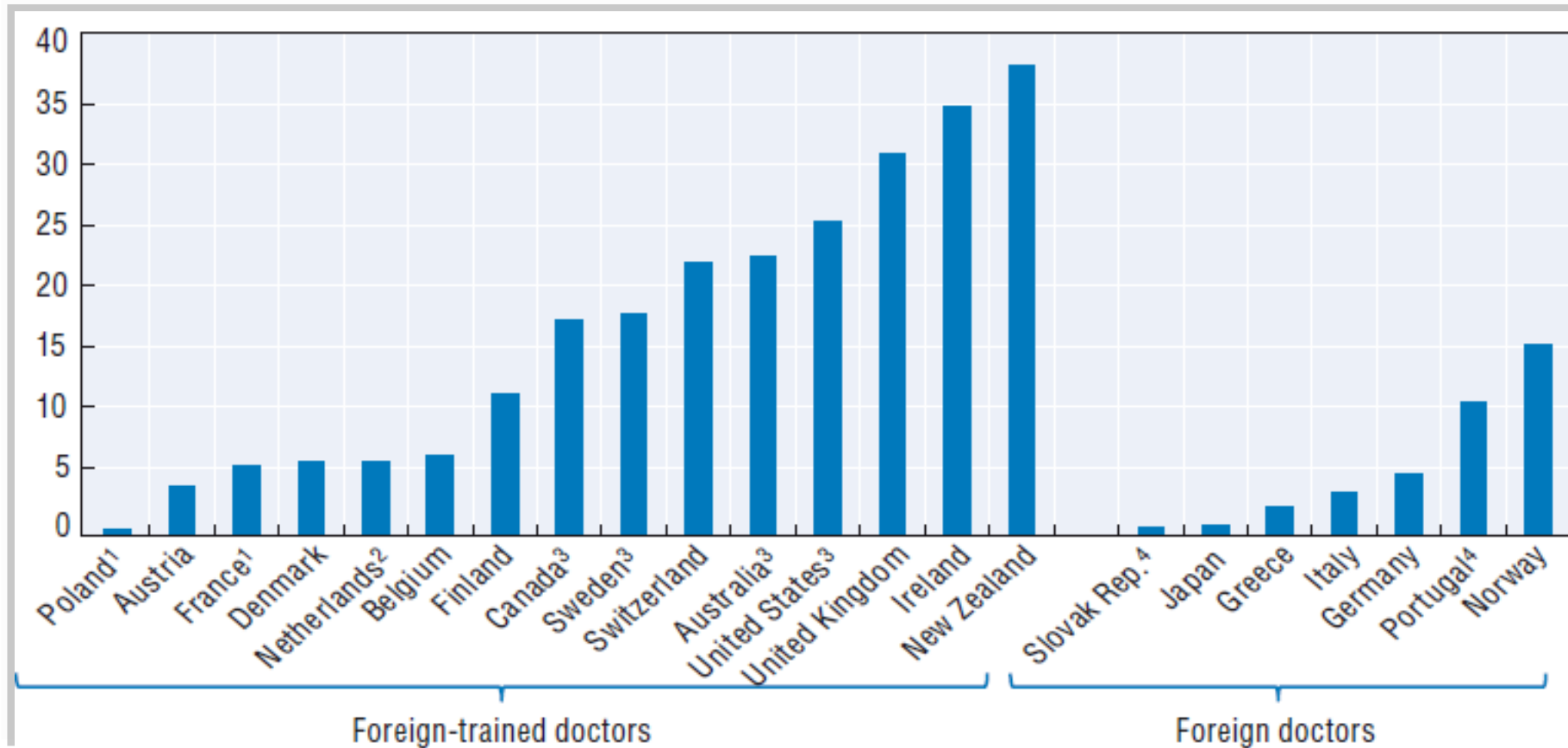


Threshold = 2.3 Health workers per 1000 pop

WHR 2006: Countries with a critical HRH shortage



International migration compounding the problem



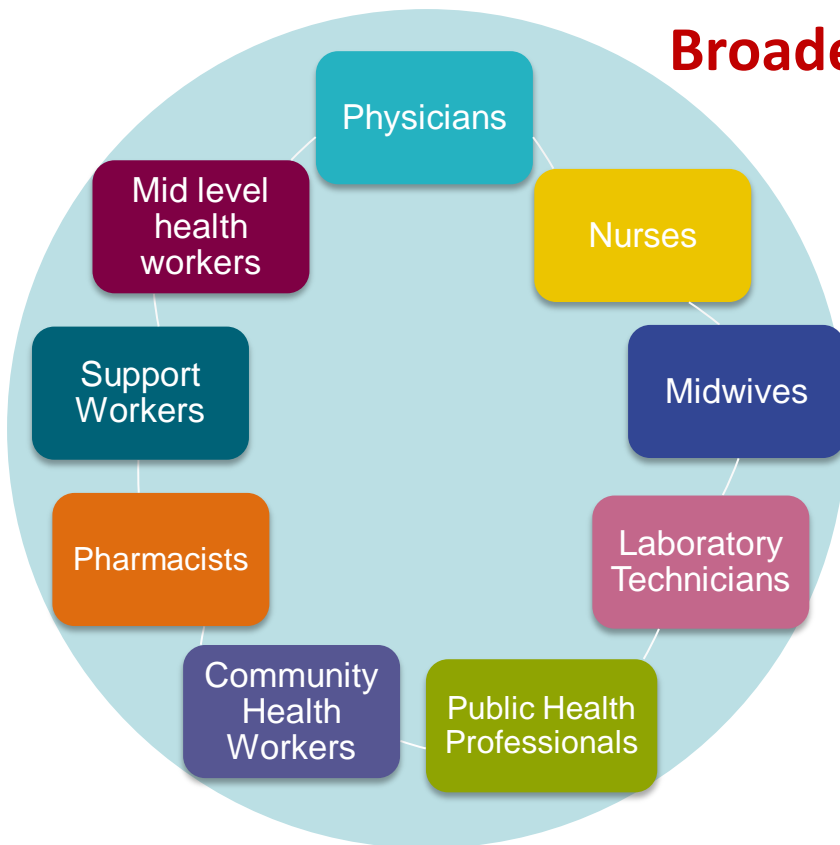
The WHO Code of Practice on International Recruitment of Health Personnel



- Born out of an Alliance-supported task force on international migration
- Taken forward through WHO, and approved at 64th World Health Assembly in 2010
- A key milestone in tackling health workforce migration challenges
- First round of reporting in 2012-13, review at WHA in 2015

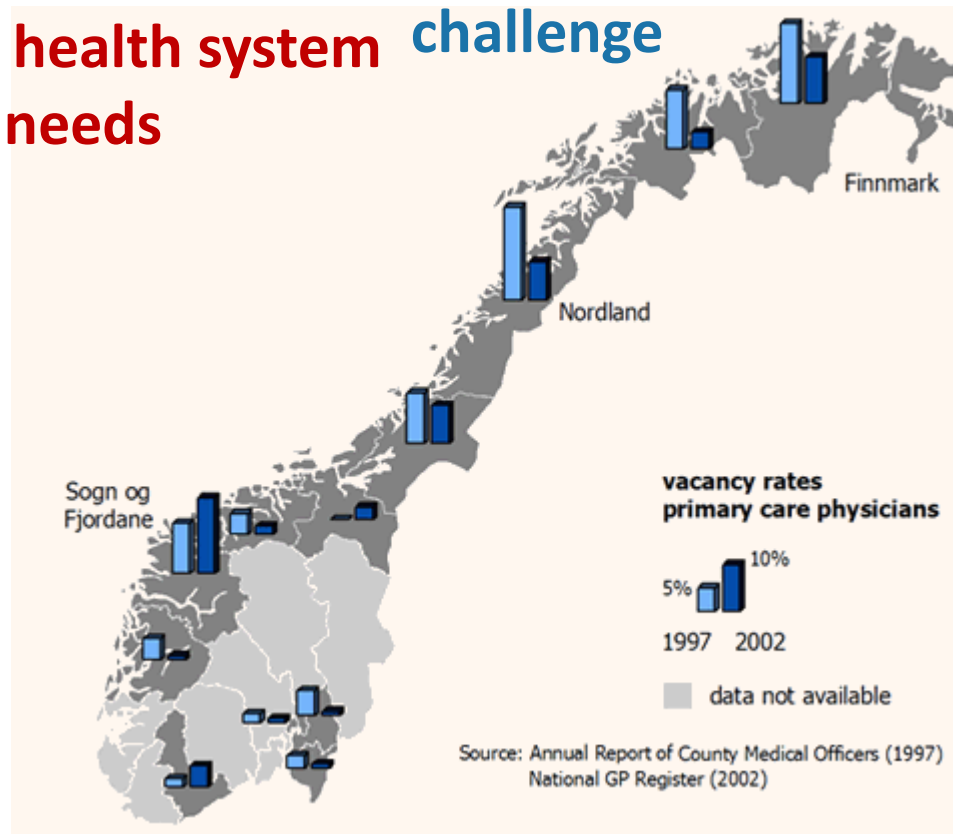
Limitations of the 2.3 benchmark

Greater diversity of health workers



Broader health system needs challenge

Equitable geographical accessibility often a



2. Health workforce for universal health coverage: a new discourse

What are the health workforce implications of UHC?

**A UNIVERSAL TRUTH:
NO HEALTH WITHOUT
A WORKFORCE**

The route to effective coverage is through the health worker: there are no shortcuts

A high-level meeting on March 5-6 in Botswana is the culmination of 6 months of discussion on the post-2015 development agenda for health. The hosts (Governments of Botswana and Sweden, with UNICEF and WHO) and participants are challenged to review the submissions to the global consultation on health and to consider an aspirational, inclusive, and yet politically palatable vision for human health after the Millennium Development Goals (MDGs) expire in 2015. Their report will be submitted to the UN Secretary General's high-level panel of eminent persons and the findings considered in the panel's publication in May, 2013. That report will go to an even higher high-level meeting at the UN General Assembly in September 2013.

health—described elsewhere as “old wine in a new bottle”—and will be high, higher, and even higher governance process capture the needs of men, women, and children who are seeking quality care from local health workers? The evidence exists on what is required in the world we want. More than 100 global health experts presented this evidence in 2004 through a Joint Learning Initiative.¹ Their conclusion: the only route to achieve the health MDGs is through the health worker. The same is true for UHC and post-2015, only this time with deeper consideration of effective coverage—the difference between the theoretical coverage implied by the availability of the workforce and the actual coverage resulting from the quality of the workforce. This is the grand challenge on human resources for health for all countries. Could the Botswana consensus therefore be the concept of “just

Human resources for health and universal health coverage: fostering equity and effective coverage

James Campbell,^a James Buchan,^b Giorgio Cometto,^c Benedict David,^d Gilles Dussault,^e Helga Fogstad,^f Inês Fronteira,^g Rafael Lozano,^h Frank Nyong'o,ⁱ Ariel Pablos-Méndez,^j Estelle E Quain,^k Ann Starrs,^l Viroj Tangcharoensathien^m

Abstract Achieving universal health coverage (UHC) involves addressing population needs. This paper explores the policy lessons on HRH from Brazil, Ghana, Mexico and Thailand. Its purpose is to inform global health policy on country experiences using an analysis of accessibility, acceptability and quality (AAAQ) of HRH. The AAQ findings since 1990 in the four countries of interest in relation to health services are discussed.

Universal health coverage and the post-2015 agenda

In her Comment (Jan 19, p 179), Jeanette Vega recognises that, to achieve universal health coverage, “challenges such as human resources for health must be addressed”—a point also explicitly mentioned in a recent UN resolution¹ which calls for an “adequate skilled, well-trained and motivated workforce”. Yet investment by development partners is not adequate to improve the availability, distribution, quality, and performance of human resources for health as an integral element of robust health systems. According to a recent analysis,² the proportion of support provided by development partners for health workforce development has declined from 27% in 1990 to 17% in 2002-10, despite the recognition from the Task Force for International Financing Systems to target 25% of related official development assistance to human resources for health.³

To help address this, the Global Health Workforce Alliance is holding the Third Human Resources for Health Summit in Recife, Brazil, on Nov 11-12, 2013. The theme “Human Resources for Health: Foundational coverage and the management agenda” is an opportunity and lessons learned from the actions and interventions required for the development of universal health coverage and the management agenda. The summit will bring together stakeholders from government, academia, and the private sector to discuss human resource development mechanisms and progress on those commitments and to monitor health workforce development towards universal health coverage.

Towards universal health coverage: a health workforce fit for purpose and practice

James Campbell^a

The finality of universal health coverage (UHC) is to ensure that all people are able to access the *quality* health services they need without suffering undue financial hardship. Margaret Chan describes it as the ultimate expression of *fairness*.¹ The italicized words above should therefore frame the starting point for a contemporary discourse on human resources for health.

Bull World Health Organ 2013;91:886 | doi: <http://dx.doi.org/10.2471/BLT.13.126656>

A new era for human resources for health?

COMMENT



In a guest piece, James Buchan (left), a Professor at Queen Margaret University, Edinburgh and Jim Campbell (right), a Director at Instituto de Cooperación Social Integrare, Barcelona, Spain, reflect on the health workforce policy and planning challenges being considered internationally and how recent events are spearheading new thinking.

The Third Global Forum on Human Resources for Health, held in Recife, Brazil, in November 2013, was the largest ever health workforce event. Some 1,800 participants from 93 Member States took part, including 40 ministers or deputy ministers. The forum reports “A Universal Truth: No health without a workforce”. It includes discussion on a big picture challenge associated with the attainment of universal health coverage.

The challenge is daunting for some health systems. On the basis of population, physicians and health workers, the world is short of 7.2 million health workers, without account of the 12.9 million in coming decades. The challenge is to ensure that health systems are able to meet the needs of a world with ever growing populations and ageing populations.

Another “Big Truth” outcome has been that the adoption of the World Health Organization’s Declaration on Human Resources for Health, renewed commitments towards universal health coverage (see box).

- The Recife Declaration has a ten-point plan for countries:
1. Adopt a systemic approach to monitoring, implementing and funding strategies and plans for a sustainable health workforce.
 2. Enhance information systems to generate and link needs-based planning and projections to innovative health workforce strategies.
 3. Enhance competences and skills of health personnel through and continuous professional development approaches.

Global health workforce shortage to reach 12.9 million in coming decades

News release

11 NOVEMBER 2013 | RECIFE, BRAZIL - The world will be short of 12.9 million health-care workers by 2035; today, that figure stands at 7.2 million. A WHO report released today warns that the findings – if not addressed now – will have serious implications for the health of billions of people across all regions of the world.

The report, “A universal truth: No health without a workforce”, identifies several key causes. They include an ageing health workforce with staff retiring or leaving for better paid jobs without being replaced, while inversely, not enough young people are entering the profession or being adequately trained. Increasing demands are also being put on the sector from a growing world population with risks of noncommunicable diseases (e.g. cancer, heart disease, stroke etc.) increasing. Internal and international migration of health workers is also exacerbating regional imbalances.

“The report, ‘A universal truth: No health without a workforce’, identifies several key causes. They include an ageing health workforce with staff retiring or leaving for better paid jobs without being replaced, while inversely, not enough young people are entering the profession or being adequately trained. Increasing demands are also being put on the sector from a growing world population with risks of noncommunicable diseases (e.g. cancer, heart disease, stroke etc.) increasing. Internal and international migration of health workers is also exacerbating regional imbalances.”

More on the Third Global Forum on Human Resources for Health
WHO’s work on health workforce
Global Health Workforce Alliance
More on health workforce

Effective coverage: what it entails

CRUDE COVERAGE

EFFECTIVE COVERAGE

AVAILABILITY

ACCESSIBILITY

ACCEPTABILITY

QUALITY



workforce is
AVAILABLE?



workforce is
ACCESSIBLE?



workforce is
ACCEPTABLE?



workforce
provides **QUALITY CARE?**



- A midwife **is available** in or close to the community
- As part of an integrated team of professionals, lay workers and community health services

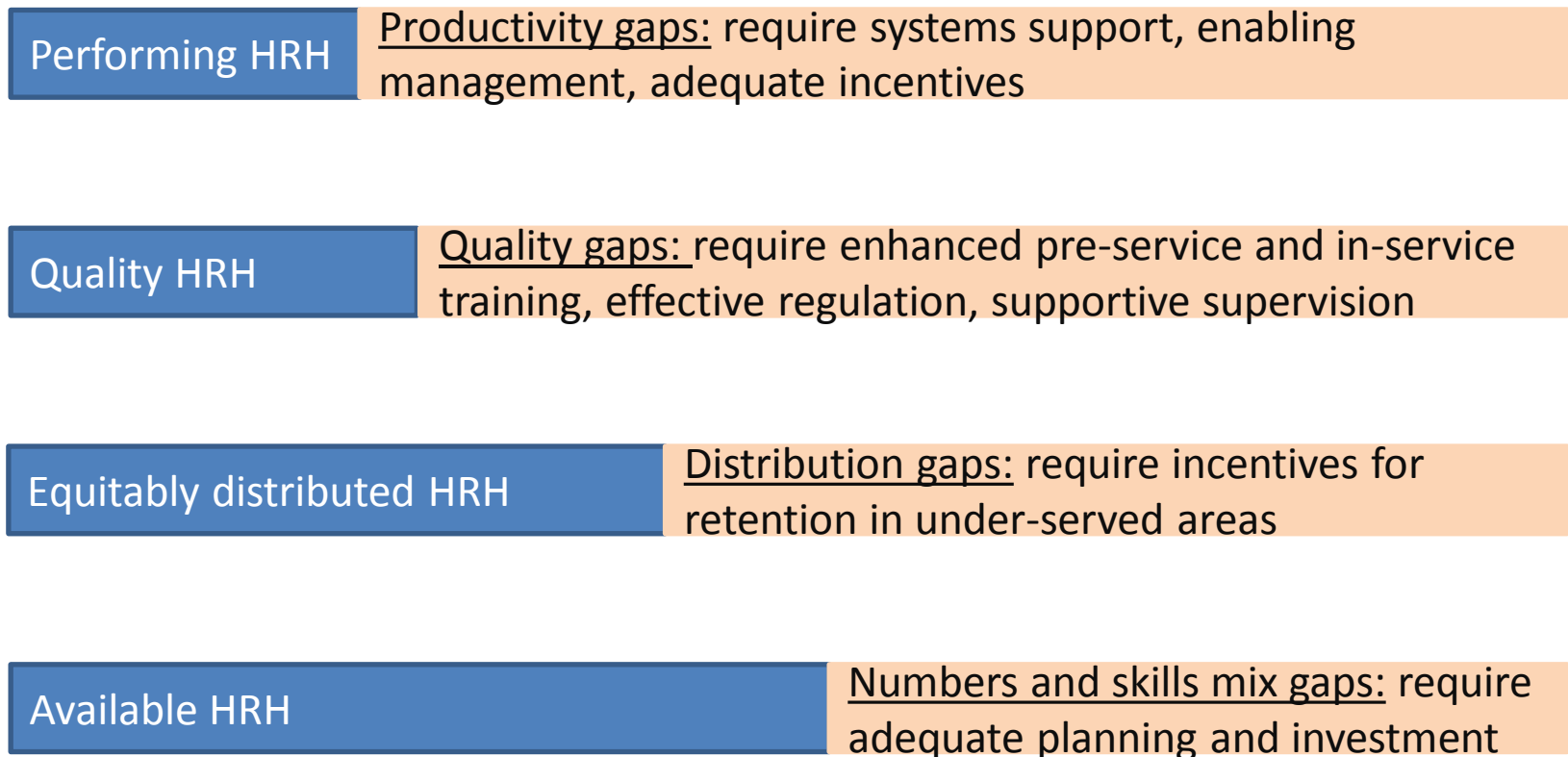
- Woman attends
- A midwife is available
- **As and where needed**
- Financial protection ensures **no barriers to access**

- Woman attends
- A midwife is available
- As and where needed
- **Providing respectful care**

- Woman attends
- A midwife is available
- As and where needed
- Providing respectful care
- **Competent and enabled to provide quality care.**

Bridging health workforce gaps to achieve Universal Health Coverage

Population without access to well-performing health workers

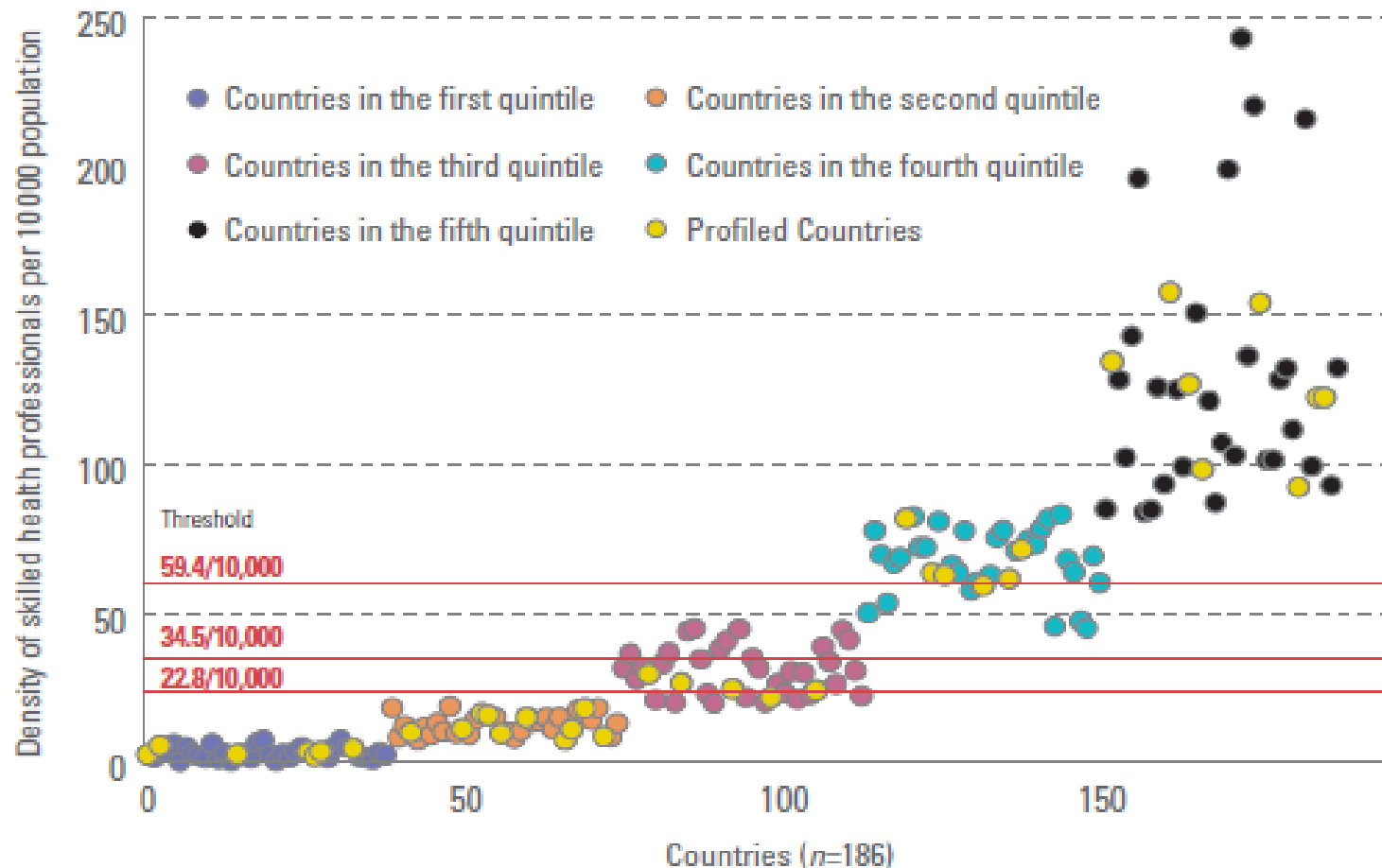


A universal truth....

A UNIVERSAL TRUTH: NO HEALTH WITHOUT A WORKFORCE

Campbell J, Dussault G, Buchan J, Pozo-Martin F, Guerra Arias M, Leone C, Siyam A, Cometto G. *A universal truth: no health without a workforce*. Global Health Workforce Alliance and World Health Organization, 2013.

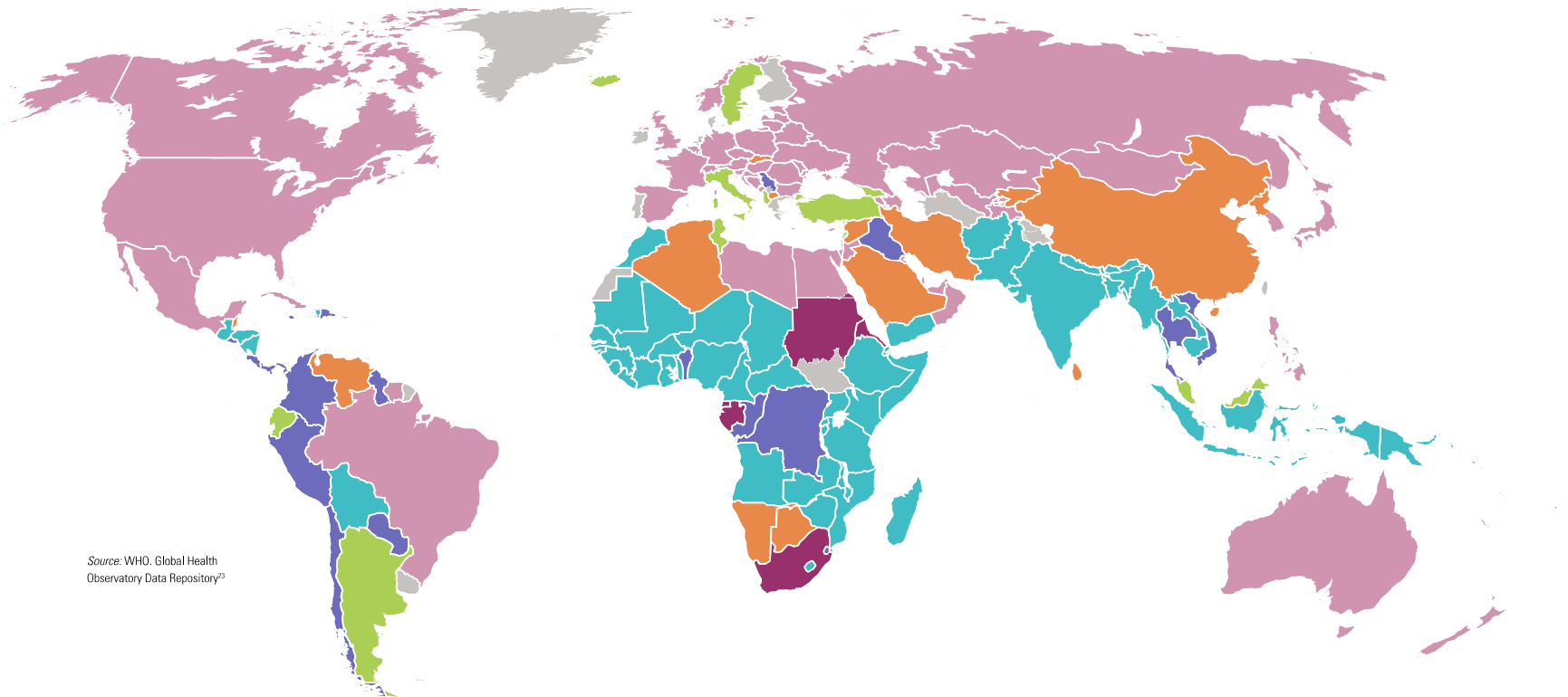
Density of skilled health professionals per 10 000 population



Human resources for health: global challenges, global opportunities

FIGURE 4 Workforce to population ratios for 186 countries

- **Group 1:** density of skilled workforce lower than 22.8/10 000 population and a coverage of births attended by SBA less than 80%
- **Group 2:** density of skilled workforce lower than 22.8 /10 000 population and coverage of births attended by SBA greater than 80%
- **Group 3:** density of skilled workforce lower than 22.8/10 000 population but no recent data on coverage of births attended by SBA
- **Group 4:** density is equal or greater than 22.8/10 000 and smaller than 34.5/10 000
- **Group 5:** density is equal or greater than 34.5/10 000 and smaller than 59.4/10 000
- **Group 6:** density is equal or greater than 59.4/10 000



Source: WHO, Global Health Observatory Data Repository²³

Estimates of shortages and deficits...



global health
workforce
alliance

عربي

中文

English

Français

Русский

Español

*Health workers for all
and all for health workers*

Search

Global health workforce shortage to reach 12.9 million in coming decades

11 November 2013 | RECIFE, BRAZIL - The world will be short of 12.9 million healthcare workers by 2035; today, that figure stands at 7.2 million. A World Health Organization (WHO) report released today warns that the findings - if not addressed now - will have serious implications for the health of billions of people across all regions of the world.

The report, *A Universal Truth: No health without a workforce*, identifies several key causes. They include an ageing health workforce with staff retiring or leaving for

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[Report: "A Universal Truth: No health without a workforce"](#)

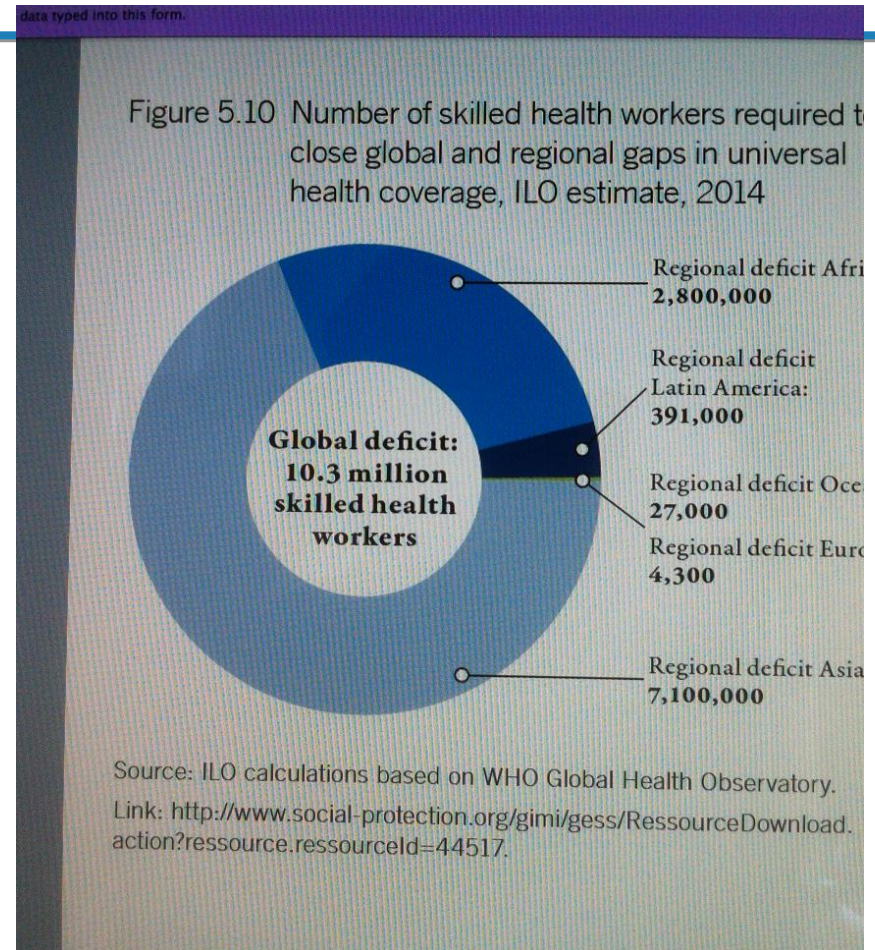
[More information on the meeting in Brazil](#)

Different estimates of shortages and deficits

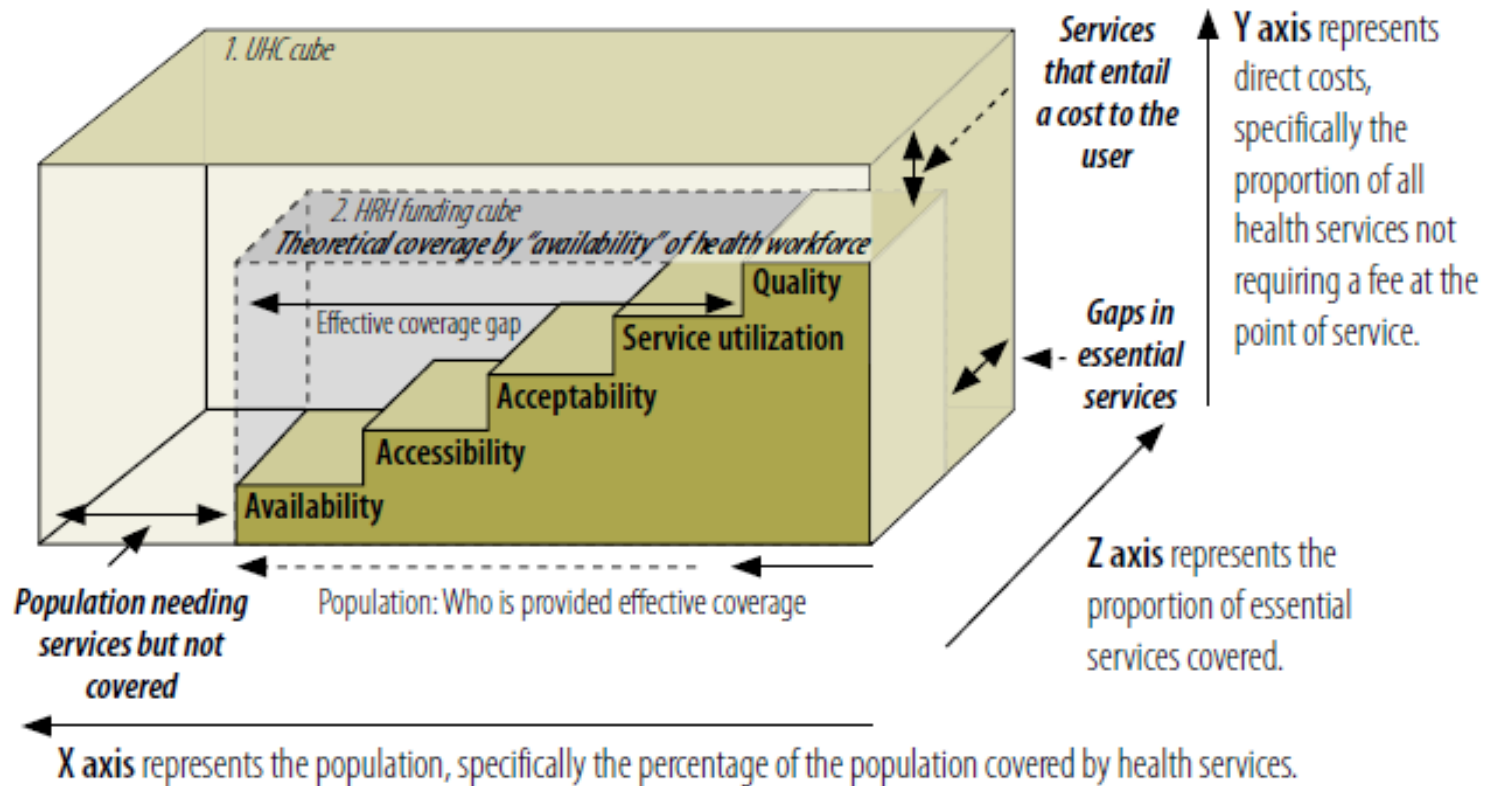
ILO – World Social Protection Report (2014)

The ILO estimates that at least 41.1 health workers per 10,000 population are necessary to provide services to all in need. The figure is based on calculations of median values of the density of health workers in countries where socio-economic conditions and health financing characteristics are conducive to universal coverage.

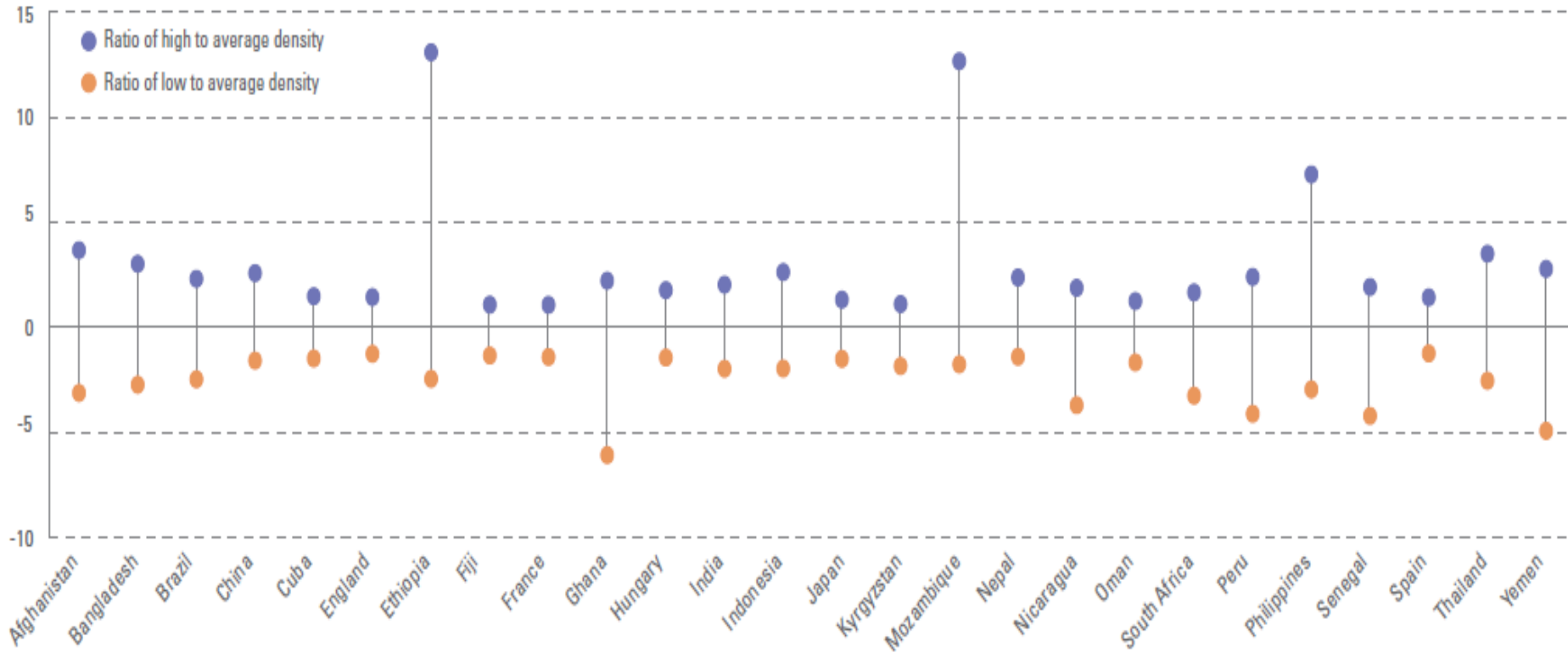
<http://www.ilo.org/global/research/global-reports/world-social-security-report/2014/lang--en/index.htm>



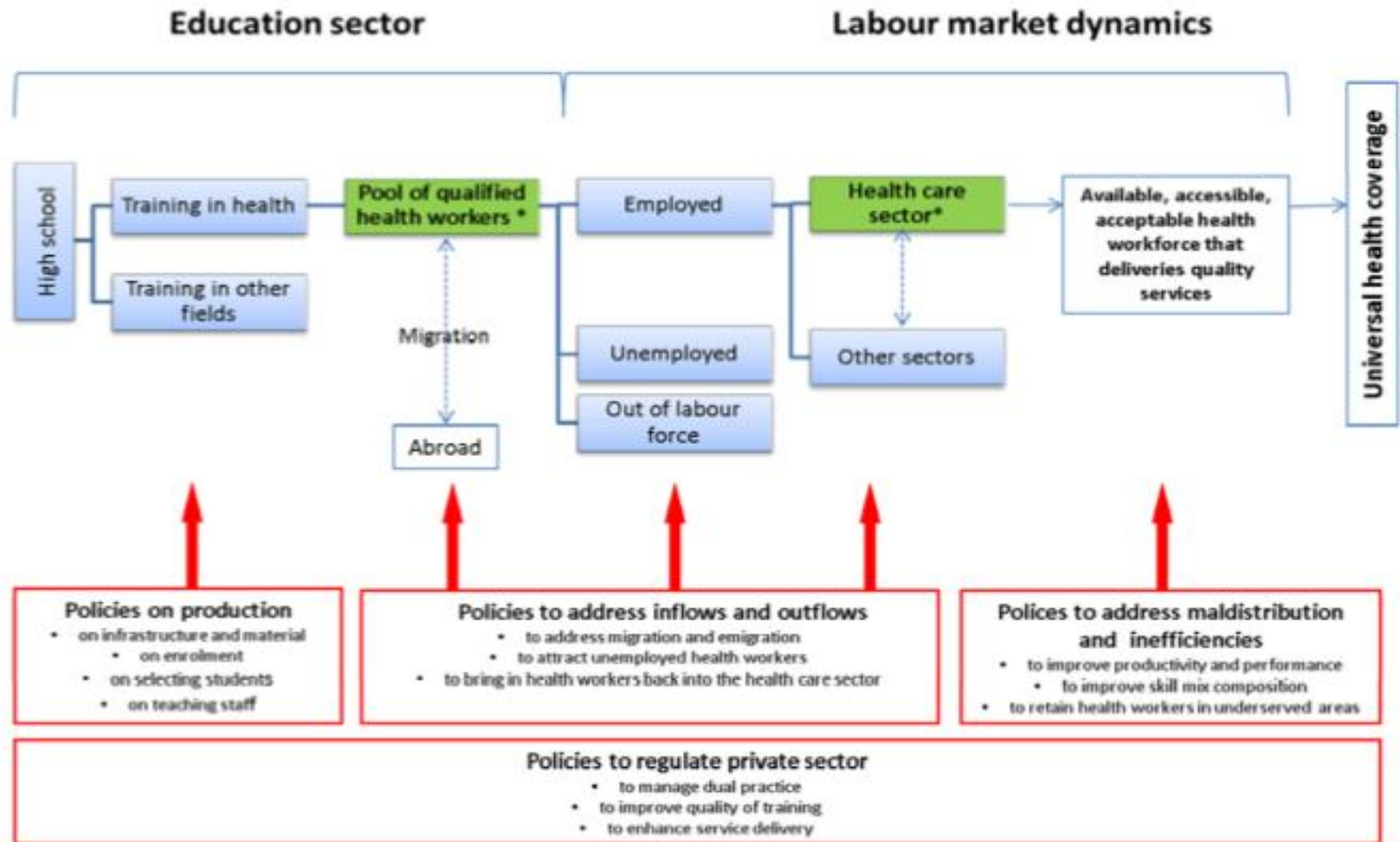
Health workforce for UHC: not just numbers



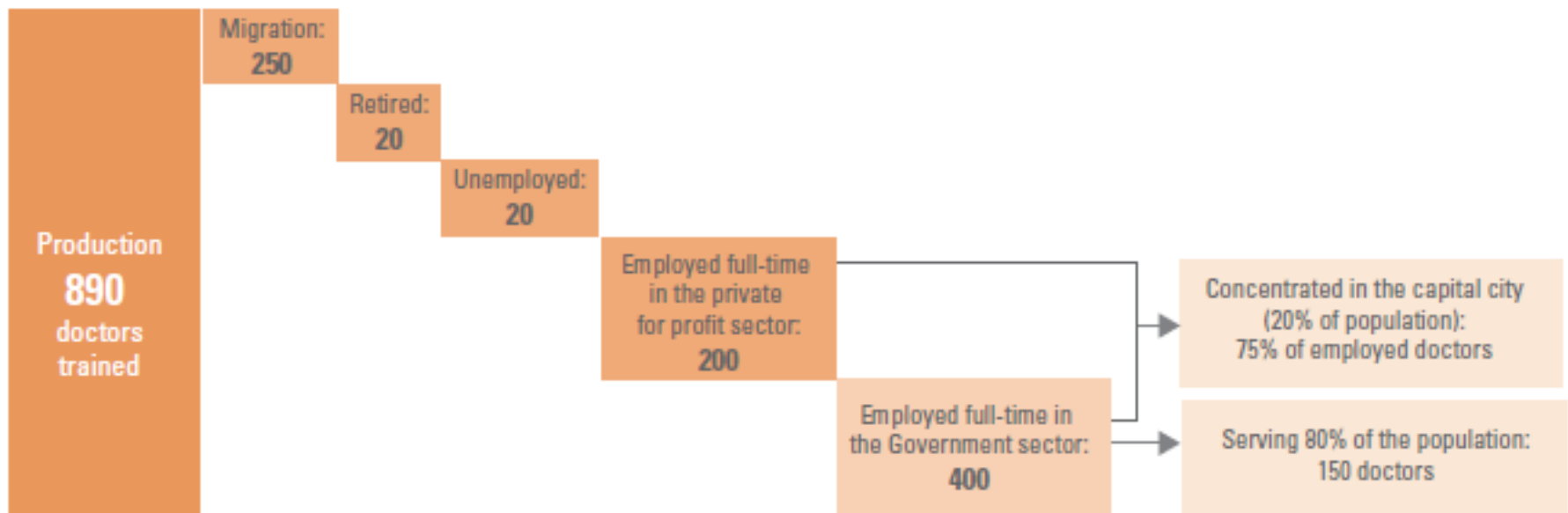
Ratios of highest to lowest sub-national density of physicians to national average



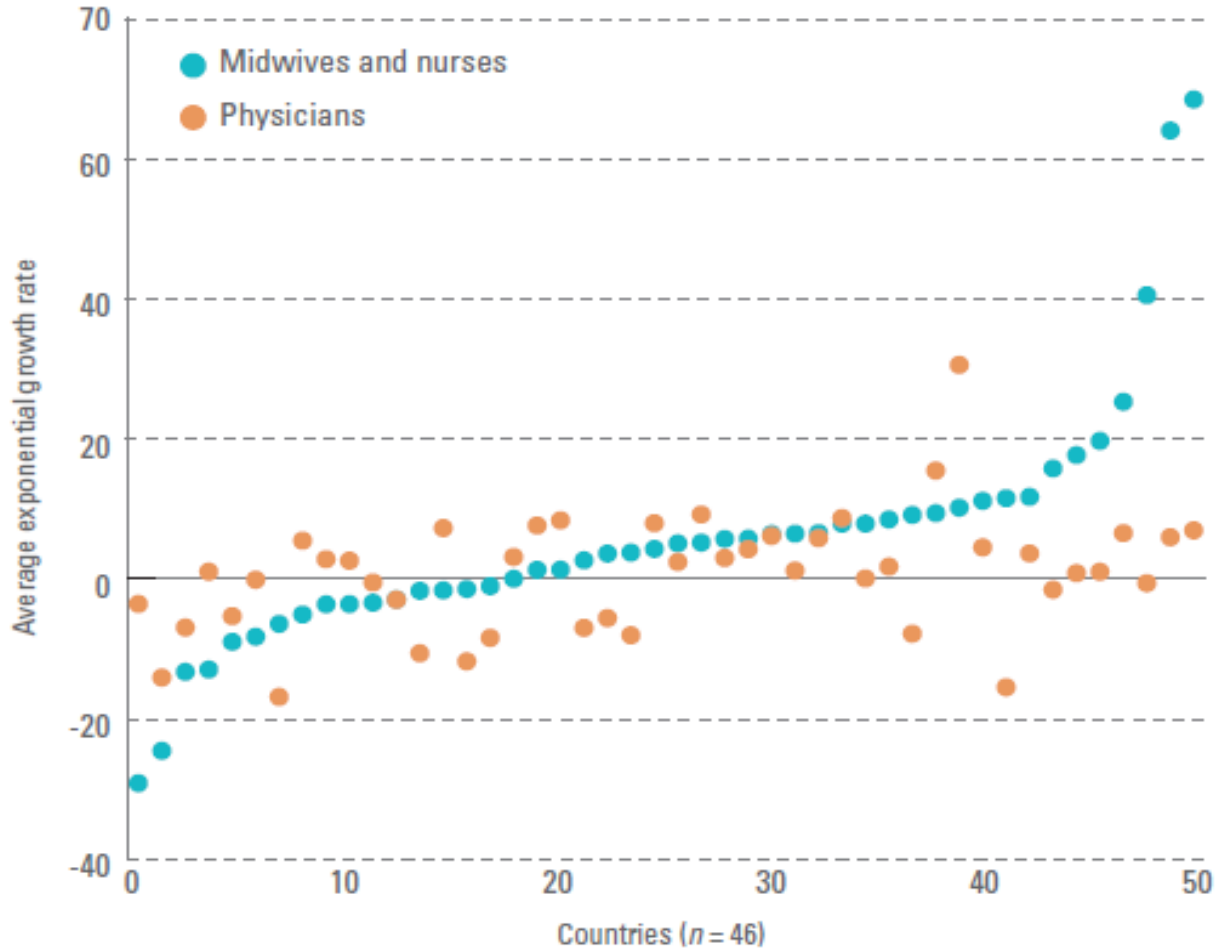
Assessing health labour market dynamics for universal health coverage



Health workforce labour market dynamics, Togo



Progress in improving availability, but uneven and not fast enough



3. Sustainable Development Goals (2016-2030): the health workforce implications

Health workforce: the foundation for any health target in the SDGs

By 2030

Reduce MMR to less than 70/100,000

End preventable newborn and under 5 deaths

End the epidemics of AIDS, TB, malaria, neglected tropical diseases

Reduce by 1/3 premature mortality due to non-communicable diseases

Universal access to family planning, financial risk protection, UHC, ...

increase substantially health financing and the recruitment, development and training and retention of the health workforce

The Ebola Outbreak

- Global health security depends on resilient health systems
- A clear reminder that Human Resources for Health and Health Systems Strengthening is a critical investment



Time to “rethink and improve”...

*“The foundations for a strong and effective health workforce for the future are being corroded in front of our very eyes **by failing to match today’s supply of professionals with the demands of tomorrow’s populations.**”*

*To prevent this happening, we must **rethink and improve** how we teach, train, deploy and pay health workers so that their impact can widen.”*

Dr. Marie-Paule Kieny, WHO Assistant Director-General for Health Systems and Innovation.

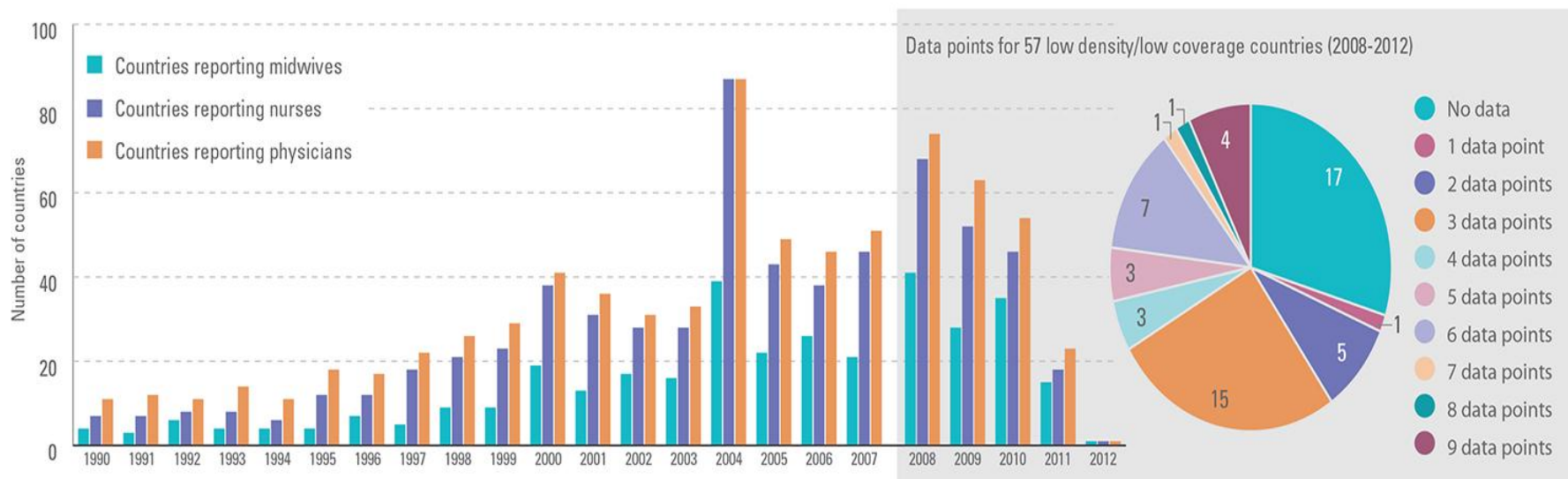
The building blocks of a fit-for-purpose workforce in the post-2015 era



4. Evidence and data requirements for HRH development at national level

Dwindling health workforce intelligence

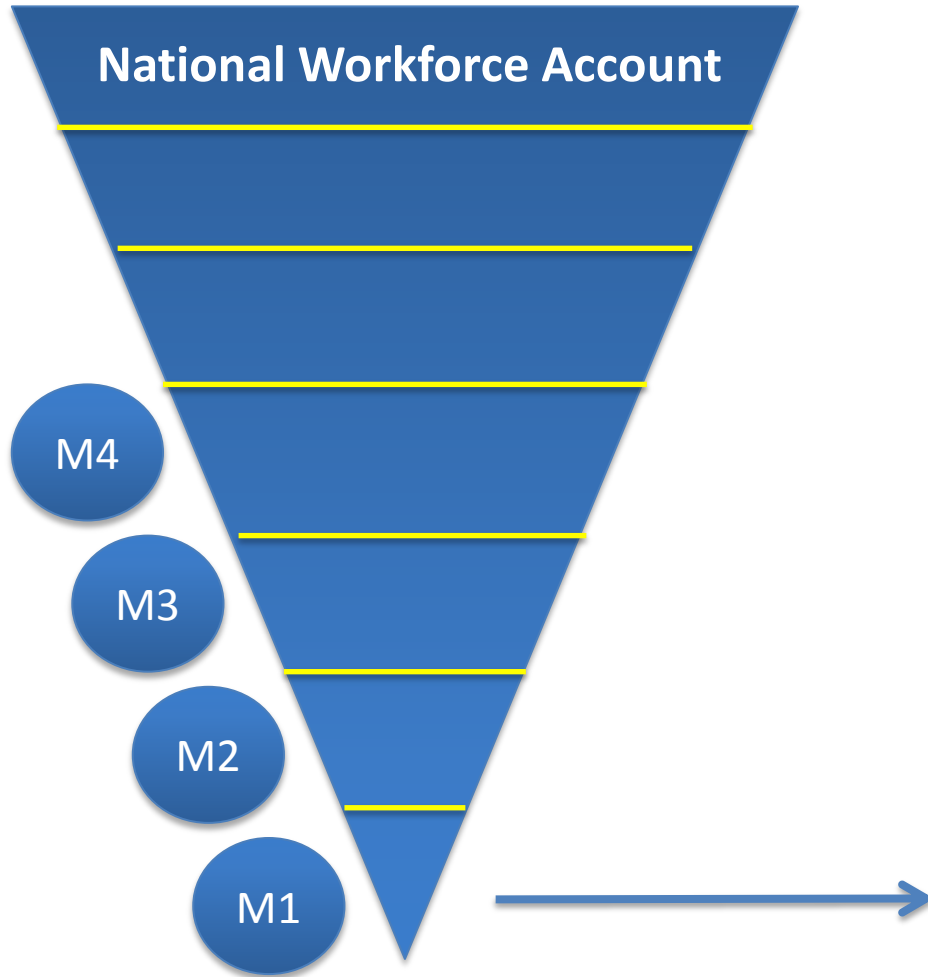
FIGURE 2 Frequency of all country reporting of workforce data to WHO's Global Health Observatory (1990–2012) and a focus on 57 low-density and low-coverage countries (2008–2012)



Source: Global Health Observatory Data Repository.²³

Inter-operable standard: “National Workforce Account”

Creating a workforce science



Human Resources for Health
Information System

**Minimum Data Set
for National Health
Workforce Registry**



HW data sources....

An example: Health workforce data sources in Maldives

Maldives
Medical
Council

Maldives
Nursing
Council

Maldives
Board of Health
Sciences

MoH
Payroll,
Retirement

Ministry
of Defense

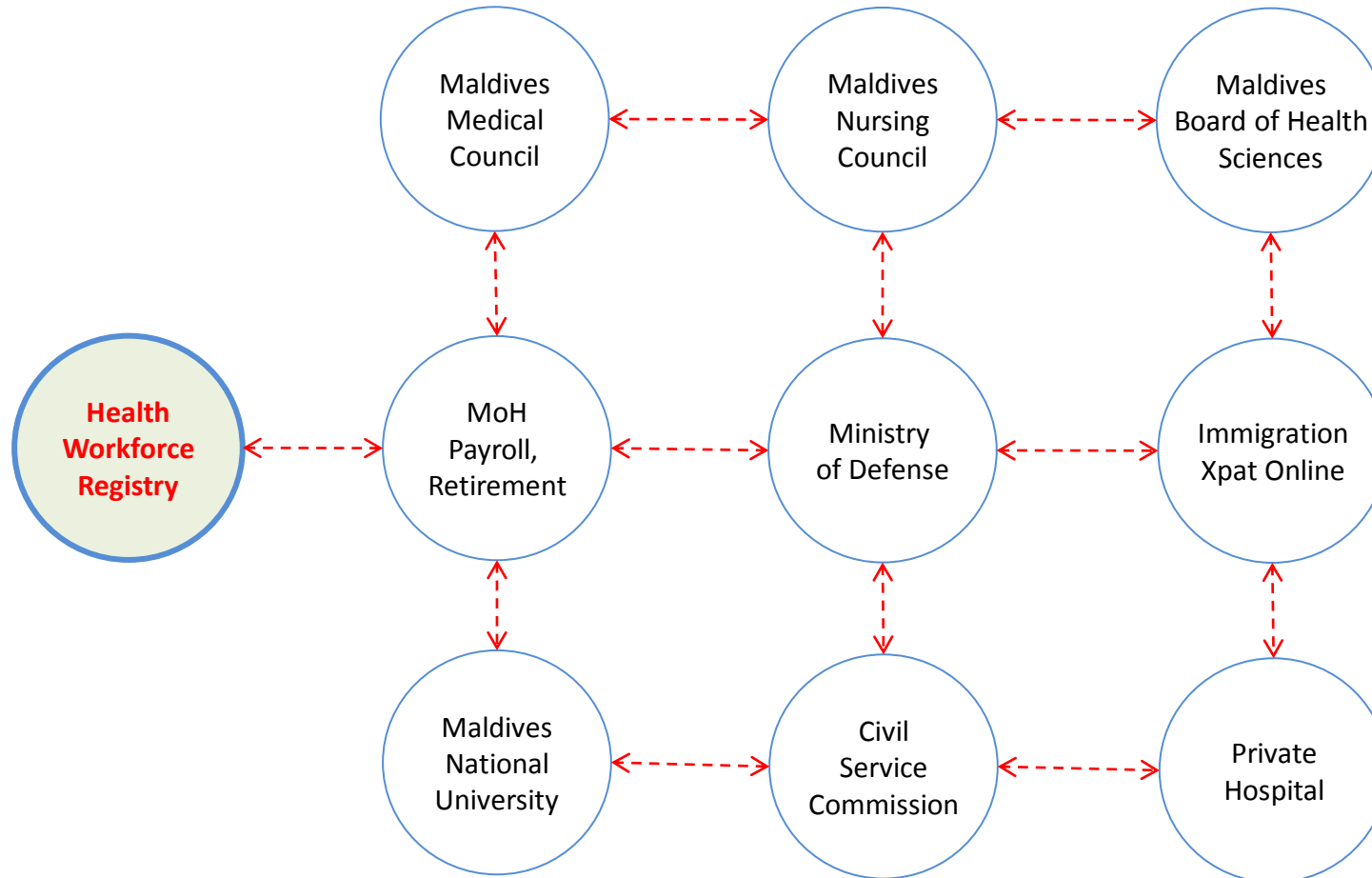
Immigration
Xpat Online

Maldives
National
University

Civil
Service
Commission

Private
Hospital

The HW Registry - concept



*Need for
Unique Person
ID system*

*using Minimum Data Set

MDS – 10 key fields

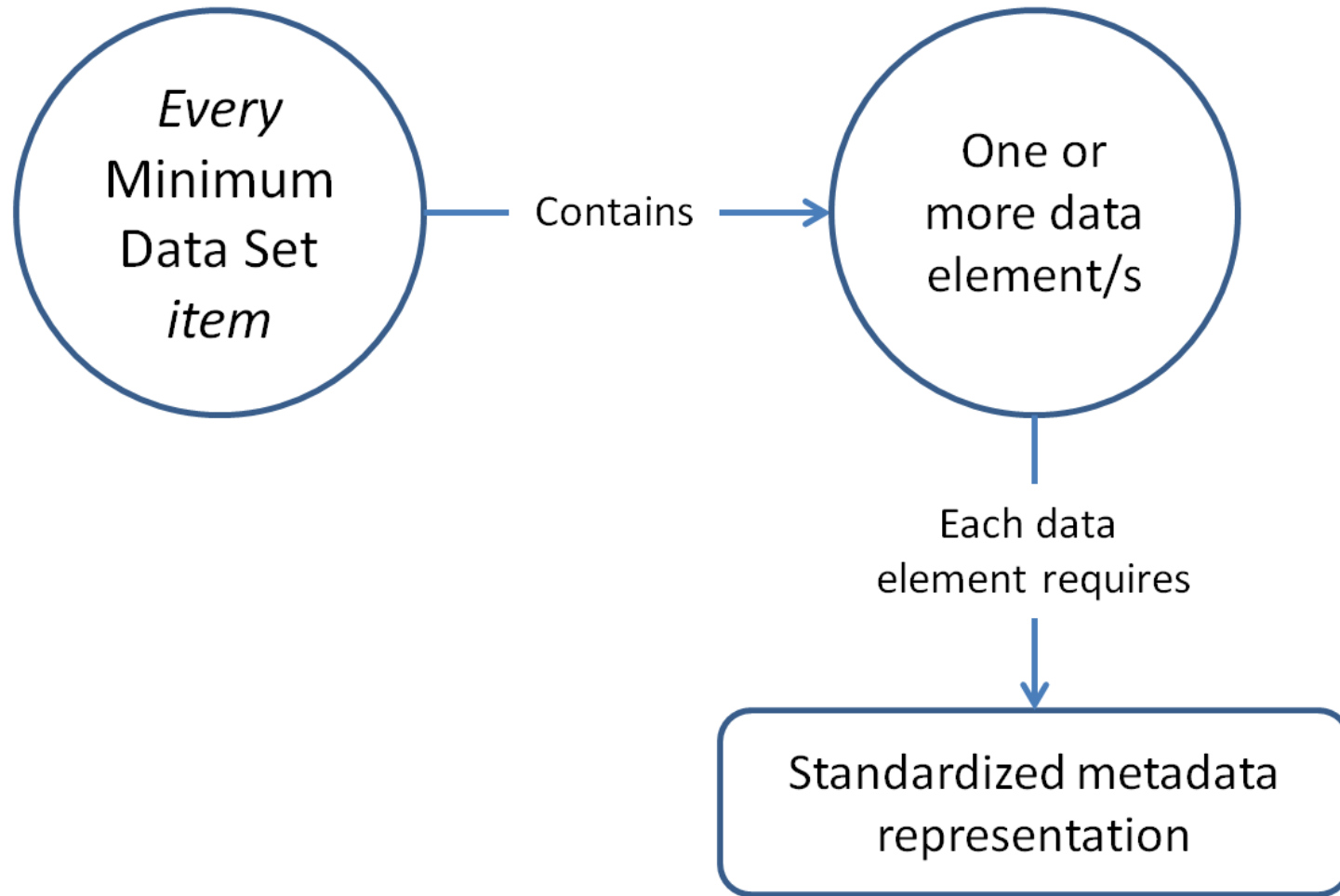
Minimum Data Set for Health Workforce Registry HRH Information System

- 1 Identification Number
- 2 Full Name
- 3 Birth History
- 4 Citizenship, Country of Residence, and Language
- 5 Address
- 6 Contact Information
- 7 Professional License and Certification
- 8 Employment Status
- 9 Employment Address
- 10 Data Submission Institution

MDS...

Minimum Data Set	Data Elements
Identification Number	<i>Unique Identification Number, Date of Issue, Date of Expiration, Place of Issue</i>
Full Name	<i>First name, last name, middle name, maiden name, other names</i>
Birth History	<i>Date of Birth, Sex at Birth, Place of Birth, father's name and mother's name, photograph</i>
Citizenship, Country of Residence, and Language	<i>Citizenship at birth, citizenship at present, country of residence, ability in spoken and written languages</i>
Address	<i>Physical address</i>
Contact Information	<i>Telephone number, email address, emergency contact name</i>
Professional License and Certification	<i>License and certification name, issuing institution, date of issue and date of expiration, photograph</i>
Employment Status	<i>Employment status, employment title and occupational category</i>
Employment Address	<i>Full address of current employer</i>
Data Submission Institution	<i>Name of the institution submitting data; date and time of submission</i>

MDS – standardized metadata



Making use of HRH data for improved efficiency of health spending

Payroll analysis in Dominican Republic revealed **10,000 ghost workers**, representing more than \$7.5 million per year in economic waste

Ministry of Health eliminated 2,717 ghost workers in the first phases of payroll cleanup and fully retired 1,090 people—**saving \$6.2 million per year**

Service coverage already rising for early detection of HIV and syphilis, family planning (particularly for HIV-positive women), and access to prenatal care for HIV-positive women.

Savings re-invested in
-hiring 2,511 new health workers
-10% salary increase for doctors and nurses,
-raised health workers' retirement benefits.

5. The Global Strategy on Human Resources for Health

Recife Political Declaration and WHA Resolution 67.24

Political demand from WHO Member States to develop a global strategy for Human Resources for Health.

"We as leaders are committed to attaining universal health coverage and recognize that we need an improved health workforce to achieve it."

Recife Political Declaration (3rd Global Forum on HRH, Brazil, November 2013)

"The 67th World Health Assembly ENDORSES the call to action in the Recife Political Declaration; ... REQUESTS the Director-General to develop and submit a new global strategy for human resources for health"

WHA Resolution 67.24 (World Health Assembly, Geneva, May 2014)

Global HRH strategy: Key objectives and principles

**Inclusive,
participatory and
transparent
consultation
process**



GLOBAL HRH STRATEGY: KEY TIMELINES

2013

GHWA Board working group on HRH strategy established

16th GHWA Board meeting decides to trigger process to develop a global strategy on HRH

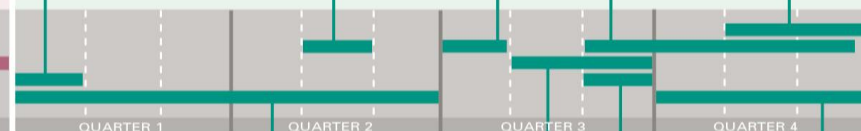


Consultation at PMAC 2014: 8 thematic working groups established

World Health Assembly requests WHO DG to develop global strategy on HRH

Third (final draft) of 8 thematic papers reflecting inputs of public consultation and outcome of UNGA 2014

Public consultation on the 8 thematic papers (launch at Cape Town health system research symposium)



8 thematic working groups develop collate evidence for papers with inputs from stakeholders

Production of second drafts of 8 thematic papers

UNGA debates post-2015 development agenda and goals

Development of synthesis paper with overarching recommendations

2014



2015

18th GHWA Board meeting reviews synthesis paper with recommendation on global HRH strategy

Development of 0 draft WHO global strategy on HRH

UNGA 2015 defines post-2015 development agenda, goals and targets



© World Bank

QUARTER 1 QUARTER 2 QUARTER 3 QUARTER 4

Collation of evidence and external consultation opportunities with member states

WHO Regional Committees (RCs) consider draft WHO Global Strategy on HRH

Contents of WHO Global Strategy on HRH adapted to reflect RCs inputs and outcome of UNGA 2015

QUARTER 1 QUARTER 2 QUARTER 3 QUARTER 4

69th WHA considers WHO Global Strategy on HRH

WHO EB considers WHO Global Strategy on HRH

2016



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Are health workers worth the investment?



16-fold ROI*

**through investments in
midwifery education and
deployment to community-
based services.**

*ROI in terms of lives saved and costs of caesarean sections avoided

(State of the World's Midwifery, 2014)

Are health workers worth the investment?



Broader socio-economic impact

through improved education, career opportunities for women, and economic growth.

Conclusions

HRH benchmarks in MDG era: significant inherent limitations; substantive yet uneven progress

Universal health coverage and Sustainable Development Goals: require greater level of ambition for HRH investment; relevant for countries at all levels of socio-economic development

Standardized and inter-operable workforce data required for effective planning and decision-making

Global strategy for HRH represents an opportunity to jointly identify and commit to a long-term agenda for HRH development

Further information

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Email: ghwa@who.int

www.who.int/workforcealliance

www.who.int/hrh

