Strengthening human resources for health in ACP countries

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According to the report on health in the post-2015 development agenda (2013), the health Millennium Development Goals (MDGs) have raised the profile of global health to the highest political level, mobilised civil society, increased development assistance for health, and contributed to considerable improvements in health outcomes in low- and middle-income countries. Commitment to the MDGs alone, however, was not stated to be enough to achieve great strides in policy co-ordination and planning. In fact the report stated that the MDGs have also contributed to fragmented approaches to development: between the different health MDGs; between the health MDGs and other MDGs, such as gender equality; and between the MDGs and priorities omitted from the MDG agenda.

The MDGs include concepts such as human rights, equity, democracy and governance, which at a glance one can see go beyond just the health sector. This does not negate the role or importance of health as critical to sustainable development and as a key indicator of what people-centred, rights-based, inclusive and equitable development seeks to achieve. Hence (as may appear obvious, but is not consistently applied in practice), any planning model for health systems' human resources (HR) cannot be considered separately from wider national health policies – which in turn must be linked to development goals of any country.

The strategy paper on intra-African, Caribbean and Pacific (ACP) co-operation under the Tenth European Development Fund (EDF) strategy recognised the 'uneven progress on improving human and social development around the world', stemming 'from countries' inability to provide sufficient and equitable health care services, due to crisis in their financial and human resources'. While the statistical evidence points to the absolute shortage of health workers in the majority of ACP countries as a contributor to disappointing progress towards the health MDGs, there are many other issues related to the health workforce which lead to sub-optimal health outcomes.

Small island states encounter all the human resources for health (HRH) problems of larger states, but the problems take on a special flavour owing to the small scale of their populations and economies. One example of this stems from the fact that education for the health professions is not scalable, with the consequence that small nations have to train most of their future health workers abroad. This in turn has consequences for the propensity to emigrate and expectations of practice at home. Continuity of services can be disrupted by the departure of a single individual because there is work for only one of that particular category in a very small country. Conversely, a returning national with advanced skills may expect the government to invest in the equipment and supporting staff he/she needs to exercise his/her specialty, even if it distorts national priorities. Another less tangible effect is that the government of a small state is liable to become overly dependent on the advice of one or two prominent health professionals, because they are the only accessible sources of specialist knowledge about health and health service organisation.

Classifying the challenges

There are many possible classifications of problem areas in HRH, and a different language or perspective may be adopted by different commentators, but there is a considerable degree of consensus around the salient issues affecting ACP countries. Consider Figure 1, which extracts the key issues from four documents.[1] These issues can be broadly divided into two groups:

Box 1 ACP countries

The African, Caribbean and Pacific Group of States (ACP) was created by the Georgetown Agreement in 1975 and consists of countries in Africa, the Caribbean and the Pacific. The group strives towards the goals of sustainable development and poverty reduction within member states, and facilitates greater integration into the world economy. All of ACP's member states, with the exception of Cuba, are signatories to the Conconou Agreement with the European Union.

All of the African, Caribbean and Pacific states of the Commonwealth of Nations are members of the ACP.

Box 2 The wealth gap

MDG 5 (to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio) is one of the health indicators that shows the greatest gap between the rich and the poor, and this applies both between countries and within them. The 2009 report showed that more than 99 per cent of women who died in childbirth lived in developing countries, 56 per cent in Sub-Saharan Africa and 29 per cent in South Asia. The comparison between developed and developing countries is said to be 'stark' with developed countries reporting 16 maternal deaths per 100,000 live births compared to 240 maternal deaths in developing regions, where 14 countries have maternal mortality ratios of at least 1,000 per 100,000 live births.

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Deployment of health workforce assets faces a range of distribution issues, including rural/urban and other geographic imbalances

Figure 1 The HR challenge

Issue	*WHO African region*	*WHO Western Pacific region*	*Pacific*	*Caribbean*
Weak HRH policy and leadership	*	*	*	*
Weak regulation of health professions	*	*		
Weak or absent HRH information systems	*	*	*	*
Health worker shortages and quality deficits:				
Too few entrants	*	*	*	
Inappropriate skill mix	*	*		*
Suboptimal deployment	*	*		*
Low productivity	*	*		*
Problems of retention	*	*	*	*
Losses to emigration	*	*	*	*
Special problems of small island states			*	

An asterisk indicates that the issue was treated at some length in the relevant document. The absence of an asterisk does not imply that the issue is not relevant to the area concerned.

Box 3 Technical assistance

WHO tools and technical guidance

WHO has at its disposal a battery of tools for use in different aspects of health workforce planning and management. For example, there are tools for:

- Costing the scaling up of education for the health professions and the resultant increased employment cost
- Measuring the numbers of health workers required to provide various services
- Forecasting future supply and demand of different categories of health workers – a comprehensive tool

Policy guidance exists in the form of various documents distilling global experience. For example, recently published guidelines have dealt with retention of health workers in rural and remote areas, as well as the access of health workers to services for HIV/AIDS and tuberculosis, and guidelines on transformative education for the health professions are imminent. In addition, the May 2013 World Health Assembly (WHA66.23) passed a resolution on 'Transforming health workforce education in support of universal health coverage' which sets out a course of action for the WHO Secretariat to be implemented with support from partners.

The deployment of tools and guidance to specific situations often calls for the intervention of experienced personnel; WHO capacity here consists of HRH specialists employed at headquarters, its six regional offices, selected sub-regional offices (three in the African region) and some country offices. In addition, WHO works with collaborating centres and engages consultants.

EU programme of action

A contribution agreement[3] (CA) was signed in order to provide financial support to an action by WHO to strengthen health workforce development and tackle the critical shortage of health workers. The principal objective of the programme, which targeted 29 countries (18 of them ACP states) and ended on 30 June 2012, has been to contribute to the improvement of health sector performance and progress in attaining the MDGs through the development and implementation of health workforce policies, strategies and plans to tackle critical shortage of health workers. The main operational objectives of the programme were to: 1) strengthen governance for the health workforce; 2) improve health workforce evidence and information; 3) establish mechanisms for effective management of health workforce migration and retention; 4) scale up health workforce production; and 5) support countries in addressing their critical HRH bottlenecks for priority health service.

Building the capacity of regional institutions, especially the African Union's New Partnership for Africa's Development (NEPAD), to strengthen co-ordination of the regional response has been an important element of this work

institutional management issues and substantive deficiencies in the quantity or quality of the health workforce.

Policy competencies and constraints

Each of these shorthand designations of problematic areas conceals a variety of topics and concerns. For example, 'weak HRH policy and leadership' is used as an umbrella term that covers the absence of HRH policy and/or plan documents; negotiating position vis-à-vis other government agencies (such as ministries of finance or Public Service Commission) and other items. Suboptimal deployment of health workforce assets includes a range of distributional issues, including rural/urban and other geographic imbalances; relative numbers in public and private employment; and distribution among medical specialties, generally with clinical specialties being over-subscribed and public health, including general medical practice, being under-staffed.

Many of the problems in HRH can be traced back to financial constraints. Lack of public finance helps explain the low salaries and poor working conditions that many health workers experience, with associated consequences for recruitment, productivity and retention. Even in the private sector, incomes are limited by the low purchasing power of the majority of the population in ACP countries. Given the disparity between incomes achievable in their home countries and those available to qualified health professionals in richer countries, the lure of emigration (and loss to the country of origin) is extremely powerful. Lack of funds is at least a contributory factor to the frequent observation of inadequate investment over decades in the education and training of health professionals, or the absence of systems to collect and analyse data on the health workforce. But shortage of money is not the sole source of problems in HRH, nor would an injection of funds necessarily have the optimal impact unless it was well directed.

In many ACP countries, the public sector is a dominant provider of public health services and thus a dominant employer of health workers. The implication of this is that the rewards and conditions of service of health professionals are embedded in public service-wide structures which are typically rigid and antiquated, and rely excessively on pre-service formal educational qualifications. These structures militate against desirable adaptations to the health sector context, such as incentives for remote area or out-of-hours service, progression based on performance and continuing professional development, or de-centralised disciplinary procedures. In some countries, ministries of health have been successful in negotiating derogations from the standard public service rules, but in many more the stranglehold of the Public Service Commission or its equivalent remains a negative factor in the efficient management of the health workforce.

What WHO can and cannot do

WHO has a role in ensuring that any standards or norms that it sets call for mechanisms that facilitate policy dialogue, not for its own sake but with a measurable agenda for change that is evaluated to determine how far such processes result in change at the country level. This is indeed challenging. The report on the MDGs articulates the view that there is a need in the post-2015 agenda for a rigorous framework that clearly articulates both how sustainable development differs from (and is preferable to) existing

development models, and how health and development are inextricably linked. Greater synergies between health and other sectors could be achieved by framing the goals in such a way that their attainment requires policy coherence and shared solutions across multiple sectors: that is, a whole-of-government or 'health-in-all-policies' approach. Examples of effective intersectoral action should be shared and widely disseminated so that others can learn from these experiences.

Each of the problem areas identified above has potential solutions. In the documents[2] under discussion these solutions are elaborated in slightly varying content and format, according to WHO region. They each lay out a plan of action, but by the nature of the documents they use normative rather than positive language – they delineate a desirable course of action, but they are often silent or unclear on the location of the responsibility for action. This is evidently because the great bulk of the resources that would be needed to implement the plans lie in the hands of national governments and external donors. The document exploring HRH issues in the Pacific Island Countries differs from the other three in that it focuses less on potential solutions to the problems identified, but it does reach a clear conclusion that the priority issues for attention are workforce policy and planning, and expanding and improving the quality of pre-service education for the health professions. In our view, these priorities appear soundly judged.

The reference above to resources gives a clue to what can and what cannot be expected of WHO. To strengthen institutions, technical assistance provided by WHO can be used, for example, to support establishing and guiding HRH units in ministries of health, advise on regulatory bodies' roles and functions, and design HRH information systems. WHO can also provide guidance on effective solutions to the substantive problems of the health workforce, such as scaling up the education system for the health professions or designing incentives for the recruitment to, and retention in, rural and remote areas of health workers (WHO, 2010a).

What WHO cannot do is finance the capital and personnel costs of an expanded education system, or supplement the salaries of an underpaid workforce. These tasks must be taken up by a combination of national actors and external donors. In practice, the distinctions between institutional reforms and substantive changes in the workforce situation, and between WHO support and donor financial contributions, often become blurred, because even institutional reforms on occasion need external finance for their implementation and because donors sometimes make infrastructure investments contingent on institutional reforms. As a consequence, WHO often becomes involved in multilateral partnerships with national actors and external donors to accomplish the necessary steps to strengthen the health workforce.

It is also important to note here that the World Health Assembly resolution on health workforce strengthening (WHA64.6; WHO, 2010b) urges member states, among others, to: implement the voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel; prioritise public sector spending on health, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale up and retain the health workforce; developing or maintaining a national health workforce plan as an integral part of a validated national health plan; and develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas. The resolution also requests WHO to provide leadership by generating evidence and recommending effective interventions to address factors that hinder access to health workers; provide technical support to member states to scale up education and training and improve the retention of the health workforce: and encourage and support member states in developing and maintaining a framework for health workforce information systems.

Endnotes

1 Touré et al, 2012; WHO/WPRO, 2006; Doyle et al., 2011; WHO/PAHO, 2012.

2 Ibid.

3 Contribution agreement DCI SANTE/2008/153–644.

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