Human resources for universal health coverage: leadership needed

Alexandre Padilha,[a] Joseph Kasonde,[b] Ghufron Mukti,[c] Nigel Crisp,[d] Keizo Takemi[e] & Eric Buch[f]

Global leaders have recently reaffirmed their commitment to the principle of universal health coverage (UHC).[1] The experience of the health-related Millennium Development Goals (MDGs) has taught us, however, that to translate such a principle into reality, health systems must be strengthened. Key to such strengthening and to improving health service coverage and health outcomes is the availability of a sufficient, equitably distributed, skilled and motivated workforce.[2] Yet in many countries health workforce shortages and poor worker distribution, training and performance hinder the attainment of the health-related MDGs and UHC.

Human resources for health (HRH) challenges are complex. Piecemeal solutions, such as short-term in-service training initiatives, abound. However, strategies to systematically address deep-rooted human resource problems require a long-term perspective and collaboration among many stakeholders and constituencies, brokered and led by national governments.[3] Several different paths towards strengthening the health workforce are possible, as the following examples illustrate.

In Brazil, the Unified Health System, grounded in the national constitution, has brought improved HRH policy-making and management. It took intersectoral and interagency collaboration to secure the required thrust and resources. No single HRH plan was developed, and yet Brazil succeeded in achieving sustained growth and more equitable worker distribution. Between 1990 and 2007 physician density rose from 1.17 to 1.74 per 1000 population and family health teams were deployed to rural areas.[4]

In Indonesia, the HRH agenda was bolstered by the decentralization reforms of 1999, whereby almost 2.4 million central government civil servants were successfully reassigned to local governments.[5] To overcome persistent worker shortages, maldistribution and dual practice, the government has enacted measures for improving health workforce education, equitable deployment and performance. HRH information systems have been strengthened. Coordination of national stakeholders has improved and resource allocation from both domestic and international sources has increased.[6] The national density of physicians, nurses and midwives has risen from 1.25 per 1000 population in 1997 to 2.06 in 2012.[7,8]

In Zambia, important innovations took place in HRH development, including initiatives to upgrade the training of existing staff, create new cadres to formalize task delegation and provide direct access to mid-level specialist training.[9] A new national HRH strategy, built on lessons learnt in the last decade, complements the traditional focus on producing new health workers with improved worker management, performance, distribution and retention.

Brazil and Indonesia are on track to achieve MDG 4 and are making progress towards MDG 5 targets.[10] Zambia has seen an important reduction in child mortality. In all three countries sustained, high-level political commitment across several sectors, including the health sector, accounts for these achievements.

In health service delivery, human resources are arguably the most critical component, alongside pharmaceutical products, information systems and equitable financing mechanisms. Weakness in any of these interdependent components can thwart efforts to attain UHC and undermine health service effectiveness. Without an adequate health workforce, UHC cannot be achieved.

Decisions influencing the health labour market – e.g. education policies, remuneration packages, employment conditions and private sector regulation – go beyond the technical and sectoral remit of health ministries. For instance, a national HRH strategy should take into account the health sector's potential as a source of qualified employment opportunities and a driver of economic growth,[11] but also its need to be compatible with a country's macroeconomic context.[12]

The multisectoral, long-term nature of HRH actions demands strategic leadership and robust coordination, nationally and locally, which only high-level political commitment can guarantee. Such commitment, which is necessary to align and sustain the efforts of different line ministries and other constituencies, should shape national health and broader development strategies, whose implementation should be regularly monitored.[13]

The international community can contribute by providing technical and financial assistance, aligned with national priorities, and by promoting periodic reviews of progress and opportunities for shared learning. Rather than copy staffing structures and arrangements from abroad, countries planning for UHC should meld these with lessons from their own rich traditions, especially in mid-level and community health worker programmes. This is an area in which everyone has something to teach and something to learn.

Advancing the 21st century HRH agenda towards UHC requires committed political leadership to match affordability and sustainability, demand and supply, to serve population needs. The upcoming Third Global Forum on Human Resources for Health can serve as a platform to jointly commit to this agenda. Much progress has been made towards resolving the global HRH crisis since the launch of the Global Health Workforce Alliance in 2006, but it is up to leaders around the globe to harness the resulting momentum towards making UHC a reality. ■

References

Available at: http://www.who.int/bulletin/volumes/91/11/13-118661

[a] Ministry of Health, Brasília, Brazil.
[b] Ministry of Health, Lusaka, Zambia.
[c] Ministry of Health, Jakarta, Indonesia.
[d] House of Lords, London, England.
[e] House of Councillors, Tokyo, Japan.
[f] Faculty of Health Sciences, University of Pretoria, PO Box 667, Pretoria, 0001 South Africa.
Correspondence to Eric Buch (e-mail: eric.buch@up.ac.za).

References

1. Resolution A/RES.63/33. Global health and foreign policy. In: United Nations documentation: research guide [Internet]. New York: United Nations General Assembly; 2012. Available from: http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36 [accessed 16 July 2013].
2. Anand S, Bärnighausen T. Human resources and health outcomes: cross-country econometric study. *Lancet* 2004;364:1603–9. doi: http://dx.doi.org/10.1016/S0140-6736(04)17313-3 PMID:15519630
3. Chapter 4: Making the most of existing health workers. In: *The world health report 2006: working together for health.* Geneva: World Health Organization; 2006. Available from: http://www.who.int/whr/2006/chapter4/en/index.html [accessed 16 July 2013].
4. Buchan J, Fronteira I, Dussault G. Continuity and change in human resources policies for health: lessons from Brazil. *Hum Resour Health* 2011;9:17. doi: http://dx.doi.org/10.1186/1478-4491-9-17 PMID:21729318
5. Kolehmainen-Aitken RL. Decentralization's impact on the health workforce: perspectives of managers, workers and national leaders. *Hum Resour Health* 2004;2:5. doi: http://dx.doi.org/10.1186/1478-4491-2-5 PMID:15144558
6. Windisch R, Wyss K, Prytherch H. A cross-country review of strategies of the German development cooperation to strengthen human resources. *Hum Resour Health* 2009;7:46. doi: http://dx.doi.org/10.1186/1478-4491-7-46 PMID:19500357
7. Indonesia, Ministry of Health. *Policy on human resources in health 2000–2010*. Jakarta: MOH; 2000.
8. Indonesia, Ministry of Health. *Planning of human resources in health needs for 2013*. Jakarta: MOH; 2013.
9. Ferrinho P, Siziya S, Goma F, Dussault G. The human resource for health situation in Zambia: deficit and maldistribution. *Human Resour Health* 2011;9:30.
10. Countdown to 2015 [Internet]. Building a future for women and children: the 2012 report. Geneva: World Health Organization & United Nations Children's Fund; 2012. Available from: http://www.countdown2015mnch.org/reports-and-articles/2012-report [accessed 16 July 2013].
11. Commission on Macroeconomics and Health [Internet]. Investing in health: a summary of the findings of the Commission on Macroeconomics and Health. Geneva: World Health Organization; 2001. Available from: http://www.who.int/macrohealth/infocentre/advocacy/en/index.html [accessed 16 July 2013].
12. Global Health Workforce Alliance. *Financing and economic aspects of health workforce scale-up and improvement: framework paper*. Geneva: World Health Organization; 2008. Available from: http://www.who.int/workforcealliance/knowledge/publications/taskforces/ftfproducts/en/index.html [accessed 16 July 2013].
13. International Health Partnership [Internet]. Joint assessment of national health strategies (JANS) tool & guidelines. Geneva: World Health Organization; 2011. Available from: http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/ [accessed 16 July 2013].