Can human resources for health in the context of noncommunicable disease control be a lever for health system changes?

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Major global shifts are shaping health priorities in the wake of new challenges and emerging opportunities. While reaffirming a commitment to accelerate progress on the Millennium Development Goals, discussions on the post-2015 agenda have also focused on the importance of noncommunicable diseases (NCDs).[1] Efforts are also under way to enhance countries' commitment to universal health coverage (UHC) and to overcome the system constraints that are hampering progress towards achieving disease-specific targets. Despite auspicious directions, the journey is fraught with obstacles. A focus on human resources for health (HRH) in the context of NCD control could be a lever for health system change after 2015 by leading to measures designed to improve health systems more broadly.

This view is supported by several trends. First, the required shift from the care of acute infectious diseases to chronic conditions entails a reorientation of health systems for which human resources can be an important lever. This effect has been shown in programmes for the control of human immunodeficiency virus (HIV) infection that have relied heavily on changes in the terms and conditions of employment: task sharing and task shifting strategies were designed; information systems, supply chains and service delivery norms were tailored towards chronic disease care; new referral systems and appointment and defaulter tracking methods were introduced; and worker training was focused on the use of new instruments, such as appointment books, patient counselling guidelines, medical records and standardized treatment protocols.[2] Besides these measures, HIV programmes have also employed non-traditional human resource strategies in the form of engagement with nongovernmental organizations, service recipients, peer educators, treatment partners and expert clients.[3] In the context of NCD management, human resources can be strategically leveraged in similar fashion to reorient systems towards chronic care more broadly.

Second, the "health in all policies" approach is gaining appeal with the growing recognition that many paths towards improving health lie outside the health-care system.[4] New stewardship capacities are required to ensure appropriate institutional mechanisms and partisan agreements, a collaborative division of labour, a commitment to shared goals and accountability for results. Change is possible only if the right human resource competencies are present at the starting point. The prevention and control of NCDs provide a platform for intersectoral engagement, both through "health in all policies" and through a more issue-centric approach, such as tobacco control.[5]

Third, NCDs are the focus of most of the information and communication technology-based solutions designed to overcome human resource shortages and geographic access constraints to health care. Among them are health education to promote patient screening for NCDs and cell-phone-enabled medication adherence tools for the management of asthma and diabetes, some of which have shown clinical benefits in trials.[6,7] Now that 95% of the world's population has access to mobile signals, these approaches could help to overcome critical health worker shortages, to the benefit of the one billion people in the world who would otherwise never have access to a health professional. Sim card applications, which can be powered by any type of phone, can provide health service access to patients and communities in settings where health worker shortages are not amenable to quick fixes. These emerging tools for NCD control create opportunities for revising health worker roles and maximizing the effectiveness of health systems.

HRH are also an important lever in post-2015 efforts to attain UHC. Of all the resources that factor into the health system – financial, physical, technological and human – human resources are the most strategic. Individually or collectively, they can generate change within the system.[8] For example, decentralization of authority from a higher government level to the subnational level can enhance accountability. Outsourcing of health service management and new service delivery arrangements can lead to improved performance. Definition of new rules of engagement between public and private entities in the health system and new recruitment and retention mechanisms, together with empowerment of facilities by granting them increased autonomy, can affect staff incentives and, consequently, morale and performance. As health systems are reoriented towards the control of NCDs, these measures become potential pathways towards health system reform.

In summary, human resources for health are vital for mainstreaming changes in health systems and in the broader social system that affects the health of the population. Emerging agendas in the post-2015 landscape offer an opportunity to tap to the fullest the potential of human resources for health. ■

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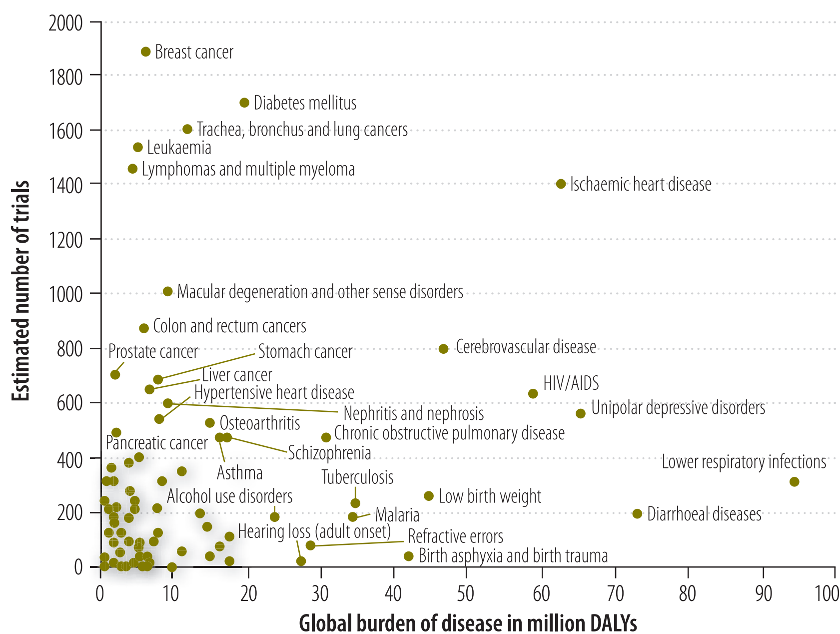
Corrigendum

In Volume 91, Issue 6, June 2013, page 420, the x-axis of Fig. 3 should read "Global burden of disease in million DALYs".



In Volume 91, Issue 9, September 2013, on page 704: the 10th author's name should read "Jennifer Kidwell Drake".

In Volume 91, Issue 10, October 2013, on page 722, paragraph 6, the 2nd sentence should read: "Cardiovascular disease, including heart disease and stroke, accounts for 62% of those deaths – higher than the global average of 48% – while cancer causes almost 13% of them."