What are the major global HRH challenges to halving inequalities in access to a health worker?……

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Strengthening capacity to optimize the existing HWF towards UHC / SDGs

- HRH distribution and retention- key to UHC attainment
- Distribution and retention in context
- Labour market dimensions and dynamics
- Policies to address retention/ distribution- typology of key findings of “what works”
- Critical knowledge gaps

UHC- “AAAQ”the workforce dimension

Availability

– the sufficient supply and stock of health workers, with the relevant competencies and skill mix that correspond to the health needs of the population;

Accessibility

– the equitable access to health workers, including in terms of travel time and transport, opening hours and corresponding workforce attendance, whether the infrastructure is disability-friendly, referral mechanisms and the direct and indirect cost of services, both formal and informal;

Acceptability

– the characteristics and ability of the workforce to treat everyone with dignity, create trust and enable or promote demand for services; and

Quality

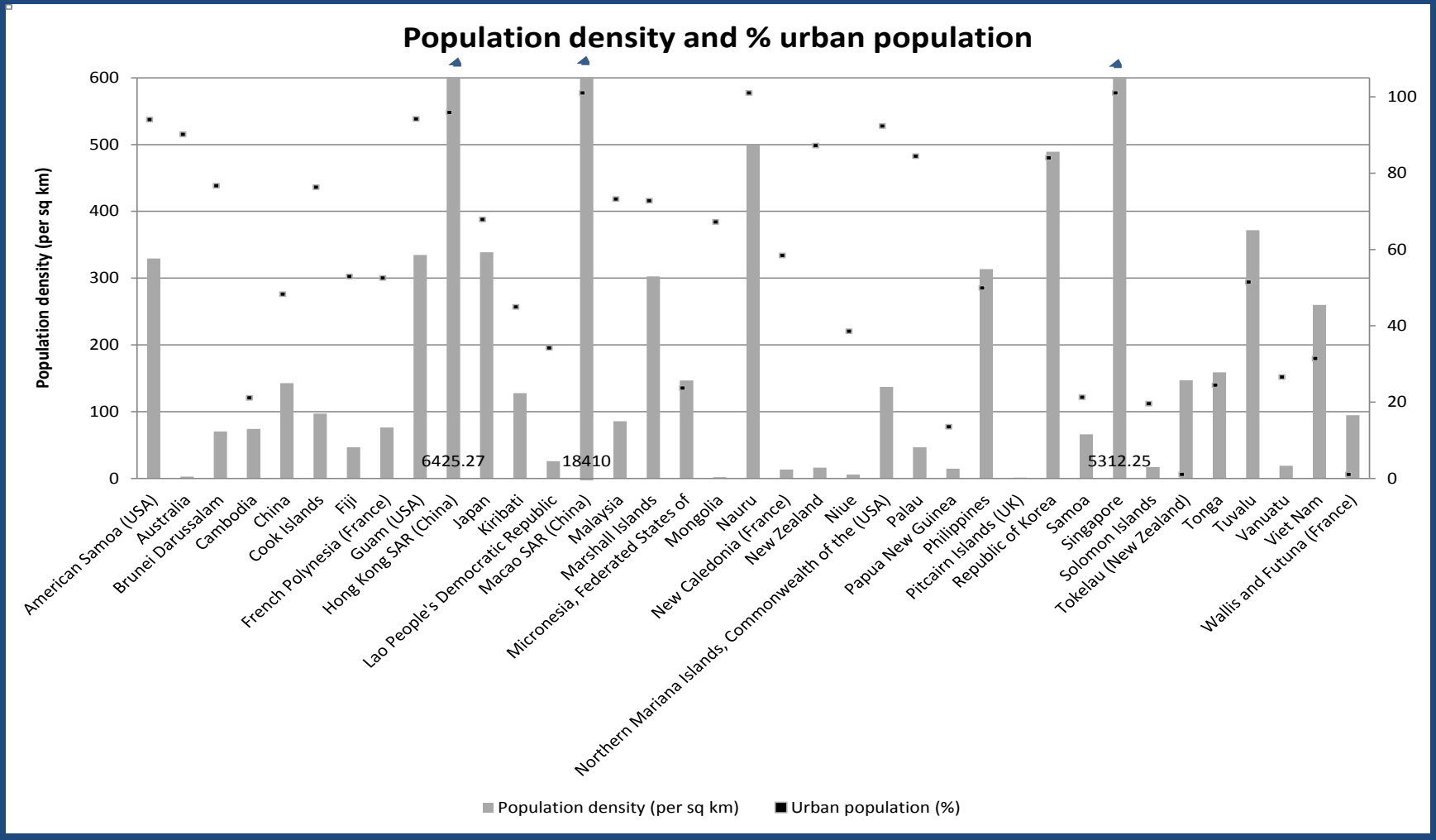
– the competencies, skills, knowledge and behaviour of the health worker as assessed according to professional norms and as perceived by users

GHWA (2013) “No Health without a Workforce”

Distribution and retention in context: Key questions from the Health Minister

- How do we plan how many health workers to educate, and employ?
- How can we improve recruitment, retention?
- Which incentives are effective in motivating / distributing staff?
- How can we determine and deploy the most effective skill mix of staff?
- How do we improve productivity, the performance of individuals and teams of health workers?

Population density and urbanisation in Western-Pacific countries



Source: http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf

Some HRH realities in Asia- Pacific

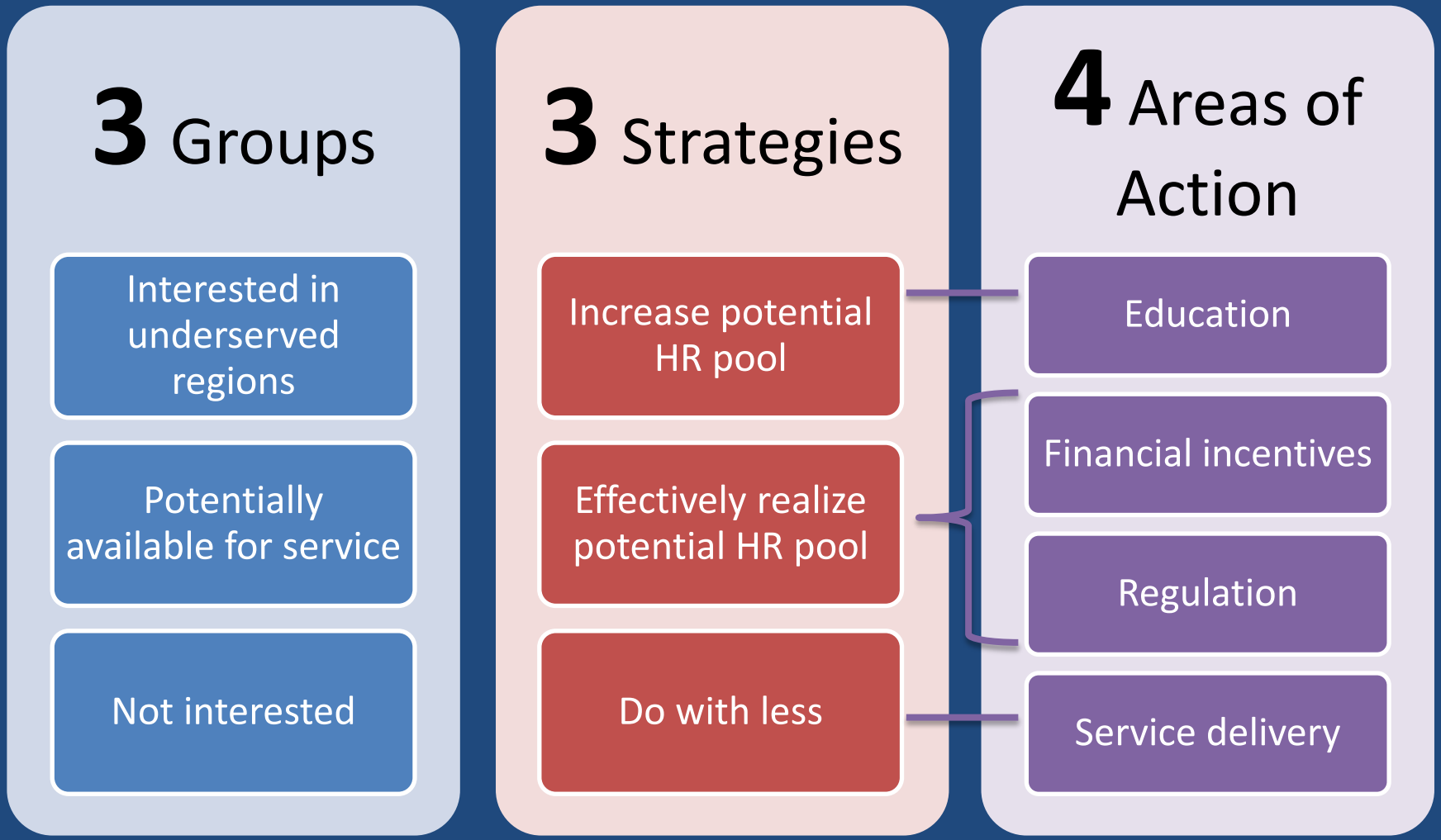
- Growth of private sector education [and health sector employment]-regulation/quality
- Dual practice for health professionals
- Variable/ high absenteeism
- Recruitment/retention in rural/remote areas
- Relatively high ratio of physicians to other health professionals
- Small islands states- small absolute number of staff: vulnerability to migration; difficulty in providing specialist/tertiary services; cost of support for “out of country” training

Framing policy responses: WHO recommendations on retention in underserved areas

Category of intervention	Examples
A. Education	A1 Students from rural backgrounds
	A2 Health professional schools outside of major cities
	A3 Clinical rotations in rural areas during studies
	A4 Curricula that reflect rural health issues
	A5 Continuous professional development for rural health workers
B. Regulatory	B1 Enhanced scope of practice
	B2 Different types of health workers
	B3 Compulsory service
	B4 Subsidized education for return of service
C. Financial incentives	C1 Appropriate financial incentives
D. Professional and personal support	D1 Better living conditions
	D2 Safe and supportive working environment
	D3 Outreach support
	D4 Career development programmes
	D5 Professional networks
	D6 Public recognition measures

Source: http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf

Framing policy responses: OECD report on physician distribution



Sources: Bennett, 2010 and Schoenstein et al, 2014

“What works”: Typologies

Wilson et al 2009 (distribution)	Bucyx et al 2010 (retention)	WHO 2010 (rec and retention)	Viscomi et al 2013 (rec and retention)	OECD 2014 (distribution)	Kousa et al, 2016 (retention/ attrition)
Selection	Staffing	Education	Life before medical school	Education	Education
Education	Infrastructure	Regulation	Experiences during medical school	Financial incentives	Financial incentives
Coercion	Remuneration	Financial incentives	Experiences during postgraduate training	Regulation	Career development
Incentives	Workplace organisation	Professional and peer support	Recruitment/retention after completion	Service delivery	Infrastructure and staffing
Support	Professional environment		Maintenance: remaining satisfied		Professional work environment
	Social, family, community support				Workload and autonomy

Key points from the evidence

- “Bundles” of co-ordinated policy interventions rather than single shot
- A moving target: Be clear about the context- Circumstances and priorities vary- and change over time
- Education!!!!- Recruit/ train local = stay local
- Its not just a workforce “problem” – service solutions [redesign/ relocate services, use of tele-health, IT, mobile teams etc]

Evidence coverage: Critical gaps

- Coverage by occupation- OK for doctors; little on nurses/AHP; virtually nothing on others
- Coverage by country/ region- some on OECD countries [Aus, Can]; little on low income
- Coverage by intervention- more on education, some on financial incentives, little on other
- Coverage by methods- mainly descriptive/ surveys of motivation/ need; some use of turnover/ retention/ stability measures; little on cost/ effect/impact of intervention[s]
- Abandoned/ ineffective policies: virtually no examples

Summary

- The push on UHC and SDG's will refocus policy on HRH as a block or as an enabler
- Asia- Pacific: be clear that the HRH "solutions" to identified challenges matches policy context and priorities, and take account of labour market dynamics and realities
- For most countries, the health workforce in 10 years time will [mainly] be the workforce you have now- invest!!
- HRH must be considered in context of other linked issues- education, governance and regulation, finance, service planning (Typology)
- Planning for a moving target: Adaptive strategy, not a fixed -in- time plan.

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