HARNESSING THE POWER OF HUMAN RESOURCES FOR ACHIEVING THE MDGs

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JOINT LEARNING INITIATIVE

Over the past year, I've been privileged to coordinate the Joint Learning Initiative, a global network of more than 100 members organized into seven working groups to review evidence for developing new strategies and landscaping human resources for health and development. Impetus for the initiative came from concern that mobilization of money and drugs would expose the fragility of the human infrastructure as the primary constraint to achieving the MDGs. Our working groups consulted around the world, commissioning more than 50 studies including "voices" of health workers themselves. For supporting this open, independent, and creative quest for practical answers, we thank our core funders (Sida/Sweden, Gates and Rockefeller Foundations), in-kind contributors (DFID/UK, GTZ/Germany), and the unstinting support of the WHO and the World Bank.

What are we learning? And why am I here today? The problem is both simple and complex -- simple in that some human resource situations are very obvious and complex in that human resources are invariably imbedded in a seamless web of interconnecting issues. People, after all, are complicated! While we do not have definitive answers; we hope we're asking the right questions. We would like to convey four points:

First, human resources are in crisis, yet absolutely critical for achieving the MDGs in the world's poorest countries.

Second, an effective workforce should be urgently mobilized to implement priority national programs, triggering the longer-term building of sustainable human resource capacities -- positive work environments, education and training, and enabling economic policies.

Third, country-based strategies must involve sectors beyond health and engage stakeholders beyond government.

Finally, an action alliance should be started immediately to harness the power of human resources for the MDGs

CRISIS IN HUMAN RESOURCES

Human resource is an old problem buffeted by new forces. The unprecedented HIV/AIDS epidemic poses a triple threat -- increasing the workload of health workers, decimating the workforce, and exposing frontline workers to infectious hazards and social stigma. The loss of workers due to HIV/AIDS is shared by all sectors, but health workers especially have to cope with the extra work and the contagious risk.

Labor markets and migration are also intensifying. Highly-skilled workers are shifting from poorer to richer regions and from public to private sectors. Well recognized is the concentration of professionals in capital cities, but regional and international migrations are assuming new dynamics. Anecdotal stories abound. There are allegedly more Malawian doctors in Manchester than in the home country; only 50 of 600 trained Zambian doctors continue to practice in the country. Recruitment firms batch together nurses for wholesale export. Each year, Cuba dispatches thousands of medical workers abroad, mostly to African and Caribbean countries. Doctors in the Philippines are retraining themselves as nurses to meet changing export markets. These flows, within and across countries, are creating severe mal-distribution and imbalances. The problems are unlikely to go away as many nations depend upon the import of workers. The demography of ageing in Northern countries ensures continuing demand for care workers well into the future.

New stresses are being imposed on fragile human resource bases severely eroded by two decades of neglect. As a field, human resource is considered a "backwater" -- personnel administration, not elite science or policy economics. Health sector "mis-reforms" of recent decades imposed ceilings on staff numbers and salaries while capping investment in the educational pipeline. The cupboards are now bare! The next phase of health sector reform will have to restock the shelves!

Donors and agencies are part of the problem. Many classify human resources as recurring expenditures, not an investment. Amazingly, buildings are considered capital assets, while human capital are considered recurring obligations! Donor projects tap available local talent but shy away from investing in people for the long-term. Under-investment in pre-service training characterizes aid-supported projects that have narrowly defined objectives. Donors finance foreign technical assistance and foreign training, for example so-called "flagship courses." Short-term training in countries is ad hoc and fragmentary, without coordination or staff career plans. These training programs often compete with each other, sometimes degenerating into "per diem bidding wars." Like a black box, short-term training has no data, no budgetary tracking, and no impact evaluation. To be fair, some counterpart governments have their own malpractices, including "ghost-workers" and under-the-table payment for university admissions or post transfers.

We must finally acknowledge great uncertainties surrounding human resources in poor countries. Rapidly changing situations are not well captured by data, although worker voices offer many insights. Despite worries about physical safety, economic livelihoods, and psychological stress, many frontline workers display enormous dedication and fortitude in the face of hardship. In many cases, they demonstrate leadership and craft innovations under severely constrained circumstances. In all situations, a gender lens is important for understanding human resources.

WHY HUMAN RESOURCES MATTER!

Workers spearhead health results, and thus human resources are absolutely critical for achieving the MDGs! Workers are active, not passive, agents who glue together all resources -- information, drugs, and money -- to generate health outputs. Without an effective workforce, money and drugs will be wasted. In the sequencing of resources, the workforce is paramount. People are the "ultimate resource" -- not substitutable, not easily fungible, and not available on short-notice.

In collaboration with the WHO and the World Bank, our research confirms the powerful connection between the workforce and the health of populations. Few countries achieve 80% coverage of measles immunization without a minimum density of 1.5 workers per 1,000 population (Figure 1). About 2.5 workers per 1,000 are required for skilled birth attendance, an indicator of maternal mortality. As tasks become more complex, the required worker density increases. In several years, we will gain sufficient experience to learn of threshold requirements for 80% coverage of anti-retroviral drug treatment for AIDS.

The relationship between worker density and health outcomes is even more powerful. Not unexpectedly, countries with the highest worker density have the lowest child mortality, and vice versa (Figure 2). Additional analyses show similar relationships to maternal mortality. Worker density joins other well-established determinants of child and maternal health, such as income and girls education. Importantly, worker density exerts an independent effect on mortality when income and education are controlled, and its mortality effects are strongest in the poorest countries. Note that worker density here combines doctors, nurses, and midwives, an imperfect measure based on the only data available.

COUNTRY-BASED ACTION

The question is not whether human resources are important but what can be done and how to do it! No country is free of human resources challenges, and no single approach is appropriate because of enormous global diversity. In other words, one size doesn't fit all!

Our analysis suggests four basic patterns. First are poorer worker-deficit countries; these are nearly all in sub-Saharan Africa. Second are the richer worker-dense countries, mostly OECD countries. Exceptional worker-density is also found in countries of the Former Soviet Union and in exporting countries like Cuba and the Philippines. The remaining countries of Asia, Latin America, and the Middle East suffer variably from maldistribution and imbalances. Country representatives presenting later in this session -- Ghana, Japan, and China -- reflect in sequence these first three clusters.

High variability in human resource patterns is noteworthy. Poorer countries are not only worker-deficit but also have lower skill-mix, lower cost, and poorer health status. Richer countries enjoy the converse. High variability within clusters suggests a huge potential for efficiency gains. In other words, many countries have the potential for generating much higher health returns per unit investment from improved planning and management of human resources. Importantly, these efficiency gains are achievable within clusters, without countries having to shift to human resource patterns beyond realistic feasibility.

For achieving the MDGs, highest priority must be accorded to the poorest worker-deficit countries. The 54 countries in this cluster, nearly all in sub-Saharan Africa, face the biggest MDG-achievement gap. In these countries, the workforce deficit is massive. Chris Kurowski of the World Bank estimates that Tanzania and Chad would need to increase their worker stock three-to-four fold by 2015 to provide the essential services aligned with the health MDGs.

Actions in countries are indicated along three fronts -- urgent mobilization, sustained capacity building, and policy development. But first, let's be clear about who are health workers? Health workers link people and communities to information, technology, and services that enable them to produce and improve their own health. Health workers are all who contribute to the health of populations. This includes large numbers and types of workers, beyond doctors and nurses. Health workers are also leaders, innovators, and entrepreneurs, not simply functionaries. A gender lens also helps us to understand the nature and composition of the health workforce.

We are entering a "decade of human resources!" National mobilization is urgently needed to develop the workforce for achieving the MDGs in the world's poorest countries. The mobilization should advance and harmonize priority national programs, scaling-up core services. Focused time-bound targets should be set and monitored for progress. Urgent mobilization of briefly-trained paraprofessionals based in communities is the only viable strategy under the emergency contexts faced in many countries, as exemplified by WHO's plan to train 100,000 workers for the 3-by-5 program. History demonstrates that such mobilization can be highly effective, as demonstrated by workforce deployment in successful disease control and primary health care programs.

Immediate action must spark the longer-term sustained building human resource capacities. In so doing, three inter-related strategies should be harmonized. First, demand strategies must focus on strengthening the workforce in public and private health

systems. Second, supply strategies must prepare a future workforce through education and training. And third, matching demand and supply to health needs is the primary challenge of policies that address the macroeconomy, civil service, and labor markets.

We have documented literally scores of success stories in pursuit of these strategies. As positive working incentives, for example, Uganda developed a lunch allowance to increase compensation of health workers. Ghana is now undergoing yet another round of civil service reforms to retain health workers. Non-financial incentives in India were presented earlier and are also well documented in East Africa. In education, Unity in Health promotes problem-based learning and community-oriented service among a network of medical schools. PAHO's observatories bring together leaders in ministries of health and schools of medicine and public health through a regional network that harmonizes the demand and supply of human resources.

Scaling-up such innovations requires a positive policy environment, especially macroeconomic enabling policies. The earlier harmonization session discussed the critical importance of policy and procedural changes that would bring together economic and human resource policies. Human resources policies cannot be developed by ministries of health alone but require the support of ministries of finance, education, and civil service. Nor are the stakeholders simply governments. Leaders in academia, professional associations, labor unions, businesses, and non-governmental organizations can be either allies or resisters of policy change. Stakeholders must be consulted and brought into the decision-making for more effective human resource policies.

Stakeholder consultations can be strengthened and operationalized through existing country-based mechanisms -- national development plans, sector-wide approaches, NEPAD, PRSPs, METPs, and Global Fund programs. Integrating human resources into these mechanisms is a practical application of donor-recipient harmonization. These multi-sectoral and multi-stakeholder processes should be recognized as not simply technical functions but as serving important economic and political functions that constitute good governance in health.

AN ACTION ALLIANCE

Demand is growing among countries for stronger technical support about how to manage human resources. To meet this demand, global reinforcement of country actions can be facilitated by setting standards, disseminating best practices, developing metrics and tools, and promoting research to meet knowledge gaps. Many global flows, however, are beyond the control of individual nation states. International cooperation is necessary to channel transnational flows that impact on human resources -- labor migration, financing and investments, health and ICT technologies, and social networks and alliances.

To strengthen country work through harnessing global opportunities, we propose an action alliance that augments the capacity and power of existing organizations while

harnessing the contributions of key stakeholders. An alliance would bring together the vision, actors, and activities into an effective whole, much like the Forum's incubation of the global metrics network. It is important to begin immediately, to take risk, and to implement what works. We should learn as we go and grow.

Beyond an alliance, other options were considered: commissions, mainstreaming, integration, and partnerships. A study commission was not attractive because of delays in action. Useful, however, is to refer the international migration of medical professionals to the newly established UN Commission on Migration. Another alternative is to mainstream human resources into categorical or health systems programs. Categorical programs have narrow missions, urgent time-lines, and priorities beyond human resources, which require concentrated attention and a longer time horizon. Health system programs mostly focus on financing; the expertise required in human resources is strategic management. We also considered integrating health and education, which share common human resources challenges. An integrated program could be called "human resources for human development." However, health has distinctive constituencies and unique issues, like HIV risk among workers, which are best addressed distinctively. Finally, global partnership is an often-used term to describe an assortment of program arrangements. The WHO allegedly has more than 75 partnerships. Although the spirit of cooperation is valued, the term partnership is not sufficiently specific to guide the human resources work.

Energizing an action alliance will require setting clear goals and objectives, developing an evolving work plan, piloting country-based actions, forging alliances, and mobilizing technical and financial resources. Pilot country-based work should strengthen human resources in priority programs building components of primary health care. Consultations among stakeholders should be conducted to develop national plans. In the early 1970s when concerns about poverty grew, the ILO dispatched "employment missions" to several countries. Teams probed the poverty-employment problem in depth producing a series of studies that pioneered our understanding of employment and poverty, including discovery of the informal economy. The alliance should launch this type of practical applied hands-on learning engagement in a dozen countries.

HIGH STAKES, HIGH LEVERAGE

The stakes are high, and the leverage potential is enormous. Human resources drive the performance of the entire health sector, commanding a huge share (60-80%) of health budgets or more than 1% of GDP in low-income countries. Of about $57 billion in development assistance, health allocations now total about $8-9 billion. Of this amount, about $500 million is classified under education and fellowships. Donor expenditures on human resources, however, are far higher because short-term training, technical assistance, various salary support and supplements are buried under program and categorical disease budgets. We conservatively estimate that about $2-3 billion of health aid is spent on human resources broadly defined.

Improved human resources strategic planning and management, therefore, would leverage directly about two-thirds of domestic health budgets and one-third of development assistance in health. The scope for efficiency improvements is huge, as suggested by country variability. If 10% of development assistance in health were spent to leverage better performance on the remaining 90%, $200-300 million would be available for investing in human resource capacity in low-income countries. If 10% of these country investments were deployed for global reinforcement, about $20-30 million would be available for an action alliance. The leverage effects of these two investment streams would be huge. In essence, the performance of the entire health sector would be improved through strategic planning and management of human resources.

More than money is at stake! The very credibility of development assistance to genuinely achieve the MDGs is linked to the action alliance. Jan Vandermoortele of the UNDP describes development assistance as two processes -- "money changing hands" and "ideas changing minds." To these, we would add "people changing hearts!" Needed are changes in development assistance attitudes, behavior, and policies. In our learning, we were forced to confront some tough and uncomfortable questions. Under our watch, how did we allow this deplorable depletion of human resources to take place? Why did it happen? What could have been done differently? How do we avoid repeating the same mistakes?

Whatever the answers, we cannot continue with "business as usual!" We must reverse the severe under-investment in people that has dominated international health investment policies. We must confront the challenge with openness, humility, and mission. We must be willing to listen, to learn, to act, and to change during this coming decade of human resources for health.

We propose that the Forum establish a planning group consisting of the WHO, World Bank, and key stakeholders, backed by several key donors and foundations to initiate pilot actions as part of an action work plan. The group should report back at the next Forum meeting.

Who among Forum members will exercise the leadership? Who will move our joint learning into global public action? Who will take these critical steps for achieving the health MDGs? Thank you.