

## Human resources for health and universal health coverage: fostering equity and effective coverage

James Campbell,<sup>a</sup> James Buchan,<sup>b</sup> Giorgio Cometto,<sup>c</sup> Benedict David,<sup>d</sup> Gilles Dussault,<sup>e</sup> Helga Fogstad,<sup>f</sup> Inês Fronteira,<sup>e</sup> Rafael Lozano,<sup>g</sup> Frank Nyongator,<sup>h</sup> Ariel Pablos-Méndez,<sup>i</sup> Estelle E Quain,<sup>i</sup> Ann Starrs<sup>j</sup> & Viroj Tangcharoensathien<sup>k</sup>

**Abstract** Achieving universal health coverage (UHC) involves distributing resources, especially human resources for health (HRH), to match population needs. This paper explores the policy lessons on HRH from four countries that have achieved sustained improvements in UHC: Brazil, Ghana, Mexico and Thailand. Its purpose is to inform global policy and financial commitments on HRH in support of UHC.

The paper reports on country experiences using an analytical framework that examines effective coverage in relation to the availability, accessibility, acceptability and quality (AAAQ) of HRH. The AAAQ dimensions make it possible to perform tracing analysis on HRH policy actions since 1990 in the four countries of interest in relation to national trends in workforce numbers and population mortality rates.

The findings inform key principles for evidence-based decision-making on HRH in support of UHC. First, HRH are critical to the expansion of health service coverage and the package of benefits; second, HRH strategies in each of the AAAQ dimensions collectively support achievements in effective coverage; and third, success is achieved through partnerships involving health and non-health actors.

Facing the unprecedented health and development challenges that affect all countries and transforming HRH evidence into policy and practice must be at the heart of UHC and the post-2015 development agenda. It is a political imperative requiring national commitment and leadership to maximize the impact of available financial and human resources, and improve healthy life expectancy, with the recognition that improvements in health care are enabled by a health workforce that is fit for purpose.

Abstracts in **عربي**, **中文**, **Français**, **Русский** and **Español** at the end of each article.

### Introduction

In December 2012, the United Nations General Assembly called upon all governments to “urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services”.<sup>1</sup> The evolving momentum for universal health coverage (UHC), with its principles of equity and social justice, aims to ensure that all members of a society can access the health-care services they need without incurring financial hardship.<sup>2,3</sup> UHC encompasses the three dimensions of *who* is covered (population coverage), *what* is covered (health-care benefits) and *how much* of the cost is covered (financial protection), all of which may expand over time.<sup>4</sup>

Addressing these three dimensions of UHC<sup>5–7</sup> within the boundaries of fiscal space<sup>8</sup> is challenging for all countries. It requires continuing political commitment and leadership to distribute available resources, especially human resources for health (HRH),<sup>9</sup> in an efficient, equitable and sustainable manner to match population needs. Overcoming the inequitable distribution of services is particularly critical.<sup>10</sup>

High-, middle- and low-income countries alike are facing fundamental health challenges stemming from demographic changes, ageing populations, the growing burden of noncommunicable diseases and emerging public health threats such as drug-resistant malaria, tuberculosis and pandemics. Several countries of the Organisation for Economic Co-operation and Development (OECD), hit by the global financial crisis, are revisiting health benefits, coverage and protection – either to reaffirm commitments or cut services.<sup>11</sup> In low- and middle-income countries, other evolving dynamics will shape efforts to achieve UHC, including epidemiological transitions,<sup>12</sup> economic growth, increased health expenditure and diminishing international health aid – or its reprioritization.<sup>13–15</sup> In the next decade, an increasing number of African and Asian countries will become able to finance essential health services from domestic resources and will then face critical decisions on how to invest these funds most effectively to accelerate progress towards UHC.<sup>16</sup>

The health workforce is central to a country’s response to these challenges. Reaching a greater percentage of the population, extending the benefit package and improving the qual-

<sup>a</sup> Instituto de Cooperación Social Integrare, Calle Balmes 30, 3<sup>o</sup>-1, 08007 Barcelona, Spain.

<sup>b</sup> Queen Margaret University, Edinburgh, Scotland.

<sup>c</sup> Global Health Workforce Alliance, World Health Organization, Geneva, Switzerland.

<sup>d</sup> Australian Agency for International Development, Canberra, Australia.

<sup>e</sup> Universidade Nova de Lisboa, Lisbon, Portugal.

<sup>f</sup> Norwegian Agency for Development Cooperation, Oslo, Norway.

<sup>g</sup> National Institute of Public Health, Cuernavaca, Mexico.

<sup>h</sup> Ministry of Health, Accra, Ghana.

<sup>i</sup> United States Agency for International Development, Washington, United States of America (USA).

<sup>j</sup> Family Care International, New York, USA.

<sup>k</sup> International Health Policy Programme, Ministry of Public Health, Nonthaburi, Thailand.

Correspondence to Jim Campbell (e-mail: jim.campbell@integrare.es).

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ity of the care provided requires commensurate attention to the governance and management of the health-care workforce, including its stock, skill mix, distribution, productivity and quality. Matching population health needs with a supply of competent and motivated health workers that are both *fit for purpose* and *fit to practise* in the country context is therefore the foundation for accelerating the attainment of UHC.

## Case studies: methods and findings

This paper explores the HRH policy lessons from four countries – Brazil, Ghana, Mexico and Thailand (Table 1) – purposefully selected for having achieved sustained improvements in accelerating progress towards UHC since 1990.<sup>7</sup> Part of their success lies in the policy focus on the health workforce to expand population coverage and the health benefits package. The paper reviews the available literature on the impact of HRH policy to identify the key actions and lessons that support accelerated progress towards UHC, with special attention to “effective coverage” and equity. By effective coverage we mean the proportion of people who have received satisfactory health services relative to the number needing such services.<sup>19,20</sup> We focus on maternal and neonatal health – areas in which comparative data are widely available, given that measuring effective coverage of UHC within and across countries is feasible by establishing “tracers” or a subset of activities indicative of overall service quality and quantity.<sup>21</sup>

We use an analytical framework (Fig. 1) specifically adapted from the UHC “cube”<sup>4</sup> – integrating Tanahashi’s health coverage model and the right to health<sup>2,19,22</sup> – to characterize the dimensions of effective coverage: availability, accessibility, acceptability, utilization and quality. The paper focuses on these four dimensions as they apply specifically to the health workforce: availability (e.g. stock and production); accessibility (e.g. spatial, temporal and financial dimensions); acceptability (e.g. gender and sociocultural); and quality (e.g. competencies and regulation).

The framework shifts the focus beyond the current monitoring of access to and contact with a health worker – i.e. skilled attendance at birth, or density of

Table 1. Selected demographic, economic and health sector indicators, by country, 2011

Country	Population (thousands)	GNI per capita <sup>a</sup>	THE as a fraction of GDP (%)	UHC <sup>b</sup>
Brazil	196 935	11 420	8.9	191 million (100%) in 2009
Ghana	24 821	1810	4.8	12 million (61%) in 2008
Mexico	119 361	15 390	6.2	104 million (98%) in 2011
Thailand	66 576	8360	4.1	65 million (98%) in 2007

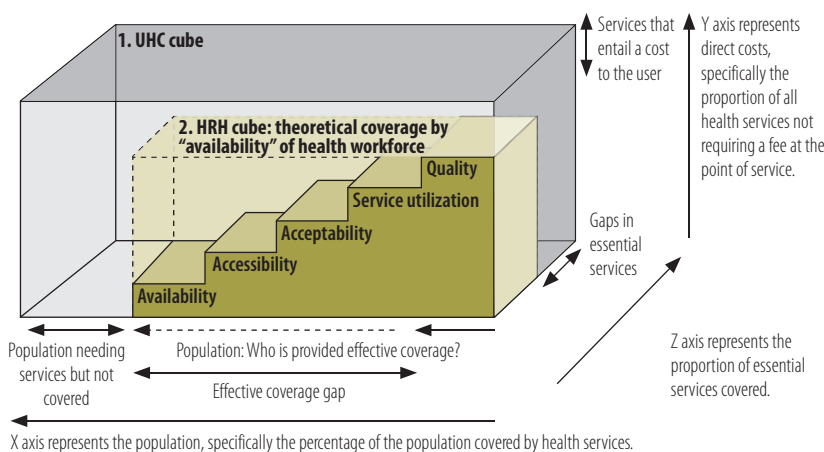
GDP, gross domestic product; GNI, gross national income; PPP, purchasing power parity; THE, total health expenditure; UHC, universal health coverage.

<sup>a</sup> In PPP international dollars.

<sup>b</sup> Population with health-care coverage and extent to which each country had attained UHC by the year indicated.

Sources: Population, GNI per capita, health expenditure: *World health statistics* (2012)<sup>17</sup> and Joint Learning Network for Universal Health Coverage (2013).<sup>18</sup>

Fig. 1. Dimensions of universal health coverage (UHC) pertaining to human resources for health (HRH): effective coverage



Adapted from *The world health report* (2010),<sup>4</sup> UN Economic and Social Council (2000)<sup>22</sup> and Tanahashi (1978).<sup>19</sup>

health professionals per 1000 population – and turns the AAAQ dimensions of the workforce into the key determining factors of the quality of care,<sup>23</sup> represented in Fig. 1 as the “effective coverage gap”.

We apply the four workforce dimensions to guide a process-tracing analysis of HRH policy actions since 1990. Process tracing is an analytical tool for exploring causal mechanisms and contributory steps in the chain of events that collectively support a desired outcome.<sup>24–26</sup> We collated historical data (Fig. 2, Fig. 3, Fig. 4 and Fig. 5) on national trends in the number of skilled birth attendants (midwives, nurses and physicians) employed in the public sector. Subject to data availability, the figures also show the rates for maternal mortality, under-five mortality and either infant or neonatal mortality. We have disaggregated the national policy and governance steps on HRH by their respective AAAQ dimensions

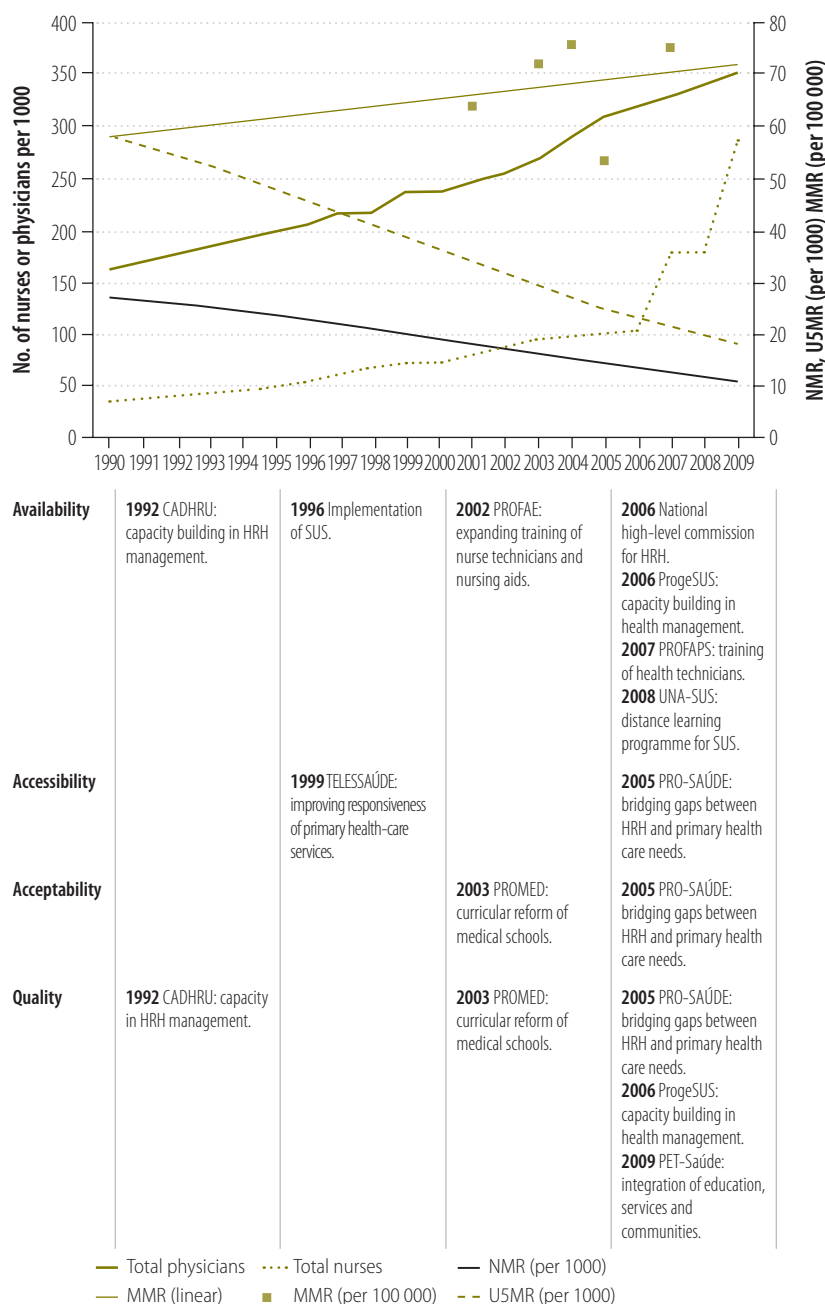
(Table 2).<sup>27</sup> The respective policies are captured chronologically to explore their linkages to national trends in the health workforce and maternal, neonatal and child health outcomes.

We recognize the limitations inherent in an ex post analysis such as this. The complexity of decision-making and the confounders influencing improved health outcomes are not discussed here. Hence, while the paper explores causal mechanisms, it is beyond its scope to express causal conclusions. Instead, we use the case studies and wider published literature to identify what appears to have worked and where and draw examples of good practice from this evidence base.

## Brazil

Since the adoption of its current constitution in 1988, Brazil has worked progressively to achieve UHC by setting up the *Sistema Único de Saúde* (SUS) [Unified Health System], an integrated health

Fig. 2. **Process-tracing of human resources for health policy in relation to the number of employed health professionals and health outcomes (1990–2009): Brazil**



CADHRU, *Capacitação e Desenvolvimento de Recursos Humanos em Saúde*; HRH, human resources for health; MMR, maternal mortality rate; NMR, neonatal mortality rate; PET-Saúde, *Programa de Educação pelo Trabalho para a Saúde*; PROFABE, *Projeto de Profissionalização dos Trabalhadores da Área de Enfermagem*; PROFAPS, *Programa de Formação de Profissionais de Nível Médio para a Saúde*; ProgeSUS, *Programa de Qualificação e Estruturação da Gestão do Trabalho e da Educação no SUS*; PROMED, *Programa de Incentivo a Mudanças Curriculares nos Cursos de Medicina*; PRO-SAÚDE, *Programa Nacional de Reorientação da Formação Profissional em Saúde*; SUS, *Sistema Único de Saúde*; TELESSAÚDE, telehealth; USMR, under-five mortality rate; UNA-SUS, *Universidade Aberta do SUS*.

Note: Data sources available from the corresponding author upon request.

service system based on the provision of community care and improved access for underserved populations. The SUS revealed the need to expand the health workforce, both in terms of adding staff and rationalizing roles and responsibili-

ties, especially in relation to developing new skills and building management capacity at the municipal level – the locus of health service delivery.

The government implemented several steps to produce more staff, improve

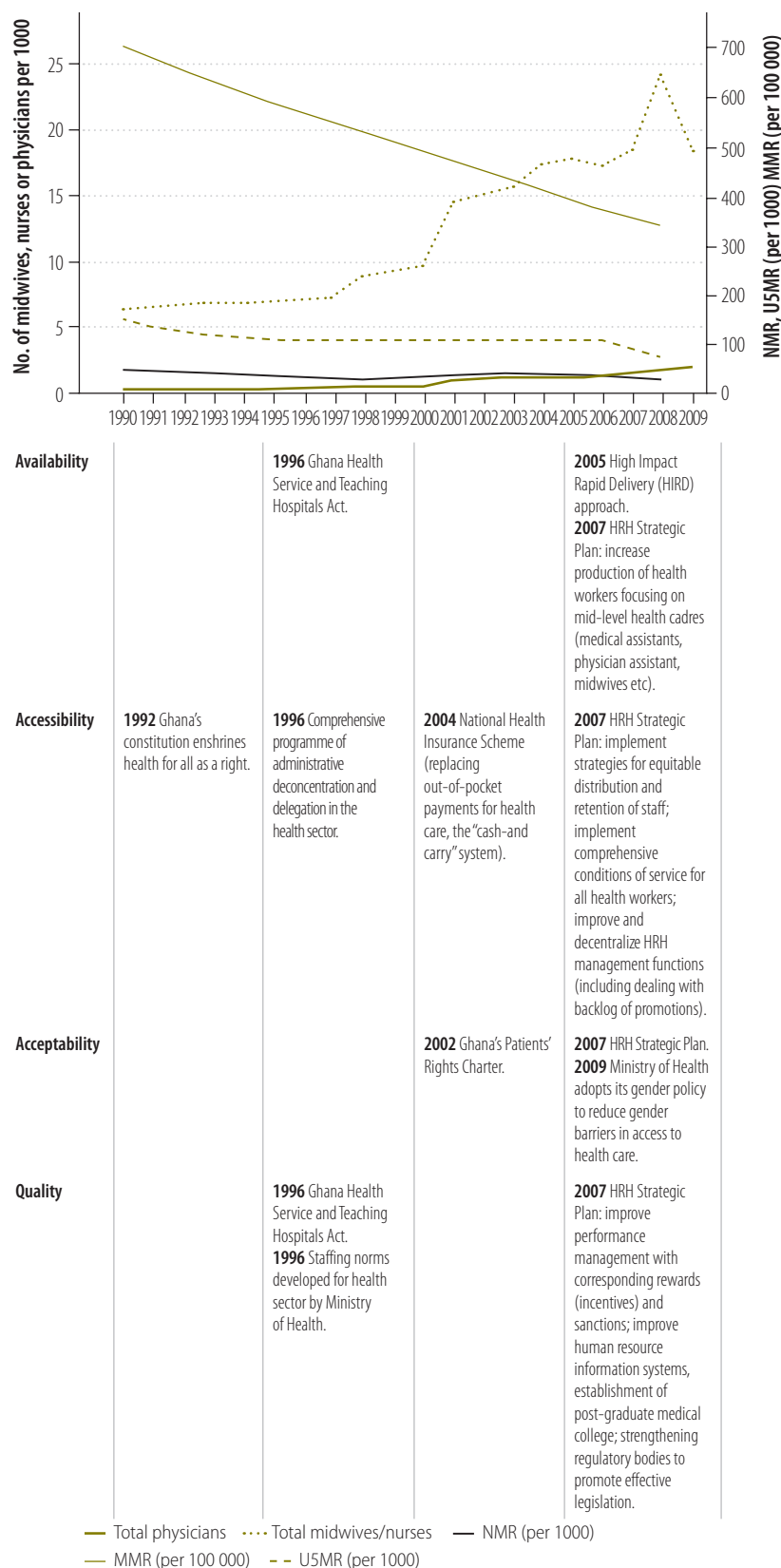
their training, enhance working conditions and strengthen management capacity. The first major effort in the 1980s was the *Programa Larga Escala* [Long-term Programme], designed to qualify staff who had not received formal training. In 1987, before the SUS was created, the *Capacitação em Desenvolvimento de Recursos Humanos* initiative was launched to build capacity in HRH training and management. This was followed in 2006 by the establishment of the *Programa de Qualificação e Estruturação da Gestão do Trabalho e da Educação no SUS* (ProgeSUS) [Programme of Qualification and Structuring of the Management of Work and Education in the Unified Health System], a programme for strengthening HRH and, more generally, health service management.<sup>28</sup> Other programmes, such as the 2003 *Programa de Incentivo a Mudanças Curriculares nos Cursos de Medicina* (PROMED) and the 2009 *Programa de Educação pelo Trabalho para a Saúde* (PET-Saúde) [Programme of Incentives for Curricular Changes in Medical Schools], have sought to improve service acceptability and quality and to bridge the gaps between HRH availability and need in the area of primary care. The family health team model, based on a multidisciplinary team of health workers oriented towards primary care, entails a re-orientation of the values and practices of health professionals towards the community<sup>29</sup> and improvements in population health and, indirectly, in labour supply.<sup>30</sup> The successes of these HRH policies have been made possible by strong political commitment and a sustained policy focus.

Through the implementation of these policies and programmes, between 1990 and 2009 Brazil managed to increase the number of health workers – nurses by 500% and physicians by 66% – well above the 31% in population growth. Between 2002 and 2012 the number of family health teams doubled – from 15 000 to 30 000 – and in 2013 access to basic health units reached 57% of the population (i.e. 108 million people).<sup>31</sup> Over the same period neonatal mortality decreased from 26.8 to 9.7 per 1000 live births and under-five mortality from 58 to 15.6 per 1000 live births, respectively.

## Ghana

A 1992 constitutional amendment to ensure the right to health enhanced the political and financial commitment to a supply-driven expansion of the health

Fig. 3. **Process-tracing of human resources for health policy in relation to the number of employed health professionals and health outcomes (1990–2009): Ghana**



workforce in Ghana. In 1996 new regulation, accompanied by administrative decentralization and the definition of HRH staffing norms, paved the way for Ghana's Patient's Rights Charter of 2002. The improved availability and accessibility of health workers since the turn of the millennium enabled the development of the High-Impact Rapid Delivery strategy (2005), aimed at expanding the package of essential interventions for maternal and child health and extending population coverage. The Human Resources for Health Strategic Plan (2007–2011), which integrated the accessibility, acceptability and quality dimensions, was instituted to improve deployment and retention strategies, accreditation, regulation and licensing and continuous professional development for staff.

In 1990–2009, Ghana witnessed a rapid increase in its supply of professional health workers: 185% more midwives, 260% more nurses and 1300% more physicians. Approximately 14 000 additional professional health workers were trained and employed, a number representing four times the increase in population growth (240% versus 59%) over the same period. In the case of physicians, the growth in each 5-year period is fairly uniform, but in the case of midwives and nurses such growth dropped sharply towards the end of the period (2005–2009). The reduction has since been corrected, however, with the addition of more workers in 2010–12.

Achieving equity in access to and use of essential services continues to be challenging.<sup>32</sup> A large share of national health expenditure – approximately 85% – is committed to health workforce salaries and incentives, but the steps taken in 1990–2009 have reduced workforce attrition, increased the capacity of health training institutions – Ghana is now one of the largest producers of physicians in sub-Saharan Africa – and improved the number and distribution of health workers.

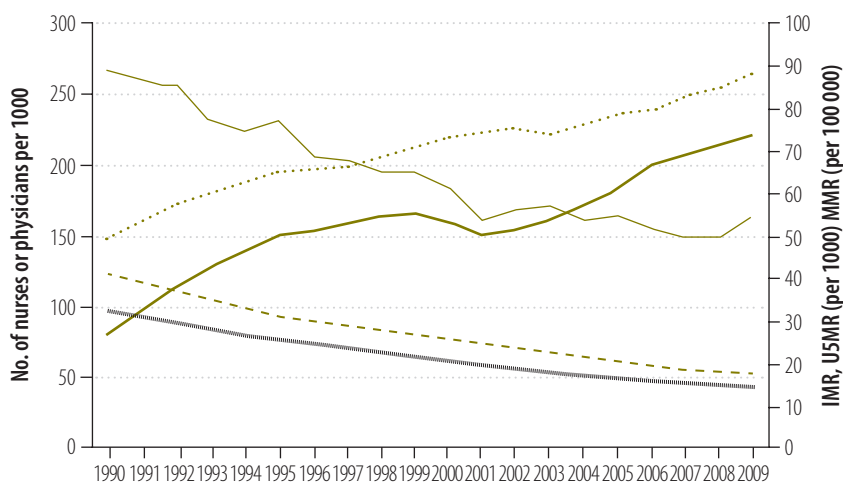
### Mexico

Policies and programmes have generated large increases in the health workforce,<sup>33</sup> beginning with the 1995 Health Sector Reform (1995–2000), which established agreements with educational institutions for the training of human resources and increased the number of health workers nationwide.<sup>34</sup> The coverage expansion programme (PAC) initiated in 1996 to

HRH, human resources for health; MMR, maternal mortality rate; NMR, neonatal mortality rate; USMR, under-five mortality rate.

Note: Data sources available from the corresponding author upon request.

Fig. 4. **Process-tracing of human resources for health policy in relation to the number of employed health professionals and health outcomes (1990–2009): Mexico**



<b>Availability</b>	<p><b>1995</b> Health sector reform: increase in numbers of health workers nationwide.</p> <p><b>2003</b> National licensing examination for all medical graduates to gain professional practice licence.</p>
<b>Accessibility</b>	<p><b>1995</b> Health sector reform: upward wage equalization between federal and state workers.</p> <p><b>1996</b> Coverage Expansion Programme (PAC): increase in recruitment to support health activities in areas of difficult access.</p> <p><b>2002</b> PAC is integrated into the Programme for Quality, and Equity and Development in Health (PROCEDES).</p> <p><b>2003</b> Creation of the System for Social Protection in Health (SPSS) and Popular Health Insurance (SPS) as medical insurance.</p>
<b>Acceptability</b>	<p><b>1995</b> Health sector reform: enrolment policies in educational institutes based on the labour market.</p>
<b>Quality</b>	<p><b>1995</b> Health sector reform: establishment of cooperation agreements with educational institutions for regulation, improved technical training and ongoing professional training.</p> <p><b>2006</b> Establishment of National Commission for the Regulation of Trade in Human Resources in the Federal States (CNRCRHEF).</p> <p><b>2008</b> Regularization of 25 000 health personnel.</p>

— Total physicians    ···· Total nurses    — IMR (per 1000)  
— MMR (per 100 000)    - - - U5MR (per 1000)

IMR, infant mortality rate; MMR, maternal mortality rate; U5MR, under-five mortality rate.  
Note: Data sources available from the corresponding author upon request.

address accessibility employed thousands of workers to support health activities in underserved areas. Staff remuneration was initially covered by loans from the Inter-American Development Bank, but the health ministry committed to paying wages in subsequent phases of the programme. In 2002 the PAC was integrated into the new *Programa de Calidad, Equidad y Desarrollo en Salud* (PROCEDES) [Programme for Quality, Equity and Development in Health].<sup>35,36</sup>

The *Sistema de Protección Social en Salud* (SPSS) [System for Social Protection in Health] and the *Seguro Popular de Salud* (SPS) [Popular Health Insurance] were created in 2003 to pursue the goal of UHC, with encouraging results across all AAAQ domains.<sup>37</sup>

The number of nurses and physicians increased over 1990–2009. More than 250 000 additional professionals were trained and the 80% increase in nurses and the 170% increase in physi-

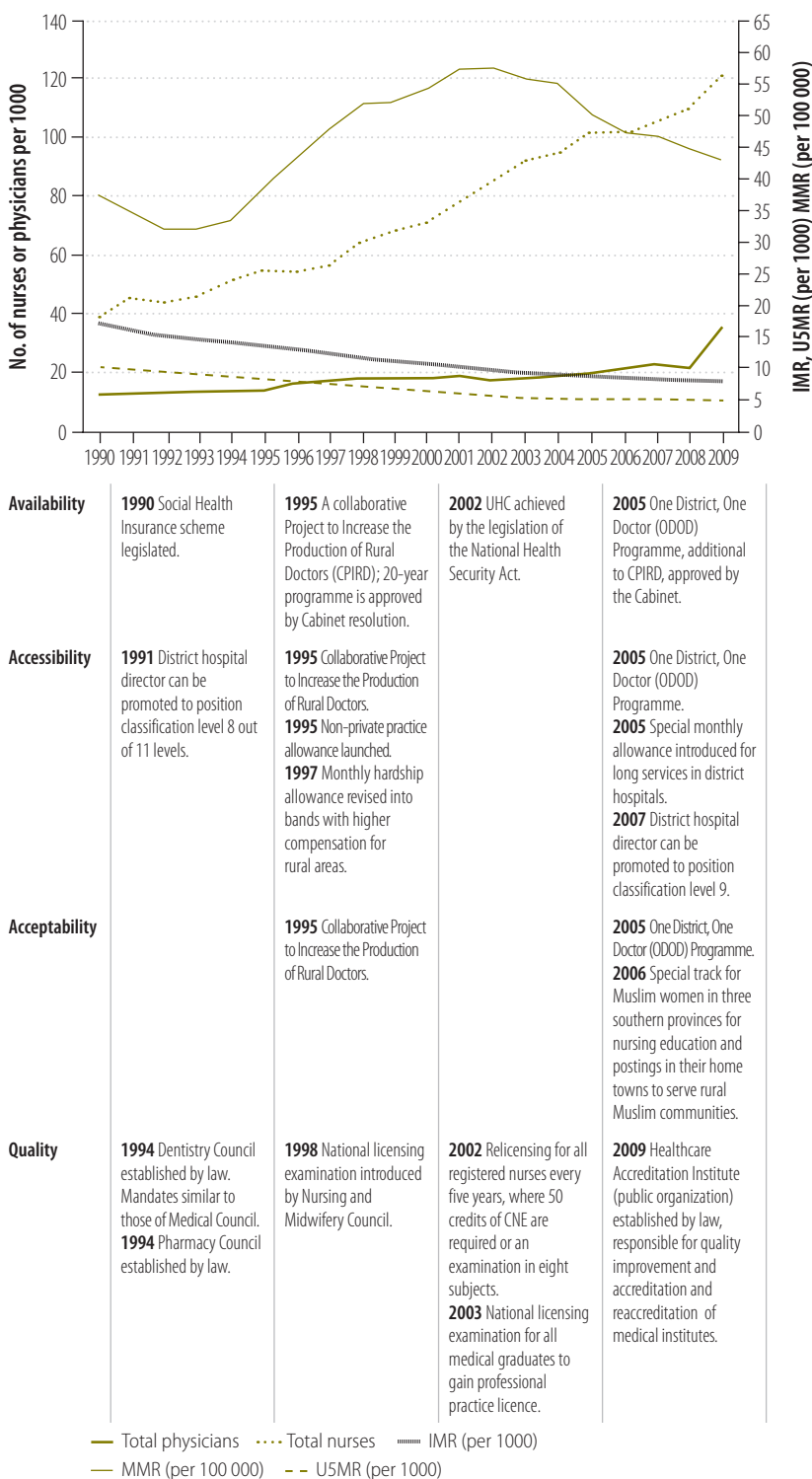
cians outstripped the population growth of 30%. In the same period, infant mortality and under-five mortality more than halved: from 32.6 to 14.6 per 1000 live births and from 41 to 17.8 per 1000 live births, respectively.<sup>38–41</sup> Maternal mortality fluctuated over the period but was reduced by more than 50% overall, according to data from 2011.<sup>42</sup>

Attrition between education and employment is an important workforce problem that remains to be addressed. According to an analysis of the 2008 *Encuesta Nacional de Ocupación y Empleo* (ENOE) [National Survey of Occupation and Employment], 87% of physicians are employed, but of those who are, approximately 10% work outside the health sector. Thus, nearly one in every five physicians is not participating in the health labour market, a rate that requires further scrutiny in light of the growing private sector for medical education. In 1990, only 7% of medical students were in private schools, but by 2010 the proportion had risen to 20%. Of the 27 new medical schools established during this period, five are publicly funded and the other 22 are funded by private investments.<sup>43–45</sup>

## Thailand

Although the HRH policy and governance milestones of 1990–2009 were clearly influential in Thailand's success, critical decisions were also made in the 1970s. Such decisions continue to exert an influence 40 years later.<sup>46,47</sup> Policies on the provision and financing of health services are pro-poor.<sup>48</sup> Primary health care at the district level was made possible through a comprehensive health workforce policy developed in 1995 that centred on retention and professional satisfaction to encourage rural deployment,<sup>49</sup> as well as through policy revisions introduced in 1997 and 2005. Several policies adopted from 1994 to 2009, emphasizing continuous reflection and improvement, have aimed to improve quality: development and strengthening of professional councils, regulation over curriculum standards and quality of training institutes, worker licensing and re-licensing. The establishment of the Healthcare Accreditation Institute in 2009 has consolidated these quality efforts. Post-service training in advanced practice for nursing cadres, such as nurse practitioners, intensive care unit nurses and anaesthesiology nurses, plays a significant task shifting

Fig. 5. **Process-tracing of human resources for health policy in relation to the number of employed health professionals and health outcomes (1990–2009): Thailand**



CNE, continuing nursing education; IMR, infant mortality rate; MMR, maternal mortality rate; U5MR, under-five mortality rate; UHC, universal health coverage.  
 Note: Data sources available from the corresponding author upon request.

role. Policy has centred on strengthening local and district health systems as a strategy to translate policy into practice and improve equity.

The attention to equity is particularly important. Although in 1991–2009 the overall increase in nurses (210%) and physicians (186%) outstripped

population growth (13%), the accessibility dimension improved even more. For example, the ratio of nurses to people increased from 1:7.2 to 1:3.4 in 1991–2009. Regional variations in workforce deployment between the least affluent north-eastern region and affluent areas such as Bangkok have also been substantially reduced.

### Case study overview

All governments have an obligation to support the highest attainable standard of health for their citizens, and many are expressing this through a commitment to the progressive realization of UHC. Our analysis provides several messages that can inform evidence-based decision-making on HRH in support of UHC.

First, success in awarding adequate priority to HRH depends on political leadership and commitment that is multisectoral, legislated and regulated through governance instruments and that remains coherent and consistent over electoral cycles. Second, strategies and actions in each of the AAAQ dimensions of HRH have brought about improvements in quality of care and effective coverage and these have resulted in better health outcomes. The focus on HRH goes beyond merely expanding the supply of workers. Each country aims for a workforce that is fit for purpose and fit to practise – made possible by whole-of-government approaches prioritizing equitable, efficient and effective health services. Third, the successes seen in the four countries examined in this paper reflect achievements made possible through partnerships in and outside the health sector: public and private entities; education, labour and finance; government and development partners; health workers and consumers; providers, professional associations and health workers.

### Discussion

In the past 10 years there has been increasing recognition that HRH are central to improving health.<sup>50,51</sup> However, in the initial years of the “decade of action on HRH”, the policy discourse tended to focus on two issues: the “crisis” in the availability of health workers in low- and middle-income countries and the international migration of health workers. While these were critical issues then and

Table 2. **Role of governments, partners and the health workforce in enhancing the availability, accessibility, acceptability and quality of human resources for health**

Availability	Accessibility	Acceptability	Quality
<ul style="list-style-type: none"> <li>– Strengthen, plan, finance, manage, monitor and report on the health workforce to equitably meet population needs in health based on strategic intelligence and evidence;</li> <li>– create and/or strengthen the policy, regulatory and fiscal environments to match health workforce supply, demand, affordability and sustainability in health labour markets;</li> <li>– ensure the health workforce is educated, trained and continuously supported – in sufficient numbers and across their working lifespan</li> <li>– to achieve and maintain competencies and deliver essential health services;</li> <li>– strive towards domestic security of supply (in primary, secondary and tertiary education) for qualified entrants and nationally trained health workers, with predictable, sustainable financing and adequate remuneration;</li> <li>– strengthen bilateral, multinational and regional partnerships of clear mutual benefit.</li> </ul>	<ul style="list-style-type: none"> <li>– Identify and implement solutions that remove financial, geographical and other barriers that impede access to a health worker when care is required;</li> <li>– actively steward, manage and deploy the health workforce to equitably meet population needs across urban, rural and remote areas;</li> <li>– promote population access to a quality health workforce across the continuum of care with effective referral across community, primary, secondary and tertiary services;</li> <li>– identify and implement health workforce solutions that provide equity-focused approaches to increase access for vulnerable groups, including selecting trainees from disadvantaged communities and implementing educational strategies and incentives to enhance and sustain deployment in rural areas;</li> <li>– design and implement effective policies and strategies to train and retain health workers in an enabling and productive environment.</li> </ul>	<ul style="list-style-type: none"> <li>– Actively steward, manage and support the domestic health workforce to increase population demand for and use of high-quality services;</li> <li>– explore and implement evidence-based guidance on workforce sex balance, skill mix, competencies and sociocultural needs to increase the uptake and coverage of essential services in communities and health facilities;</li> <li>– develop a workforce that is responsive to the needs of people of both sexes and all ages, ethnicities and languages, and to context-specific requirements;</li> <li>– review and strengthen health workforce education pathways and oversight mechanisms to enhance health workers' accountability to consumers;</li> <li>– identify and remove any perverse financial incentives and information asymmetries that affect health workers' treatment of consumers.</li> </ul>	<ul style="list-style-type: none"> <li>– Prioritize patients' interests and the clinical appropriateness of the care they receive;</li> <li>– review, revise and implement education and career pathways and standards, accreditation and regulatory systems, to promote and attain a quality workforce that is fit for purpose and fit to practise in relation to population-specific needs;</li> <li>– link and support professional, community and consumer organizations to accelerate and sustain a quality workforce;</li> <li>– strengthen patient pathways and human resource management to identify, manage and remove patient risk and improve the efficiency, effectiveness and quality of essential health services;</li> <li>– design and implement country-specific workforce management, performance and monitoring systems to monitor, acknowledge and sustain high-quality services, using appropriate incentive schemes if relevant.</li> </ul>

Note: Governments provide the political leadership, resolve and resources to effectively steward the education, deployment, management, financing and performance of a health workforce that equitably serves population needs, promotes the right to health and accelerates progress towards population-specific, comprehensive universal coverage.

Partners, including consumers, civil society, the private sector, professional organizations, academia, and – in those countries where it is applicable – multilateral and bilateral agencies, support and facilitate the strengthening of the health workforce through mutual respect, participation, accountability, solidarity and financial subsidy, aligned with national needs and mechanisms.

Health workers, in all cadres and sectors, should be responsive to population needs and enhance the quality of health systems and services.

Governments, partners and health workers collectively and individually support a transnational, coordinated effort to strengthen the health workforce. They do so by ensuring the effective implementation of applicable international and regional conventions and resolutions on the right to health, the social determinants of health, universal coverage and the health workforce, using evidence, innovation and technologies to do so.

Adapted from Global Health Workforce Alliance (2013).<sup>27</sup>

remain so today, there is now a growing recognition of the multifaceted nature of HRH-related challenges and of the need for HRH governance and management within dynamic, local health systems.<sup>52</sup>

Since 2006, several United Nations agencies, the Global Health Workforce Alliance, regional HRH networks, development agencies, academic institutions, civil society groups and HRH observatories<sup>53</sup> have greatly expanded the HRH evidence base and analysis, planning and management tools and have led to policy recommendations.<sup>52,53</sup> This strategic workforce intelligence now needs to inform contemporary commitments,

policy and actions beyond 2015. The key messages can be synthesized as follows:

First, training more staff is necessary in many countries, given that more than 100 countries lack enough professional health workers if the ILO's access deficit indicator<sup>5</sup> is used to set the threshold for density per 1000 population. However, increasing the numbers is not in itself sufficient to provide culturally appropriate, acceptable care to communities and to address the effective coverage gap. Expanding the supply, participation and availability of health workers also involves making informed decisions about the selection of trainees,

the location, content and mode of training, and the development of appropriate skills for individual staff and effective skill mix across multidisciplinary teams. "More staff" only becomes "better staff" when there is sufficient and targeted funding to secure the correct investment in competencies and skills' development over the longer term.<sup>54,55</sup>

Second, employing more staff is often necessary but not sufficient to improve access for underserved communities. Ensuring availability also requires planning to improve the accessibility, acceptability and quality dimensions – ensuring appropriate geographic and sec-

tor distribution combined with the right bundle of financial and non-financial incentives to direct and retain staff where they are most required and to motivate them to be responsive and productive.<sup>56</sup> "More staff" only becomes "better care" when effective local management and an enabling, "positive practice" environment<sup>57</sup> are supported by context specific, evidence-based, responsive and fully funded HRH policies that are informed by labour market analysis and relate to defined community needs.

Third, only by addressing deep-seated health system bottlenecks – health workforce constraints being prominent among them – will countries be able to achieve their health objectives.<sup>58</sup> Doing so will require sustained investments, including consideration of recurrent cost budgets for staffing, education, and incentives, and a policy focus over a longer period. There is a risk, however, that systemic HRH challenges will take second place to "quick wins" or "vertical" programmes (e.g. immunization or single-disease control initiatives). This is a governance issue for global health; it requires international solidarity to recognize and act on the available evidence.<sup>59</sup> There are no effective shortcuts

for decision-makers: without adequate policies and funding to achieve a skilled and motivated workforce, other investments in the health system will not yield the expected returns or may even be wasted. Investment in other key elements of the health system will also be necessary, as even the most motivated and skilled health worker needs essential supplies, equipment, infrastructure and financing mechanisms to provide quality care.

## Conclusion

The key messages from the process-tracing analysis are consistent with the wider evidence.<sup>60–63</sup> There is therefore a body of knowledge that can guide HRH policy, actions and commitments in relation to UHC. But evidence is not always transformed into policy and practice. A short-term horizon or wavering policy attention at the national or international level can hinder progress. Sustained improvements in HRH that enable the delivery of acceptable, quality care require consistent policies and long-term predictable funding, fully aligned with national needs, strategies and accountability mechanisms.

This debate should not be confined to HRH; it lays out the logic of how to maximize the accountability, transparency and impact of financial and human resources to keep global promises, measure results and improve health. It is a political imperative to face the unprecedented health and development challenges that transcend all country income groups and to shape discussion on the post-2015 development agenda for health and on the central role of HRH. Political commitment by national and global leaders is needed to build a global health workforce that is responsive to the challenges of the 21st century: one that is fit for purpose and fit to practise. While some argue that health care is labour intensive, it is worth remembering that UHC and improvements in health care are workforce enabled. ■

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## ملخص

### الموارد البشرية الصحية والتغطية الصحية الشاملة: تعزيز الإنصاف والتغطية الفعالة

للتغطية الصحية الشاملة. أولاً، الموارد البشرية الصحية بالغية الأهمية في توسيع تغطية الخدمات الصحية وحزمة المزاي؛ ثانياً، تدعم استراتيجيات الموارد البشرية الصحية في كل بعد من أبعاد التوافر والإتاحة والمقبولية والجودة في مجموعها الإنجازات في التغطية الفعالة؛ ثالثاً، يتحقق النجاح من خلال الشراكات التي تضم جهات فاعلة في المجال الصحي وغير الصحي.

يجب أن تكون مواجهة التحديات الصحية والإنمائية غير المسبوقة التي تؤثر على كل البلدان وتحويل بينات الموارد البشرية الصحية إلى سياسة وممارسة محور التغطية الصحية الشاملة وجدول أعمال التنمية بعد عام 2015. وتمثل زيادة أثر الموارد المالية والبشرية المتاحة إلى أقصى قدر ممكن، وتحسين متوسط العمر المأمول لدى الأصحاء مع الإقرار بتمكين القوى العاملة الصحية المناسبة للغرض من إدخال تحسينات في الرعاية الصحية واجبا سياسياً يتطلب التزاماً وقيادة على الصعيد الوطني.

يتضمن تحقيق التغطية الصحية الشاملة توزيع الموارد، لاسيما الموارد البشرية الصحية، لتلبية احتياجات السكان. وتستكشف هذه الورقة الدروس السياسية المعنية بالموارد البشرية الصحية المستفادة من أربعة بلدان حققت تحسينات مستدامة في التغطية الصحية الشاملة، هي: البرازيل وغانا والمكسيك وتايلند. وتهدف هذه الورقة إلى توفير المعلومات اللازمة للسياسة العالمية والالتزامات المالية للموارد البشرية الصحية دعماً للتغطية الصحية الشاملة.

تقدم هذه الورقة تقارير عن خبرات البلدان باستخدام إطار تحليلي يدرس التغطية الفعالة فيما يتصل بتوافر وإتاحة ومقبولية وجودة الموارد البشرية الصحية. وتتيح أبعاد التوافر والإتاحة والمقبولية والجودة تنفيذ تتبع التحليل المعني بإجراءات سياسة الموارد البشرية الصحية منذ عام 1990 في البلدان الأربع محل الاهتمام فيما يتصل بالاتجاهات الوطنية في أعداد القوى العاملة ومعدلات وفيات السكان.

توفر النتائج المعلومات اللازمة حول المبادئ الرئيسية لاتخاذ القرار المستند على البيئات المعني بالموارد البشرية الصحية دعماً



**摘要****卫生人力资源和全民医疗保障：促进公平和有效覆盖**

实现全民医保 (UHC) 涉及满足人们需求的资源分配, 尤其是卫生人力资源 (HRH) 的分配。文本探讨了巴西、加纳、墨西哥和泰国四国 HRH 相关政策的经验教训, 这四个国家在 UHC 方面取得了持续改进。本文旨在为 HRH 的相关全球政策和财务规划提供信息, 用以支持 UHC。

本文使用考查 HRH 可用性、可及性、可接受性和质量 (AAAQ) 相关有效覆盖的分析框架来报告国家经验。采用 AAAQ 维度可以对四个受关注国家执行 1990 年以来有关劳动力数量和人口死亡率国家趋势的 HRH 政策行为跟踪分析。

研究结果可以为基于证据的相关 HRH 决策的基本

原则提供参考信息, 对 UHC 加以支持。首先, HRH 对于扩大卫生服务覆盖和福利制度非常关键; 其次, 每个 AAAQ 维度中的 HRH 战略对实现有效覆盖共同起支持作用; 第三, 成功通过合作关系实现, 这种合作关系涉及卫生工作者, 也牵涉到非卫生行动者。

面对影响所有国家的前所未有的卫生和发展挑战, 将 HRH 证据转化为政策和实践必须居于 UHC 和 2015 年后发展议程的核心。一个需要国家承诺和领导的政治要务就是, 通过认识到专业对口的卫生劳动力能实现医疗卫生事业的改善, 将可用财政和人力资源的效力最大化, 并改善健康预期寿命。

**Résumé****Ressources humaines pour la santé et la couverture sanitaire universelle: promouvoir l'équité et une couverture efficace**

Parvenir à la couverture sanitaire universelle (CSU) implique la répartition des ressources, et en particulier des ressources humaines pour la santé (RHS), afin de répondre aux besoins de la population. Cet article étudie les leçons politiques sur les RHS de quatre pays ayant accompli des progrès durables en matière de CSU: le Brésil, le Ghana, le Mexique et la Thaïlande. Son but est d'informer sur les politiques globales et les engagements financiers dans les RHS visant à promouvoir la CSU.

L'article décrit les expériences des pays à l'aide d'un cadre analytique examinant la couverture efficace par rapport à la disponibilité, l'accessibilité, l'acceptabilité et la qualité (DAAQ) des RHS. Les dimensions DAAQ permettent de réaliser une analyse de traçage des actions politiques en RHS depuis 1990 dans les quatre pays étudiés, par rapport aux tendances nationales des statistiques de main-d'œuvre et des taux de mortalité de la population.

Les résultats indiquent quels sont les principes clés pour la prise de décisions basées sur les faits sur les RHS visant à promouvoir la

CSU. Premièrement, les RHS sont essentielles à l'expansion de la couverture des services de santé et de l'ensemble des avantages; deuxièmement, des stratégies RHS pour chacune des dimensions DAAQ favorisent collectivement les progrès vers une couverture efficace; et troisièmement, le succès est atteint à travers des partenariats impliquant des acteurs tant médicaux que non médicaux.

Répondre aux défis sans précédent dans les domaines de la santé et du développement, qui concernent tous les pays, et transformer les faits RHS en politiques et en pratiques doivent être à la base du programme de CSU et de l'agenda de développement post-2015. C'est un impératif politique qui exige un engagement et un leadership nationaux pour optimiser l'impact des ressources financières et humaines disponibles et accroître l'espérance de vie en bonne santé, avec la reconnaissance que les progrès dans le domaine des soins de santé ne sont possibles qu'avec une main-d'œuvre de santé adéquate.

**Резюме****Роль кадровых ресурсов здравоохранения в вопросе всеобщего охвата медико-санитарной помощью: обеспечение справедливого доступа и эффективного охвата**

Достижение всеобщего охвата медико-санитарной помощью (ВОМСП) подразумевает распределение ресурсов, особенно кадровых ресурсов здравоохранения (КРЗ), в соответствии с потребностями населения. В данной статье исследуются результаты проведения политики в области КРЗ в четырех странах, добившихся устойчивых улучшений в области ВОМСП: Бразилии, Ганы, Мексики и Таиланда. Целью статьи является информирование о глобальной политике и финансовых обязательствах по КРЗ в целях обеспечения ВОМСП.

В статье сообщается об опыте стран с применением аналитической основы, когда эффективность охвата медицинскими услугами рассматривается на основе таких параметров КРЗ, как наличие, доступность, приемлемость и качество (НДПК). Использование параметров НДПК дало возможность выполнить исторический анализ политики КРЗ в этих четырех странах с 1990 года с учетом национальных тенденций численности рабочей силы и смертности населения.

В результате были выделены основные принципы научно обоснованных решений по КРЗ для поддержки ВОМСП. В-первых, КРЗ имеет решающее значение для расширения охвата

медицинским обслуживанием и связанных с ним комплексных улучшений; во-вторых, стратегии КРЗ по каждому параметру НДПК совместно обеспечивают более эффективный охват услугами; и в-третьих, успех достигается благодаря партнерским отношениям с организациями, как связанными со здравоохранением, так и работающими вне этой области.

Эффективное преодоление беспрецедентных трудностей в области здравоохранения и развития, затрагивающих все страны, и воплощение результатов, полученных в ходе исследования КРЗ, в политику и практику, должно стать основой стратегии ВОМСП и сформировать повестку дня в целях развития после 2015 года. Политическим императивом сегодня является национальная заинтересованность и обеспечение руководства развитием здравоохранения, что позволит оптимально использовать имеющиеся финансовые и людские ресурсы и увеличить ожидаемую продолжительность здоровой жизни. При этом необходимо признание того, что улучшения в области медицинского обслуживания возможны только при наличии кадров работников здравоохранения, соответствующих данным целям.

## Resumen

### Los recursos humanos para la salud y la cobertura sanitaria universal: cómo fomentar una cobertura eficaz y justa

Lograr una cobertura sanitaria universal implica una distribución de los recursos, en particular, de los recursos humanos para la salud (RHS), a fin de satisfacer las necesidades de la población. Este documento examina las lecciones sobre políticas relacionadas con los RHS de cuatro países que han conseguido avances ininterrumpidos en materia de cobertura sanitaria universal: Brasil, Ghana, México y Tailandia. Su objetivo consiste en exponer la política mundial y los compromisos financieros sobre RHS como ayuda para una cobertura sanitaria universal.

El documento explica las experiencias de los países mencionados por medio de un marco de trabajo analítico que examina la eficacia de una cobertura en función de la disponibilidad, accesibilidad, aceptabilidad y calidad (DAAC) de los RHS. Los aspectos DAAC permiten llevar a cabo análisis de seguimiento sobre las acciones políticas relativas a los RHS desde 1990 en los cuatro países de interés en relación con las tendencias nacionales en el número de trabajadores y las tasas de mortalidad de la población.

Los resultados muestran los principios fundamentales para la toma

de decisiones basadas en pruebas científicas sobre los RHS como apoyo a una cobertura sanitaria universal. En primer lugar, los RHS son esenciales para expandir la cobertura de los servicios sanitarios y el conjunto de prestaciones. En segundo lugar, las estrategias RHS en cada uno de los aspectos DAAC respaldan de forma colectiva los logros en la eficacia de la cobertura y, en tercer lugar, los buenos resultados solo pueden conseguirse a través de la asociación de actores sanitarios y no sanitarios.

Hacer frente a los desafíos sanitarios y de desarrollo sin precedentes que afectan a todos los países y traducir las pruebas científicas sobre RHS en políticas y prácticas deben convertirse en los puntos centrales de la cobertura sanitaria universal y de la agenda de desarrollo a partir del año 2015. Se trata de un imperativo político que requiere un compromiso y liderazgo nacionales para potenciar el impacto de los recursos financieros y humanos disponibles, y así mejorar la esperanza de vida saludable, sin olvidar que las mejoras en materia de asistencia sanitaria son posibles gracias a un personal sanitario apto para tal propósito.

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