PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

52nd DIRECTING COUNCIL
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Provisional Agenda Item 4.4

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HUMAN RESOURCES FOR HEALTH

Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems

Introduction

1. Recently in the Region of the Americas Member States have made substantial progress towards implementing a more inclusive development agenda that includes social policies as a major component**.** In some countries, the synergy between sustained economic growth and inclusive social policies explains the reduction in the number of people living in poverty and the easing of inequities in wealth distribution, along with parallel improvements in employment and literacy levels. These trends in turn have contributed to the increased demand for quality social services. The affirmation of health as a fundamental human right is a central component of this agenda. The development of unified health systems, the renewal of primary health care (PHC), and the search for better integrated, people-centered, community-oriented models of health services represent core strategies for making this right a reality. A consensus is building around the concept of universal health coverage (UHC) as one of the key global development goals for the future.

2. One of the most difficult and pervasive obstacles to achieving UHC is the gap in the availability and accessibility of human resources for health (HRH). All individuals and communities need access to health care providers at the right time, in the right place, and with the right set of competencies. The goal of universal health coverage and the strategy of primary health care thus raise enormous challenges in terms of HRH. At the same time, they provide the fundamental and indispensable framework and policy orientations for the successful management of human resources in a way that is dynamic, efficient, affordable, appropriate, and responsive to varied and changing community health needs and social circumstances.

3. The 20 Regional Goals for Human Resources for Health 2007-2015, adopted by the Pan American Sanitary Conference in 2007, were formulated on the basis of the core values, and elements of a PHC-based health system. These core values include: the right to the highest attainable level of health, equity and solidarity. The current assessment and monitoring of the Regional Goals provides information on the progress being made at country and regional levels. Although it is not yet complete, the assessment has already focused attention on critical obstacles to achieving further advances in reducing inequities and improving access to qualified health workers. The goal of universal health coverage should provide additional impetus to confront these problems and make the anticipated benefits of UHC real to all members of society.

4. This document was developed at the request of the 152nd Session of the Executive Committee, 17–21 June 2013. It attempts to identify critical reforms and policy orientations needed to increase access to qualified health workers in PHC-based health systems, with particular attention to underserved and vulnerable communities. It stresses the importance of developing new models of HRH governance and of strengthening collaborative HRH planning capacity. The document builds on previous resolutions of the Pan American Health Organization (PAHO), specifically Resolutions CSP27.R7 (2007), Regional Goals for Human Resources for Health 2007-2015; CD50.R7 (2010), Strategy for Health Personnel Competency Development in Primary Health Care-Based Health Systems; CD49.R22 (2009), Integrated Health Services Delivery Networks Based on Primary Health Care; and, more generally, Resolutions CSP28.R13 (2012), Strategy for the Prevention and Control of Noncommunicable Diseases, and CD49.R13 (2009), Family and Community Health, among others.

Background

5. In addition to sustainable and equitable health financing, two health system objectives are of paramount importance for achieving UHC. The first consists of expanding the range, depth, and quality of services offered. It is expected that services that are accessible to the community will address the most prevalent and critical health problems: they will include and go beyond curative care to encompass health promotion, health protection, disease prevention, rehabilitation, and palliative care. This is an ambitious and complex objective, considering the shift needed from episodic interventions in health care to continuous care, particularly in the management of chronic conditions along the life course. The second objective, no less challenging, consists of an expansion of the proportion of the population with effective access to these services. Even in well-established and well-resourced universal health care systems, inequities in access often persist in specific population groups and vulnerable communities.

6. The barriers that impede access to quality and comprehensive health care are multiple and diverse, given the different realities of countries within the Region. In some cases, barriers are geographic in nature. In other cases, the critical barriers are

predominantly socioeconomic and cultural and are related to gender, ethnicity, age, income, religion, language, residency status, mobility, and lifestyle.

7. Three different models, each with its respective strengths and weaknesses, may be applied to forecast population health care and related HRH requirements: utilization-based, effective demand-based, and needs-based planning. Utilization-based models determine future needs by assessing past patterns of health service utilization. Effective demand-based models base needs on the resources available to meet them. Needs-based planning considers changing population characteristics, epidemiological profiles, and the corresponding options in community-based health care teams to address these needs cost-effectively.

8. Individual countries vary in the methods they use to define and estimate their shortages of health professionals. One commonly used indicator to help define the adequacy of benchmarking human resources is the health worker-to-population ratio, which typically looks at the number of doctors, nurses, or other health professionals per 1,000 population. The density of health workers can then be compared across different areas or political/administrative jurisdictions. However, this method has serious limitations, as it does not take into account other fundamental variables such as disease burden, availability of relevant competencies, productivity, models of care, and site of practice. More complex indicators have been developed to identify health professional shortage areas and medically underserved areas, which use predefined benchmarks for the ratio of population to full-time-equivalent primary care physician, dentist, or mental health professional. The ratio of the number of families or households per health team is frequently used to guide decisions regarding the expansion of health coverage at the first level of care.

9. Robust data on the health workforce and its distribution are critical to the development and monitoring of policies and programs to reduce inequities in access to qualified health professionals. There is no universal, evidence-based norm or standard for the optimum number and composition of health personnel, given the multiplicity of factors that affect output and the achievement of desired health outcomes. There is more consensus, however, on the *minimum* standard. The World Health Report 2006: Working Together for Health advanced the threshold estimate of 2.28 health workers (physicians, nurses, and midwives) per 1,000 population as the minimum needed to achieve a package of essential health interventions (such as 80% coverage of births by skilled birth attendants). This threshold estimate will need to be revisited, taking into account changes in UHC needs. It is ultimately the responsibility of each country to set its own objectives and indicators, track progress in reducing inequities, and remain accountable for implementing necessary improvements.

10. There is increasing evidence demonstrating the impact of various primary health care delivery models on health outcomes.[1] PHC delivery models within UHC systems provide team-based care that allows staff to be deployed and utilized more effectively and efficiently at their full competency level. This model values both the working relationships between the different professions and their respective contributions to health outcomes. A staff mix that is flexible and responsive to local needs frees up physicians to attend to more critical patient needs. This degree of flexibility enables improved patient contact, continuity of care, and responsibility in health delivery. Because they are community-based and are often recruited from local communities, primary care providers are often more sensitive to the local needs of various cultural, ethnic, and religious groups. Professional training curricula and continuing education programs for primary care providers place emphasis on the competencies required to address these local needs. The PHC delivery model promotes community dialogue and increases stakeholder participation in policy and program development; it also generates opportunities for linkages to other health services organizations, community services, and volunteer organizations, and for family participation in care management.

Analysis

11. The monitoring of the Regional Goals for Human Resources for Health 2007-2015 will facilitate the assessment of progress throughout the Region with regard to the situation of the health workforce and its contribution to the development of PHC-oriented health systems. Ensuring the availability and accessibility of qualified health personnel with the relevant technical and cultural competencies to address the needs of underserved and vulnerable communities remains a challenge for national health authorities. As an example, there are currently approximately 5,900 designated Primary Care Health Professionals Shortage Areas (HPSA) in the United States of America. Depending on the criteria used, it is estimated that 7,550 to 16,000 additional primary care physicians would be needed to eliminate the current primary care HPSA designations.[2] According to a similar 2010 study in Brazil, there were 1,280 municipalities with a shortage of physicians, representing more than 28 million people, mainly in the North-eastern and Northern regions.[3]

12. To achieve optimal results, PHC delivery models require medical professionals with the relevant competencies, leadership, and commitment. A study on graduate medical education in 14 Latin American countries showed that in 2010, 18% of the total

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[1] See, for example, F. C. Guanais and J. Macinko, "The Health Effects of Decentralizing Primary Health Care in Brazil," *Health Affairs* 28, no. 3 (2009): 1127-1135.

[2] See: Health Resources and Services Administration, US Department of Health and Human Services at www.hrsa.gov/shortage/.

[3] See: Índice de escassez de médicos no Brasil: Estudo exploratorio no ambito da atencao primaria, by Girardi and al., 2012. http://epsm.nescon.medicina.ufmg.br/epsm/.

first-year seats in residency programs were in family medicine or an equivalent, such as general medicine in Argentina and Costa Rica, comprehensive general medicine in Cuba, and family, community, and intercultural health in Bolivia. However, if we exclude Cuba from the analysis (69% of first-year medical residency seats in Cuba were in comprehensive general medicine, or 3,299 of a total of 4,801), the percentage is reduced by half, to 9% in the remaining countries. This compares to 11% in the United States of America, 28% in Spain, and 43% in Canada.

13. The formulation of national HRH policies and strategies requires evidence-based planning to guide decision making. A range of tools and resources exist to assist countries in developing national strategic plans.[4] Such plans are aligned with broader strategies for social and economic development and include short-term and long-term targets for scaling up education and training for health workers, reducing workforce imbalances and maldistribution, strengthening the performance of staff, improving staff retention, and adapting to major health sector reforms.

14. The production of HRH in the Region is not yet in sync with the needs of a PHC-based health system. The concepts of UHC and PHC have not permeated and transformed academic training institutions in a significant way. As a number of initiatives have shown,[5] a major paradigm shift is urgently needed in medical and health sciences education.[6] This cultural change, in turn, calls for renewed governance of human resources, expressed in innovative inter-institutional arrangements and programs, based on a sustained relationship and dialogue between national health authorities and academic institutions, and guided by the development of a common long-term vision. To have a positive effect on health outcomes, the professional education subsystem must design new instructional and institutional strategies.[7]

15. There is increasing awareness of the importance of the international migration of health workers to the development of HRH plans and strategies. The Global Code of Practice on the International Recruitment of Health Personnel adopted by the World Health Assembly in 2010 highlighted the ethical considerations relevant to source and destination countries and called for ensuring fair treatment of migrant health personnel.

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[4] For relevant planning tools and resources, see: PAHO Regional Observatory of Human Resources for Health at http://observatoriorh.org; WHO at http://who.int/hrh; and http://www.capacityproject.org/framework.

[5] A good example is *Beyond Flexner: Social Mission in Medical Education*. See: http://www.medicaleducationfutures.org/FlexnerSynposis.

[6] See for example: *Global consensus on social accountability of medical schools* at http://healthsocialaccountability.org/.

[7] See: *Health professionals for a new century: transforming education to strengthen health systems in an interdependent world*. Frenk et al. Lancet 2010; 376: 1923-58. (www.thelancet.com).

16. HRH planning based on a foundation of UHC grounded in high quality primary care in the Region, however, is limited and sporadic, and is made more complex by the competing interests of segmented health and education sectors. The process of ensuring coherency in the production of HRH and its alignment with the dynamics of labor markets and the objectives of health systems is still at a preliminary stage. It will require renewed effort and leadership to support negotiations and decision making, to engage on a sustained basis key stakeholders and interested parties to develop capacity, to produce quality data and evidence, to ensure flexibility in HR management practices, and to design a balanced system of financial incentives and regulatory approaches.

Proposal: Critical HRH Development Areas for Increasing Access to Qualified Health Professionals in PHC-based Health Systems

Strengthen capacities for planning of human resources for health

17. HRH planning requires the development of appropriate plans and management strategies to ensure that there are sufficient health workers to meet the health care needs of the population, both now and in the future. Planning human resources requires solid leadership and technical capacity and the existence of a strategic or planning unit with diversified competencies, including demographic and statistical analysis using multiple sources of information and research centers. If sound methodology and robust data are essential to support and guide the process, the ability to involve, engage, and negotiate with interested parties largely determines the outcomes. From a PHC perspective, there is clearly a need to better integrate planning across the professions, with special attention to skills mix and geographic balance. The experience of countries with established planning capacities shows that, from an initial focus on the medical workforce, attention is quickly shifting toward the relationships between the health professions that are core to PHC, such as medicine, nursing, dentistry, pharmacy, nutrition, and social work, among others.

Reform health professional education to support better quality PHC-based health systems and progress toward UHC

18. New strategies and coordination mechanisms need to be developed to align health professional education and health systems objectives. Incentives should be put in place to strengthen the social mission and community involvement of academic health centers and faculties, as well as corresponding accreditation institutions, ensuring their commitment to UHC. The creation of new schools in clinical health sciences should be needs-based and oriented toward PHC, addressing the needs of underserved populations and vulnerable communities. In addition, the expansion of decentralized clinical training centers and the creation of satellite campuses of existing schools in underserved communities should be encouraged. Recruitment of students from the community should be promoted, with explicit targets adopted to progressively diversify the student body and reflect the principal ethnic and cultural groups of the populations served. All graduates

should have demonstrable intercultural competencies. Students from the different PHC professions require an understanding of how the social determinants of health affect health and well-being in real community settings. The role of community health centers as primary sites for training should be expanded, with competent supervision of students.

19. Graduate medical education should be reformed to support PHC; toward this end, significant investment is needed in the development of academic departments of family medicine. Residents in all specialties should receive part of their training in community health centers and hospitals located in underserved communities. Specific targets should be developed to determine the number of residency seats in the specialties most relevant to PHC, such as internal medicine, general surgery, pediatrics, obstetrics and gynecology, psychiatry, and, particularly, family medicine. Financial incentives and regulatory measures should be adopted to ensure that these targets are achieved.

Empower people-centered, community-oriented collaborative PHC teams

20. Enabling conditions need to be addressed to ensure that PHC multi-professional teams achieve optimum performance and deliver high-quality, comprehensive, people-centered health care. Health promotion and prevention, as well as diagnostic and therapeutic resources, should be available in accordance with the model of care and the competencies of the team. PHC professionals should be fully supported through integrated care networks and by academic health centers. Isolation of PHC teams in remote and underserved areas may be minimized through the development of e-health strategies, including telehealth resources. The development of telemedicine and learning networks can improve the motivation, competence, and stability of the workforce.

21. Legal frameworks regulating the health professions should be updated in such a way as to enhance the scope of practice of all members of the PHC team and facilitate collaborative work, with an adequate degree of flexibility for innovation and adaptation according to local needs and circumstances. Finally, all health workers should benefit from existing social protection mechanisms. Competitive contractual arrangements, financial and nonfinancial incentives, and fair working conditions should be developed to attract and retain qualified PHC health professionals as countries move toward the achievement of universal health coverage.

Action by the Directing Council

22. The Directing Council is requested to examine the policy document and consider adopting the proposed resolution (Annex A).

Annex

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

52nd DIRECTING COUNCIL
65th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 30 September-4 October 2013

CD52/6 (Eng.)
Annex A
ORIGINAL: ENGLISH

PROPOSED RESOLUTION

HUMAN RESOURCES FOR HEALTH: INCREASING ACCESS TO QUALIFIED HEALTH WORKERS IN PRIMARY HEALTH CARE-BASED HEALTH SYSTEMS

THE 52nd DIRECTING COUNCIL,

Having reviewed the policy document *Human Resources for Health*: *Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems* (CD52/6);

Acknowledging the strategic importance of human resources for health (HRH) for the achievement of the goal of universal health coverage (UHC) grounded in the development of health systems based on primary health care (PHC), and the improvement of the health and well-being of individuals, families, and communities;

Concerned by the persistent inequalities in access to quality and comprehensive health care services attributable to health personnel shortages in remote and rural areas and among underserved or vulnerable population groups and communities;

Considering the adoption by the 63rd World Health Assembly of the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA63.16 [2010]), which addresses challenges posed by the mobility of health professionals between and within countries;

Taking into account the progress made in the Region with regard to the *Regional Goals for Human Resources for Health 2007-2015* (CSP27/10 [2007]) and the *Strategy for Health Personnel Competency Development in Primary Health Care-Based Health Systems* (CD50.R7 [2010]),

RESOLVES:

1. To urge Member States to:

(a) reiterate their commitment to achieving the Regional Goals for Human Resources for Health 2007-2015;

(b) develop national human resources plans and policies in concert with the relevant social sectors and key stakeholders to increase access to qualified health workers for PHC and to move toward the achievement of UHC;

(c) establish and strengthen a strategic planning and management unit for human resources for health with the capacity to lead, engage, and generate consensus among national education authorities, academic health centers, professional associations, state and local health authorities, health centers, and community organizations on current and future HRH needs, in particular for PHC-based health systems;

(d) empower and support PHC collaborative multi-professional teams based on established models of care, enhance the scope of practice of each profession to its fullest potential according to its competencies, and encourage and monitor innovation in improving the performance and management of PHC teams;

(e) identify, monitor, and report on specific health professional shortages, particularly in vulnerable populations and at the first level of care, as a basis for the implementation of special programs and interventions to address such shortages;

(f) invest in the production, availability, utilization, and analysis of core data on human resources for health, improve the quality of human resources information systems for planning and decision making, and support research capacity on priority HRH issues, such as the Regional Observatory of Human Resources in Health;

(g) promote the social mission and accountability of health sciences education and accreditation centers and their commitment to PHC and UHC, and enable and expand the network of community health centers and hospitals with teaching responsibilities and capacities in underserved communities;

(h) reform graduate medical education to support PHC-based health systems, increase the number of seats in the medical specialties most relevant to PHC, particularly in family medicine or its equivalent, and strengthen the development of academic departments of family medicine;

(i) put in place and evaluate on a regular basis specific regulations, benefits, and incentives, both financial and nonfinancial, to recruit, retain, and stabilize personnel for PHC-based health systems, particularly in remote and underserved areas;

(j) reiterate their commitment to the WHO Global Code of Practice on the International Recruitment of Health Personnel.

2. To request the Director to:

(a) intensify the technical cooperation of the Organization with and between Member States to develop human resources policies and plans guided by the overarching objective of universal health coverage and the strategy of primary health care;

(b) provide technical cooperation to strengthen the HRH planning capacity of national health authorities, enabling them to address inequities in access of underserved and vulnerable communities to health personnel, particularly primary care professionals, with special emphasis on availability, distribution, competency, and motivation;

(c) identify, document, analyze, and disseminate experiences, methods, and innovations taking place in the countries of the Region with regard to the availability of and access to health personnel;

(d) facilitate dialogue between education authorities, higher health education institutions, and national health authorities on the strengthening of PHC and PHC collaborative teams;

(e) sustain and expand the main regional knowledge-sharing networks in HRH, namely the Regional Observatory of Human Resources in Health, the Virtual Campus for Public Health, and the Educational Virtual Clinic;

(f) complete the assessment of the 20 Regional Goals for Human Resources for Health 2007-2015 and initiate the regional consultation on HRH in the post-2015 development agenda.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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CE152/6 (Eng.)
Annex B

Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

1.	**Agenda item:** Item 4.4. Human Resources for Health (Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems)
2.	**Linkage to Program and Budget 2014-2015:***
	(a) Outcome:
	OCM 4.5 Adequate availability of a competent, culturally-appropriate, well regulated and distributed, fairly treated health workforce
	Outcome Indicators:
	OCM 4.5.1 Health Workforce Shortages; OCM 4.5.2 Public Health Competencies; OCM 4.5.3 Distribution of Health Personnel
3.	**Financial implications:**
	(a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US$ 10,000, including staff and activities):
	Total estimated cost for implementation is $7.5 million for the period 2014-2019.
	(b) Estimated cost for the biennium 2014-2015 (estimated to the nearest US$ 10,000, including staff and activities):
	Estimated costs for the biennium 2014-2015 are approximately $3.7 million.
	(c) Of the estimated cost noted in *(b)*, what can be subsumed under existing programmed activities?
	1.2 million

* Refers to the Proposed PAHO Program and Budget 2014-2015 that was presented to the 152nd Session of the Executive Committee.

4. Administrative implications:

(a) Indicate the levels of the Organization at which the work will be undertaken:

All levels, regional, sub-regional and national will be involved.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

Additional staffing is required at regional level with expertise in management of human resources (staffing, recruitment, retention strategies, financial and non-financial incentives systems). Additional capacity will be required in demography and statistics to support the development of indicators and metrics for HRH planning and monitoring.

(c) Time frames (indicate broad time frames for the implementation and evaluation):

The proposed timeframe is 2014-2019.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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CD52/6 (Eng.)
Annex C

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** Item 4.4. Human Resources for Health (Increasing Access to Qualified Health Workers in Primary Health Care-based Health System)s

2. **Responsible unit:** Health Systems and Services (HSS/HR)

3. **Preparing officer:** Charles Godue

4. **List of collaborating centers and national institutions linked to this Agenda item:**

   Dalhousie University Collaborating Center on HRH Planning

   CC of the Universidad Estadual de Rio de Janeiro en HRH Planning

   Ministries of Health of the Region

5. **Link between Agenda item and Health Agenda for the Americas 2008-2017:**

   The Agenda Item is linked to the values and principles of the Health Agenda of the Americas, as well as to its areas for action.

   Principles and Values: Human Rights, Universality, Accessibility and Inclusiveness; Pan American solidarity; equity in health.

   Action Areas: Strengthen the national health authority; address the health determinants; increase the social protection and access to quality health services; take advantage of knowledge, science and technology.

6. **Link between Agenda item and Strategic Plan 2014-2019:***

   Agenda Item is linked to Outcome 4.5, Adequate availability of a competent, culturally-appropriate, well regulated and distributed, fairly treated health workforce

7. **Best practices in this area and examples from countries within the Region of the Americas:**

   Brazil: the Family Health Program

   Bolivia: Programa de Medicina Familiar, Comunitaria e Intercultural

   Canada: Planning of the Medical Workforce; Ontario Telemedicine Network

   Cuba: Decentralized education in health sciences at community level

* Refers to the Proposed PAHO Strategic Plan 2014-2019 that was presented to the 152nd Session of the Executive Committee.

El Salvador: The Community Teams of Family Health (Ecos Familiares)

Peru: SERUMS

USA: Health Professional Shortage Area and Medically Underserved Areas/Populations

8. Financial implications of this Agenda item:

See Annex B - Report on the Financial and Administrative Implications of the Proposed Resolution for PASB.

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