

The UN High-Level Commission on Health Employment and Economic Growth: The Opportunity for Communities and their Primary Health Systems

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Appendix 1: Complete questions and commentary submissions

Country commentary

Bent Høie, Minister of Health and Care Services,
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Dr. Benoit Vallet, Director General for Health,
Ministry of Social Affairs and Health,
Government of France, Paris, France

Dr. David Weakliam, Global Health Lead
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Dublin, Ireland

1. *This report calls for collaborative action between each country's finance, health, education, labour and social and foreign affairs, to transform the health workforce for the achievement of the SDGs. In support of this, specific actions have been identified. What needs to happen to trigger these recommendations and actions to happen? Do you see this action plan being picked up in your own country?*

B.H.: In order for these recommendations and actions to happen within each country, I believe health ministers in the relevant countries need to be advocates within their own governments for the recommendations of the commission. One basic assumption of the commission is that no single ministry can

impact the expansion and transformation of the health workforce alone.

Different actions and policies will be needed for countries depending on their current health workforce needs, and their role in the international health workforce market. Nevertheless, health ministers and their bureaucracies should work together with other ministries and develop a shared understanding of the commission and what it means for them.

I also believe WHO must continue working in concert with ILO and OECD as they approach countries with technical support. Working with other organizations at country level will demand other types of cooperation than at global level.

Finally, I think the accountability dimension of the plan needs more work. Accountability through measurability is vital. It offers not only the opportunity to hold politicians to account, but also visibility to the measures and investments that countries make. That can be a powerful inspiration for political action.

B.V.: The High-Level Commission on Health Employment and Economic Growth should pave the way for future collaborations between all relevant

stakeholders, from all those different sectors. Indeed, the mission of the Commission is unprecedented and is at the heart of the SDGs. This new approach goes beyond the health sector and has helped develop a new interagency and intersectoral approach to health professionals. Recommendations and immediate actions have been identified. What needs now to be triggered is better awareness by Member States, but also by all relevant and key stakeholders. The three agencies – ILO, OECD, WHO – have a leading role to disseminate findings and recommendations of the report, to encourage countries in appropriating these ideas and support them in their implementation, according to their national capacities, context and needs.

For more than a year now, France has been committed to supporting the Commission's work and the three agencies in the development of the 5-year action plan. Our country intends to remain highly involved in both political and technical processes to have this plan endorsed and implemented by all Member States. France has actually already engaged in a consultative process (called the "Great Conference on Health" on February 2016, as a follow-up of the new Modernization Law of our health system of January 2016), which outlined a new health system model with a focus on prevention and more integrated and patient-centered care. What is at stake is the training of health professionals and how to improve and adapt it, but also how to innovate in order to improve the conditions of exercise throughout the territory. This will lead us, in particular, to initiate a reflection on medical demography and on how to better distribute health professionals over the territory, so that it is aligned with the reality of their needs. France will also act at the European level to foster synergies among European Member States to address the issue of healthcare workforce. There are ongoing initiatives at

the EU level that can serve as best practice and contribute to improve quality of training of health professionals.

D.W.: The trigger is action by political leaders, advocates and other stakeholders to take the Commission report to each country government. They need to take the opportunities of national, regional and international forums. They need to convince government leaders and also policy makers in non-health sectors that health employment will contribute to sector specific goals and broader socioeconomic development. The Commission report presents a compelling case for investing in the health workforce to not only improve health and well-being, but also achieve gains in social protection, human security and economic empowerment of women and youth.

Government leaders and other stakeholders must then commit to progressive fiscal policies and make large-scale investments in health worker education and skills and the creation of health jobs. An important step is for governments to institute mechanisms for intersectoral engagement in health workforce planning and development. While health workforce planning may sit naturally under the Ministry of Health, an effective response also requires leadership from ministries of education, employment and finance. We can learn from responses to the HIV crisis, that Government leadership at the highest level is a key to driving effective intersectoral action. For effective implementation, Governments further need to strengthen institutional capacities for workforce planning and governance, including the implementation of National Health Workforce Accounts.

The work of the Commission is timely in the Irish context as the country emerges from a financial crisis and the Government is preparing to scale up much needed investments in the health service. An intersectoral approach to health is already in train with the Government's national framework for

improved health and well-being, ‘Healthy Ireland’ (2013). This whole-of-government approach has been continued by the Ministry of Health in developing a national integrated strategic framework for health workforce planning which will be completed in 2017. Key Ministries including Education and Skills; Jobs, Enterprise and Innovation; Public Expenditure and Reform; and Justice and Equality are engaged in the process and will continue in a permanent interdepartmental group for approving future health workforce initiatives. The Commission report has been welcomed in Ireland and the action plan can be instrumental in bringing the government jobs and finance sectors more on board, reinforcing the message that the health workforce is not a liability, rather there is economic value from investing in the education, recruitment and retention of health workers.

2. Primary healthcare at the community level forms the bedrock of SDGs and UHC. Resource constraints continue to challenge staffing, commodities movement, ongoing monitoring and evaluation, and planning and management of primary healthcare provision to rural areas. How does this global agenda help to facilitate an in-country response that (hopefully) would ultimately impact and strengthen the primary health system at the community level.

B.H.: I think this is reflected well in the recommendations of the commission, with one recommendation in particular aiming at shifting emphasis from specialized towards primary and community level care, and it is – in my opinion – one of the most important messages that this commission has issued. The shorter educations – the community health workers, the nurses, the GPs – are much more efficient in terms of input in the education system versus the health they provide in return. Prevention, as we know, is more efficient than cure. Families having access to a health clinic with basic essential

staffing and basic essential equipment and medicines gives a lot more back to the people and the economy, than a fraction of the population having access to specialized care in the larger cities. Equitable access to prevention and basic care is essential.

We have heard this before, but the major advantage this commission presents is an economic growth context. I believe that this can be crucial for the primary healthcare agenda being picked up by heads of government.

Another advantage of the commission, which has come about due to its cross-sectoral nature, is the emphasis on decent jobs. Earlier, the main focus in the retention debate has been on the abstention from active recruitment from countries with health personnel shortages. While that perspective is still highly relevant, I think the sharpened focus also on working conditions will contribute to the retention of personnel, and more people seeking this kind of work.

B.V.: In a context of limited resources, it is not enough to invest more. We have to invest better. This requires development of employment and training policy and plans based on a real assessment of present and future needs, through reliable data and appropriate regulation. The strength of the data architecture depends on the active engagement of communities, health workers, employers, training institutions, and professional and regulatory bodies.

The global agenda should thus pave the way for a new reflection at national and local levels, to:

- Set up a global framework gathering not only governments but also all relevant stakeholders. This implies sharing information, developing a common language, improving capacity building at regional, national and local levels. Civil society and communities need to be

- involved to help transform health-care systems and strengthen training models towards: redefining new models of health systems, with a stronger focus on prevention and an integrated approach on health systems strengthening and preparedness for health crises;
- developing life-long training opportunities and linking more closely with local context and available means: health workers who will be deployed in rural areas need adapted training.
 - Encourage competence-based training of health professionals using IT tools to enhance its impact on quality of care.
 - Create the conditions for a more global and intersectoral dialogue and sharing of experiences. The sheer cross-sectoral nature of the factors that determine the state of health of our populations has been recognized by the 2030 Agenda. Indeed, a successful primary health system goes hand in hand with a strong appropriation of public policies by all actors and all sectors, starting at the community level.

France engaged in this process by co-organizing with WHO an international conference to promote intersectoral and interagency action for health and well-being in the WHO European Region, in December 2016. The main goal was to promote effective collaboration between education, health and social affairs sectors.

D.W.: The power of the Commission lies in the way it brings an economic lens to the health workforce. What the report demonstrates is not just that the health workforce yields an economic benefit, but that the most efficient investment in the workforce is the one which will deliver UHC and improve

health and well-being. It presents a clear message to all countries that the curative care model is unsustainable due to demographic changes and rising costs of health-care, and that all countries will benefit from shifting to a community-based model.

Primary healthcare is not a new approach but countries have not made the investments needed to make it work. By underpinning the approach with an economic argument, the Commission report can influence governments to reform health services away from hospital-based care towards a focus on prevention and community-based primary care with special attention to underserved areas. The Commission has described a range of pathways by which the health system and health workforce contribute to economic growth. These can persuade policy makers outside the health sector that investing particularly in a community-based primary care system will increase employment of women and youth, reduce social inequalities, enhance health security and drive inclusive economic growth.

Commission co-sponsoring organizations commentary

James Campbell, Director of the Health Workforce Department, WHO, Geneva Switzerland

Akiko Meada, PhD, Senior Health Economist, OECD, Paris France

1. *What do you see as the greatest success of the Commission and its report? How do you see this report is different from many other studies and reports on human resources for health?*

A.M.: A major objective and achievement of the Commission Report was to broaden the policy dialogue beyond the health sector and to work across silos. Hence health employment was not seen just as an instrument to ensure that health services are delivered, but also as an important part of the general labour market. The Commission recommends

investment in transformative education, promoting decent job creation in the health and social sectors and mutual benefit from the international mobility of health workers; recognition of the importance of investments in health employment as a means of expanding skills development and generating decent work opportunities and career ladders for young persons, including young women; and recognizing the significance of such investments against a context of growing global youth unemployment. Among OECD countries between 2000 and 2014, employment in the health and social sector increased by nearly 50%, compared with employment growth of just 14% overall, and 27% in all services combined. Health employment continued to rise in many countries even when the economic crisis had caused there to be a sharp downturn in overall employment, underscoring the significant and increasing weight of the health sector in generating jobs.

The health labour market is rigid in many respects, with entry into employment often being restricted through controlled access to training to be a health worker; tasks restricted according to particular employment types (e.g., only doctors may perform certain tasks); self-regulation by the relevant professions; and requirements (at least in some countries and for some professions) to undertake continuous professional development. These rules and regulations are in place to assure the qualification of the health workers and protect the quality and safety of health services for the patients. Yet despite all these regulations, there is evidence of significant skills mismatch among the health professionals in the OECD countries: many nurses report on over-skilling, i.e., not being able to use the skills they have to their full ability, while many physicians report they do not have the training to perform the tasks they have been given. The Commission Report highlights the importance not only of educating and preparing the health workers

who are fit for their assignment, but also in creating a supportive work environment that will enable the workers to make the best use of their valuable skills and knowledge.

There has been a historic and systematic underinvestment in developing a new health workforce in several OECD countries, with a corresponding reliance on attracting qualified health professionals trained in other countries. This has led to tensions internationally, with some low- and middle-income countries arguing that their scarce public funds were being used to fund the training of doctors and nurses who ended up working in OECD countries. Under the auspices of WHO, a voluntary Code of Practice was approved by countries, but the Commission highlights the need for greater commitments from the international community toward the implementation of the code. Given the increasing mobility of the health professionals around the globe, the Commission sends a strong message on the importance of monitoring the movement of health workforce and promoting a governance framework for greater transparency and accountability in this area to the benefit of both the sending and receiving countries.

J.C.: The challenges in the global health workforce and concerns around increasing workforce shortfalls have been widely discussed and documented, particularly following the Joint Learning Initiative's report in 2004 and the World Health Report in 2006. This resulted in the establishment of the Global Health Workforce Alliance, with a ten-year mandate to address the global health workforce 'crisis'; which was particularly acute in 57 low- and middle-income countries. A legacy report from the Alliance documented significant contributions in the ten-year period to 2016 and confirmed greater awareness and enhanced policy dialogue. However, there was a continuing perception that these efforts did not alter the landscape of health workforce

investments over the last decade. The health and social workforce continues to be an area of chronic underinvestment in many countries, with a predominant macro-economic perspective that considers capital and recurrent costs of the health workforce as a cost to be contained rather than a productive investment.

This narrative was completely transformed with the adoption of WHO's Global Strategy on Human Resources for Health: Workforce 2030 and the subsequent work and report of the High-Level Commission on Health Employment and Economic Growth. The Global Strategy and the Commission catalyzed a paradigm shift towards a new understanding of the health labour market that recognizes the multiplier effect of health workforce investments on the economy and the broader socioeconomic returns across the 2030 Agenda for Sustainable Development, resulting in not only better health and well-being (SDG 3) but also improved quality of education (SDG 4), gender equality (SDG 5) and decent work and inclusive economic growth (SDG 8).

The Commission underlined the unprecedented opportunity for tangible socioeconomic gains to be achieved by investing in the health and social workforce, recognizing the health and social sector as a major and growing employer and force multiplier for inclusive growth. The Commission proposed ten recommendations and five immediate actions to maximize the investment opportunity arising from the unprecedented doubling in the demand for health workers by 2030 leading to the creation of around 40 million new jobs in mostly wealthier countries, whilst addressing the anticipated shortfall of 18 million health workers in mostly low- and lower-middle-income countries.

The Commission was planned and deliberately constructed as an intersectoral endeavor with the legitimacy of the UN Secretary-General's office. It built on the

foundations in WHO's Global Strategy and rapidly brought together available evidence to challenge thinking. It put forward a compelling health and social workforce investment case – one that speaks to key sectors of government such as labour and finance. This work has been essential in spurring a new generation of intersectoral commitment and policy dialogue, which will lend momentum to the implementation of the Global Strategy. The High-Level Ministerial Meeting convened by ILO, OECD and WHO on 14-15 December 2016 in Geneva proposing a five-year action plan to support country-driven implementation of the Commission's recommendations and the adoption of the UN resolution on health employment and economic growth in December 2016 (A/RES/71/159) demonstrate the growing political momentum for health workforce investments and action. The 70th World Health Assembly will consider the five-year action plan this May.

2. *There is no doubt the success of this Commission was due to the strong collaboration between your three organizations. How do you see these efforts of collaboration continuing?*

A.M.: The collaboration among WHO, ILO and OECD, will bring together the knowledge and expertise in health, labour and economic sectors. The recommendations of the Commission Report call for such an intersectoral approach, and the three agencies complement each other in this respect. The recommendations of the Commission also resonate with OECD's strategic orientation and areas of focus that require a multidisciplinary approach. OECD's strategic areas of focus include:

- the inclusive growth agenda, highlighting how right investments in the transformation of health employment can help achieve a healthy and productive population;

- the gender initiative, supporting the need to tackle gender inequalities in the health and social sectors, thus promoting women's empowerment;
- the skills strategy, stressing the necessity to measure, understand and develop health workers' skills and skills strategies to meet 21st century health needs and reduce skills mismatches;
- the jobs strategy, tackling how the health labour market can contribute to the creation of resilient and decent jobs;
- work on migration, focusing on approaches for managing health professional's migration; and
- the development strategy, emphasizing the importance of the Paris Declaration on Aid Effectiveness and the Busan Partnership for Effective Development Co-operation.

The OECD proposes sharing the work on implementing the joint ILO/OECD/WHO Action Plan which responds to the recommendations of the Commission. The OECD will work with emerging economies and OECD member countries, in close cooperation with WHO and ILO, in ensuring a coherent approach and sharing knowledge and cross-fertilisation of policies with all the countries across the globe, and in enabling low- and middle-income countries to skip a generation of health reforms as they work to achieve universal health coverage.

J.C.: The Commission was conceptualized and planned as an interagency collaboration. The ILO and OECD were specifically selected to demonstrate the links between health, labour and economics and flag that health workforce challenges are of global relevance to upper-middle and high-income countries as well as the global south. It broke new ground in establishing partnerships between WHO, ILO and OECD and

positioning the 'investing in health workers' narrative with the G20 and others.

The partnership has evolved into the development of a joint action plan that specifies deliverables that will leverage the institutional strengths and mandates of each agency to the greatest effect to enable an enhanced platform of intersectoral cooperation to amplify national, regional and international health workforce action and investments. Together, we can achieve more than any agency working standalone.

WHO embraces this collaboration as an example of interagency and intersectoral collaboration that is critical to achieving results across the 2030 Agenda.

Specific work will be taken forward that has immense potential to leverage domestic and international resources in support of a sustainable health workforce in all countries. New work will build further partnerships and alliances on labour mobility, education, skills, jobs, data and accountability.

Researchers and policy setters, and NGOs commentary participants

Dr. Jill White, Professor, Faculty of Nursing and Midwifery, Fellow of the University of Sydney Senate, Director of the USU Board, University of Sydney, Sydney Australia

Howard Catton, Director, Nursing and Health Policy, International Council of Nurses, Geneva Switzerland

1. *This report outlines an ambitious action plan. Do the issues identified in this report resonant within your own country's experience? If not, what are the gaps? If so, what do you foresee as the greatest policy challenges within your own and other countries to action this work?*
2. *The research report outlines gaps in research and the final report recommends actions to improve data collection and evaluation capabilities. Will any of these actions strengthen the evidence base needed to facilitate policy improvements for primary health systems within your country?*

J.W.: As a nurse, academic, mother, community member and global citizen I welcome the recommendations of the report. When I look at each one I am a mixture of grateful and depressed. Grateful that, although we are by no means perfect, gender equity and women's rights are further ahead than many countries; we have an excellent and accessible education system; we have a high-quality healthcare system with excellent hospitals and health professionals educated at well regarded universities; we have cutting edge technologies; and blessedly we are largely conflict free. Less joyful are the current political realities in relation to healthcare and the ramifications for the recommendations of the Report.

Australia has a complex multi-level system of government, with many social care responsibilities at local government level, hospitals largely the responsibility of the State governments, and doctors' reimbursement, indigenous health and aged care a Federal responsibility. Cost shifting and lack of coordination between levels is a huge problem. Whilst there is some political appetite for moving to an integrated health and social care system, the system complexity and short electoral cycles make this profoundly difficult.

The medical profession wields enormous political power in this country and resists any attempts to enable more cost-effective care provision. Interprofessional education is often spoken of but rare in practice. Systems issues prevent nurses and others working to their full scopes of practice. There has been a recent focus on community-based chronic care but the scheme introduced currently mandates the General Practitioner (doctor) as the named lead provider and hence the one who attracts financial reimbursement, but it is hoped that this will in future become more inclusive. Health promotion and prevention are the neglected areas in the system. Our health professional regulatory system is robust and guards its standards carefully

making "mutual recognition" a fraught issue with countries without comparable health systems. We do, however, have large numbers of internationally educated nurses working in Australia but do little to recompense the countries of origin for the costs associated with the education or the loss of personnel. One would hope a fortunate country such as Australia would offer greater assistance to countries striving for better healthcare. Our country's aid program is not currently focussed on health needs of other countries and is focused on "Aid for Trade."

The work of the Commission has received no public coverage here and no formal government recognition. The three-year electoral cycle mitigates against government level five-year planning commitments such as that suggested related to the recommendations.

Job creation is a stated priority for the current government, however, the public health sector is not the focus. Despite this the health sector job growth was the largest of any sector at 150% in the last year.

The evidence base for evaluation and action is dependent on the data captured and the cost/benefit impact of nursing practice is rarely part of the data collected. One of the most significant pieces of the Commission's work will be the identification of the metrics that will accurately indicate the factors which do influence health improvements and economic growth and the relationship between the two.

H.C.: The UN Commission has made a bold, compelling and evidence-based case for investment in the health workforce. However, the change in political mindset that is required to deliver this should not be underestimated. Many countries are still recovering from the global economic downturn and have implemented austerity programs to cut public spending. In addition, there have been significant political swings emphasizing national rather than

global priorities, turning away from big Government and focusing on trade policy. The environment could probably not be tougher in which to ask political leaders to invest in the health workforce and that's also compounded by the relatively short election cycles of 4/5 years that frame so much of political decision-making. So, the risks are that political leaders will look upwards to Global institutions to deliver on the UN Commissions action plan as opposed to inwards and downwards. A significant risk is that investment in the health workforce could be focused on quickly increasing the supply line through producing new cadres of substitute workers. All of which means that the action plan must be about developing strategies to actively engage all stakeholders and developing a shared ownership for action. This is where robust metrics and monitoring can help to focus political minds.

Data and evidence must be effectively marshalled to support the change in political mindset that's required. Having a clear and agreed baseline and relatively simple and standardised metrics will be an important start. There is starting to be a renewed concern about the international migration of healthcare staff, yet know that there is support for the principle of self-sufficiency of healthcare workers contained in the WHO Code on International Recruitment. The right data and metrics would help to put numbers on what self-sufficiency looks like.

Evidence is important but ultimately it informs rather than dictates political choices and decisions. The challenge is how to make

sure that data and evidence cannot be ignored by policy and political decision-makers.

New models of care, patient-centred services and intersectoral working are without doubt fundamentally important concepts. Moving care closer to home is a principle almost universally accepted. However, when you examine the nursing workforce required to make that a reality the nursing numbers in non-acute settings are often smaller, those that are working have an older age profile and are frequently working part time. Integral to planning new service models must be growing and developing the workforce. Again, this alignment between service and workforce planning is complex. Old services cannot be replaced with new ones overnight and staff need to be supported and receive training to work in new ways. Sustainable transitions must be planned, take time and require funding. A much stronger focus on patient and population outcomes would be a powerful way to shift thinking predicated on inputs and it can also drive more creative thinking about team working.

Final issue is the relatively poor pay of so many of the health and social care workforce. We ask people to provide the most intimate and demanding care to others. Yet in return we value care in terms of pay less than many jobs in retail, transport or travel industries for example. The reality is that the human costs and economic consequences of caring ultimately impact on the available supply of staff. The UN Commission talks about "decent" jobs but lets also be explicit and demand fair and equitable pay.