Capacity building in human resources for health: The experience of the region of the Americas

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ABSTRACT

SETTING: Since the year 2003, most countries of the Region of the Americas have experienced sustained economic growth and inclusive development policies. In the health sector, achieving universal access became the overarching goal. However, the structural limitations of the health workforce represented a formidable obstacle to change. National Health Authorities were confronted with the challenge of developing critical capacities to redress entrenched inequalities in access to qualified health personnel.

INTERVENTION: Under the auspices of the Pan American Health Organization, the Ministers of Health of the Region adopted, in September 2007, twenty regional goals for Human Resources for Health 2007–2015, aligned with the renewed strategy of Primary Health Care. Subsequently, a set of indicators and a methodology were developed to assess the goals and to monitor progress at the country level.

OUTCOMES: Fifteen countries carried out a baseline assessment in 2009 or 2010 and conducted a second assessment in 2013. Although differences were noted across goals and between countries, the results suggested improvements in all twenty goals overall. The goals linked to the distribution of personnel, the management of migration, and the cooperation with education institutions appeared to be more resilient to change.

IMPLICATIONS: The twenty Regional Goals for Human Resources for Health provided a common vision for action and a framework for cooperation within and among countries, and was a catalyst for change. Faced with evolving challenges, the countries should consider adopting a new shared agenda that builds on progress made and further supports intergovernmental policy alignment and capacity building in health workforce development, governance and management.

KEY WORDS: Human Resources for Health; capacity building; Latin America; health policy; governance; evaluation and monitoring

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Historically, the Region of the Americas has exhibited the greatest inequities in the world with regard to wealth distribution. However, in most Latin American countries, new political leadership emerged at the beginning of the millennium committed to an inclusive development agenda and participatory democracy. Sustained economic growth and inclusive social policies acted in concert to improve employment and literacy; more than 72 million people escaped poverty between 2003 and 2013.¹ In turn, these trends generated greater social expectations and demands for quality social services.²

The health sector became fully involved in the process of change. The affirmation of health as a fundamental human right and the reduction of health inequities became central components of political discourse.³ In a Region where 30% of the population did not have regular access to basic health services, the renewed strategy of Primary Health Care (PHC) became the principal policy option to expand effective coverage.^{4,5}

However, most countries suffered from a legacy of chronic underinvestment in human resources for health (HRH) after the “lost decade” of the nineties, an observation not specific to the Americas.⁶ An analysis of HRH trends in the Americas carried out by the Pan American Health Organization (PAHO) in 2005 identified a number of issues that presented significant barriers to countries’ efforts to achieve health sector reform.⁷

- While most National Health Authorities (NHAs) had a unit of personnel administration responsible for the working conditions of employees of the public sector, only two countries had a strategic HRH planning unit to identify gaps, anticipate future needs and align health workforce strategies with the needs of the health care system. Accordingly, HRH information systems were limited in scope and of poor quality.
- The distribution, composition and competencies of the workforce were severely distorted with regard to health needs. Latin American countries showed a ratio of 3–5 medical doctors per nurse. Physician supply in urban areas was eight to ten times higher than in rural areas.

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Competencies were hospital-related and considered not relevant to the health needs and cultural characteristics of the communities served.

- The English-speaking countries of the Caribbean were losing their nurses to the United States, the United Kingdom and Canada, who relied to various degrees on the international recruitment of health workers to meet their needs.⁸ Although the situation was severe in some cases, most Latin American countries did not monitor the international migration of their health workers.
- Many countries suffered a high proportion of their health workforce – sometimes more than 40% – being without a formal contract, employment benefits, or social protection. The health sector experienced a high degree of labour unrest and instability as the result of low remuneration and poor working conditions. Underemployment and dual practice frequently coexisted at the national level.
- Due to the autonomy of institutions of higher education in Latin America, NHAs had limited or no say on the number of schools of health sciences nor on the number of and expected competencies from their graduates.

It is within this context that PAHO launched in Toronto, Ontario, in 2005, during the VII Meeting of the regional network of HRH Observatories, a decade of Human Resources for Health to redress entrenched inequalities in access to qualified health personnel. The representatives of the countries at the Toronto meeting agreed on a Call to Action around five critical challenges, which formed a comprehensive policy agenda and a platform for cooperation and knowledge transfer between countries.⁹ The Ministers of Health of the Region formally followed suit in 2007 with the adoption of twenty Regional Goals for Human Resources for Health 2007–2015 structured along the five core challenges.¹⁰ Table 1 details the five challenges and twenty goals.

METHODS

Following the adoption of the twenty Regional Goals by the Pan American Sanitary Conference (PASC) in 2007, PAHO formed a working group composed of directors of HRH Units from Ministries of Health and technical experts to develop a set of indicators and a methodology for the national assessment and monitoring of the twenty goals. Given the complexity and often qualitative nature of the goals, a participatory methodology was employed, by which the NHA would convoke a broad spectrum of key informants proceeding from the ministry itself, both at the central and decentralized levels, other relevant ministries (education, labour, finance), social security institutions, schools of health sciences, professional associations, health workers unions, and other relevant stakeholders. Participants debated and agreed upon the level of achievement of each goal (expressed as a percentage), supported by the best information available. In some cases, the key informants would assess all the goals in a single session; in others, multiple sessions were organized and specialized informants were brought in according to the nature of the goals under review. A manual was produced to conduct the exercise, detailing the justification of the goals, definitions of key terms used, the proposed indicators, the data required, methodological guidelines, and the sources of data.¹¹

Technical support and training for both measurement exercises were provided by PAHO and coordinated at the subregional level with the involvement of subregional agencies, namely the Council of Ministers of Health of Central America (COMISCA) and the Andean Health Organization (ORAS). The results were collected in reports prepared by the NHAs from the respective countries and disseminated online through the [Regional Observatory of Human Resources for Health website](#).

RESULTS

Twenty-four countries of the Region of the Americas, out of a total of 35, undertook the baseline measurement of the twenty goals over the period 2009–2010. Of these countries, 15 carried out a second measurement in 2013, allowing a determination of progress made (Figure 1). The results presented here refer to the following countries: Belize, Bolivia, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, the Dominican Republic, and Uruguay. It is estimated that approximately 500 professionals were involved in the monitoring process.

The main thrust of the initiative was intended at the national level, by supporting health authorities in assessing their situation with regard to the goals and by monitoring progress. A country's perspective is therefore relevant to understand the process. As a general rule, the quality of the assessments of the goals was related to a country's degree of institutional development and the sophistication of its HRH information system. Peru is an upper middle-income country with good institutional capacity, but still confronted by serious health inequalities. Its case will serve to illustrate the changes that happened over the time period and how they informed the results.¹²

Peru carried out its first assessment of the goals in 2009 and its second in 2013, under the leadership of the General Division for the Management of Human Resources Development of the Ministry of Health. Participating institutions included organizations responsible for the provision of health services (Central and Regional Governments, Social Security for Health in Peru, Armed Forces, National Police), universities and professional colleges. The results are shown in Figure 2, and presented in the form of a star for each challenge, with each point of the star referring to one of the twenty goals.

With regard to the first challenge, the availability of human resources is low, with a density of health workers (physicians, nurses and midwives per 10,000) reaching 26.1 in 2013, slightly exceeding the objective of 25 suggested by the World Health Organization as a minimum to provide basic public health interventions.¹³ The modest proportion of the medical workforce dedicated to PHC is an issue (37%), compounded by the low availability, the mal-distribution, and the poor mix of professionals, as illustrated by a 1.1 nurse per physician ratio. The country is investing in the development of competencies for its PHC teams and has steadily strengthened its Division of Human Resources. All indicators show some progress during the reference period.

With regard to the second challenge – adequate access to health care providers – the Ministry has developed financial incentives to attract and retain health workers in rural and underserved areas, with some success. Public health competencies of PHC workers

Table 1. The five regional challenges and twenty goals in Human Resources for Health 2007–2015

Regional challenges (2005)	Regional goals (2007–2015)
1. Define long-range policies and plans to better adapt the workforce so it will be prepared to meet expected changes in the health systems and to better develop the institutional capacity for defining these policies and revising them periodically.	1. All countries of the Region will have achieved a human resources density ratio level of 25 per 10,000. 2. The regional and subregional proportions of primary health care physicians will exceed 40% of the total medical workforce. 3. All countries will have developed primary health care teams with a broad range of competencies that will systematically include community health workers to improve access, reach out to vulnerable groups, and mobilize community networks. 4. The ratio of qualified nurses to physicians will reach at least 1:1 in all countries of the Region. 5. All countries of the Region will have established a unit of Human Resources for Health responsible for the development of human resources policies and plans, the definition of strategic directions, and the negotiation with other sectors, levels of government and stakeholders.
2. Place the right people at the right places by deploying the appropriate personnel into the fitting positions and into the right areas of the countries, so as to achieve an equitable distribution of quantity and skill set of health workers in the different regions so that they match the specific health needs of those populations.	6. The gap in the distribution of health personnel between urban and rural areas will have been reduced by half in 2015. 7. At least 70% of the primary health care workers will have demonstrable public health and intercultural competencies. 8. 70% of nurses, nursing auxiliaries and health technicians, including community health workers, will have upgraded their skills and competencies appropriate to the complexity of their functions. 9. 30% of health workers in primary health care settings will have been recruited from their own communities.
3. Regulate the migrations and displacements of health workers so as to ensure access to health care for all the population.	10. All countries of the Region will have adopted a global code of practice or developed ethical norms on the international recruitment of health care workers. 11. All countries of the Region will have a policy regarding self-sufficiency to meet its needs in Human Resources for Health. 12. All subregions will have developed mechanisms for the recognition of foreign-trained professionals.
4. Generate labour relationships between the workers and the health organizations that promote healthy work environments and foster commitment to the institutional mission to guarantee quality health services for all the population.	13. The proportion of precarious, unprotected employment for health service providers will have been reduced by half in all countries. 14. 80% of the countries of the Region will have in place a policy of health and safety for the health workers, including the support programs to reduce work-related diseases and injuries. 15. At least 60% of health services and program managers will fulfill specific requirements for public health and management competencies, including ethics. 16. 100% of the countries of the Region will have in place effective negotiation mechanisms and legislations to prevent, mitigate or resolve labour conflicts and ensure essential services if they happen.
5. Develop mechanisms of cooperation between training institutions (universities and schools) and the health services institutions so that it is possible to adapt the education of health workers to a universal and equitable model of providing quality care to meet the health needs of the entire population.	17. 80% of schools of clinical sciences will have reoriented their education towards primary health care and community health needs and adopted interprofessional training strategies. 18. 80% of schools in clinical health sciences will have adopted specific programs to recruit and train students from underserved populations with, when appropriate, a special emphasis on Indigenous, or First Nations, communities. 19. Attrition rates in schools of nursing and medicine will not exceed 20%. 20. 70% of schools of clinical health sciences and public health will be accredited by a recognized accreditation body.

Source: Pan American Health Organization.

have improved, but problems persist in critical topics such as epidemiological surveillance. PHC nurses have made progress in upgrading their skills, but less so the community health agents. Less than 10% of PHC personnel were recruited from their own communities.

Challenge three refers to the management of migration. Until recently, Peru had recorded among the highest losses of physicians due to emigration in Latin America. The country has made progress with the adoption of a Law on the Social and Economic Reinsertion for Returning Migrants, which provides a package of benefits for physicians returning to Peru or for foreign-trained Peruvians, such as those formed in Cuba. Peru is strengthening its planning capacity to determine current deficits and future workforce needs, prerequisites to a policy for self-sufficiency in health workforce management. Agreements have been signed with 24 countries on the recognition of foreign-trained professionals.

Challenge four relates to working conditions. Precarious work in health has been reduced from 50% of the workforce in 2009 to 4% in 2013, guaranteeing the right to social protection with an explicit package of entitlements. Similarly, substantive improvements have been achieved with respect to the health and safety of health workers, as a result of a Supreme Decree on Labor Health and Safety. The Ministry of Health, in accordance with the National Authority of Civil Service (SERVIR), has developed the competency profiles of managers of health services; hospital and health services networks directors have been trained all across the country. While legislation to prevent and mitigate labour conflict in the health sector was introduced, its impact was limited due to a lack of enforcement.

Under Challenge five, major universities in health sciences are progressively transforming their curriculum towards primary health care in line with health system needs. However, there is a paucity of programs aimed at recruiting and training

Countries that participated in the assessment of the 20 HRH regional goals 2009-2013

Figure 1. Countries that participated in the assessment of the twenty HRH regional goals 2009–2013

students from underserved communities, including Indigenous people. Notoriously high attrition rates in faculties of health sciences have been reduced during the period, and accreditation processes by independent entities were expanded and strengthened.

The results of the measurements of the twenty goals for each of the 15 countries are available on the [Regional Observatory of Human Resources website](#).

If we look at the aggregated results for the 15 countries, and further regroup them by challenge, we observe that progress has been made in each one of the five challenges (Figure 3). Challenges 1 and 4, long-term planning and working conditions, showed the highest level of achievement at the end of the period. The challenges related to the distribution, migration and education of health workers proved amenable to change, but despite progress achieved, remained those facing the most difficulties.

Results of the assessments of the 20 HRH regional goals by Peru

Figure 2. Results of the assessment of the twenty HRH regional goals by Peru. Source: Ministry of Health of Peru

At the individual goal level, the three goals aimed at improving the specific skills and competencies of the workforce (#7, #8, #15) made important progress, as well as those pursuing the development of a policy of self-sufficiency (#11) and the reduction of attrition rates in schools of health sciences (#19). Conversely, the goals concerned with the proportion of PHC physicians with regard to the medical workforce (#2), the

development of PHC teams (#3), and a policy of health and safety for health workers (#14), proved to be the more resilient to change.

DISCUSSION

The assessment of the twenty Regional Goals for HRH is in many ways illustrative both of the potential for capacity building of an

Figure 3. Changes in the level of achievement of the critical challenges for the 15 participating countries, 2009–2013

initiative driven by an intergovernmental organization, and of its inherent methodological limitations. Some of the experienced tensions or trade-off are briefly reviewed here.

The decision to join the initiative belongs to the individual Member States, implying an institutional commitment with its objectives. However, the decision of a given country might have been influenced by the priority given to HRH and an interest in demonstrating achievements. Other factors are also at play, most importantly subregional dynamics and the opportunity to obtain external technical support. The level of participation was high in countries where a subregional health entity was actively involved in the promotion and technical support of the initiative. This is the case for all countries of the subregion of Central America and the Dominican Republic, including Belize, and for the Andean countries with the exception of Venezuela. Most countries of the English-speaking Caribbean joined the initiative for the first assessment; their absence in the second assessment was partly attributable to insufficient internal and/or external technical and financial resources. In the South Cone, the Ministry of Health of Argentina, being a federal state, carried out the baseline assessment at the national level and opted thereafter to support the exercise at the provincial level. The reasons for individual countries not to participate were not documented; Canada and Brazil contributed actively to the initiative in participating countries but opted not to do their own assessment, possibly because many of the goals had already been achieved.

Similarly, the participating Ministries of Health controlled the process of the assessment and prepared the reports, which is important given the fact that the exercise was designed to improve their management of HRH. The inherent tensions have to be found (even taking into account the training, guidelines and expertise provided to foster the quality and consistency of the two measurements) in the inter-measurement and intercountry differences in the rigour of the process, from the selection of stakeholders, to the professional facilitation of the workshops and

the quality of reporting. Furthermore, the motivation, expertise and resources available at the country level to conduct the exercise varied considerably. Of particular relevance was the “coverage” of HRH information systems or health professional directories. Some countries, such as Chile, provided information on the total workforce for specific goals, but in many cases the information available was limited to the public sector and possibly social security institutes.

In an effort to validate and explain the progress made between the first and second assessments, an additional component was added to the initiative, which identified and evaluated priority health workforce programs that were designed and implemented by each country to impact on one or more of the twenty goals. The evaluation of program implementation in the 15 countries evidenced common problems, such as lack of political will, financial unsustainability, poor supporting data, and issues with continuity of the program.¹⁴ These findings raise important questions on the results of the assessment of the twenty goals and their relationship to intended action. Strengthening capacities in program design, support, implementation and evaluation appears a promising strategy for the coming years.

Assessing twenty goals for HRH was an ambitious undertaking for participating countries. The initiative was designed to promote a comprehensive approach to HRH policies, overcoming the historical fragmentation of the field along institutional frontiers between jurisdictions, sectors, organizations and social actors. However, given the restrictions of resources and time, the assessment of so many goals limited the rigour and depth of analysis. The prescriptive nature of the twenty goals was also questioned in terms of their relevance to specific contexts; a given goal considered too low and therefore not challenging enough for one country, might be deemed unachievable for another.

Citizens and communities were not involved in the assessment of the twenty Regional Goals, an important limitation of the initiative. Even though such an involvement would involve

significant challenges, it represents an essential dimension of HRH governance, beyond the bureaucratic and expert levels. Community participation would contribute greatly to the assessment of the goals from the perspective of the intended beneficiaries.

Overall, the initiative contributed to identifying policy gaps and promoting intersectoral action; it raised the profile and importance of health workforce planning, helped mobilize political and fiscal support for workforce program development and implementation, stressed the need for quality HRH data and comprehensive information systems, reinforced a culture of monitoring and evaluation, and evidenced the merit of collaboration between external experts and policy-makers. At the subregional levels, it highlighted the need for better and standardized health workforce metrics to guide and monitor progress, and for the harmonization of terminology and occupational categories across countries.

Perspectives

The importance of HRH is expected to increase in the future in response to a growing demand for social and health care worldwide. Labour mobility is on the rise, both within and across countries. The majority of new employment opportunities in health will be created in high-income and upper middle-income countries, thus aggravating existing deficits in low-income countries.¹⁵ The international community is responding at unprecedented levels to the challenge. The General Assembly of the United Nations adopted in September 2015 a new generation of 17 Sustainable Development Goals 2030, with Goal 3 dedicated to health and well-being, and implementation target 3.c referring specifically to the health workforce.¹⁶ For its part, the World Health Assembly adopted in May 2016, and for the first time, a Global Strategy on Human Resources for Health: Workforce 2030.¹⁷

The countries of the Region of the Americas were innovative in 2007 when they committed themselves to work together in achieving twenty HRH Regional Goals aimed at universal access. This momentum should not be lost as new challenges emerge. The experience of the past decade points in clear directions. In view of the fragmentation of health systems in most countries and the plurality of actors in HRH, new collaborative, intersectoral and intragovernmental HRH governance models should be developed and strengthened at national and regional levels, supported by dynamic accountability frameworks and strong monitoring and evaluation mechanisms; a health labour market framework would provide indispensable insights for integrated policy development. The adoption of a *change management* approach may serve to further strengthen the Region's capacity for health workforce planning. By recognizing the full range of partners involved in developing, implementing, managing and evaluating health workforce policies and programs, and through clearly identifying their respective roles and responsibilities, stronger collaborative leadership is provided, communication is enhanced at all levels, and greater accountabilities are achieved. The new post-2015 HRH regional agenda should be designed to support integrated, people-centered health services models, with a limited number of objectives relevant to all countries, and flexible in a way that allows countries to define their own related targets.

PAHO should lead the development of a new HRH agenda, tailored to the characteristics of the Region, and strengthen its own

capacities for technical cooperation, monitoring and evaluation. Canada might benefit from continuing to actively support ongoing initiatives with respect to evaluating models and scope of intersectoral partnerships and planning. Ultimately, a competent, well-supported and motivated workforce is essential if universal health access and coverage are to be achieved.

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RÉSUMÉ

LIEU : Depuis 2003, la plupart des pays de la Région des Amériques connaissent une croissance économique soutenue et ont adopté des politiques de développement axées sur l'inclusion. Dans le secteur de la

santé, l'accès universel est devenu l'objectif primordial. Les contraintes structurelles des personnels de santé ont cependant représenté un obstacle formidable au changement. Les autorités sanitaires nationales ont été confrontées à la difficulté de renforcer les capacités critiques pour redresser les inégalités enracinées face à l'accès aux personnels de santé qualifiés.

INTERVENTION : Sous les auspices de l'Organisation panaméricaine de la Santé, les ministres de la Santé de la région ont adopté, en septembre 2007, vingt objectifs régionaux liés aux Ressources humaines pour la santé 2007–2015, qui correspondent à la stratégie des Soins de santé primaires renouvelée. Par la suite, on a élaboré un jeu d'indicateurs et une méthode pour évaluer les objectifs et surveiller les progrès accomplis dans chaque pays.

RÉSULTATS : Quinze pays ont mené une évaluation préliminaire en 2009 ou 2010 et une seconde évaluation en 2013. Malgré les différences constatées entre les objectifs et d'un pays à l'autre, les résultats suggèrent une amélioration pour l'ensemble des vingt objectifs. Ceux qui étaient liés à

la répartition des personnels, à la gestion des migrations et à la coopération avec les établissements d'enseignement se sont avérés plus réfractaires au changement.

IMPLICATIONS : Les vingt objectifs régionaux liés aux Ressources humaines pour la santé ont offert une vision commune des mesures à prendre et un cadre de coopération à l'intérieur des pays et entre eux; ils ont de ce fait été des catalyseurs de changement. Confrontés à des défis mouvants, les pays devraient considérer l'adoption d'un nouveau plan d'action commun qui s'appuie sur les progrès accomplis et qui promeut l'harmonisation des politiques intergouvernementales et le renforcement des capacités de développement, de gouvernance et de gestion des personnels de santé.

MOTS CLÉS : Ressources humaines pour la santé; renforcement des capacités; Amérique latine; politique sanitaire; gouvernance; évaluation et surveillance