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Developing a new Human Resources for Health Agenda

Health Teams Addressing New and Renewed Challenges

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I. Background

In October 2005, the Seventh Regional Meeting of the Observatories of Human Resources for Health was held in Toronto, Canada. The meeting issued a “Call to Action”¹ to mobilize national and international stakeholders in the health sector and in other relevant sectors, including civil society, to collectively construct policies and interventions for the development of human resources for health (HRH) in the framework of the Millennium Development Goals. The participants also conceived the Toronto Call to Action as a tool to promote joint efforts for a Decade of Human Resources in Health for the Americas (2006-2015). With this purpose in mind, five critical challenges were defined for developing human resources for health (HRH) in the region.

Subsequently, the 27th Pan American Sanitary Conference, held in October 2007, set 20 regional goals for HRH. The goals cover the 2007-2015 period, and are organized according to the five critical challenges defined in the Toronto Call to Action². On this basis, each country could create a roadmap to define its priority areas for development, with strategic plans and actions to monitor progress.

In order to identify the situation in each country, a methodology was implemented for measuring progress toward pre-established goals. This made it possible to obtain valuable information on progress in the region’s various countries, and to establish a baseline. The first measurement was made in 24 countries between 2009 and 2012.³

Between April and November of 2013, 15 countries in the Region of the Americas conducted a second measurement to evaluate progress, deadlocks, and challenges, in relation to the baseline. Along with the second measurement, a process was put in motion to evaluate HRH programs. Here the purpose was to create an inventory of interventions and to exchange and disseminate experiences. Fifteen countries carried out the evaluation.

The Toronto Call to Action and the 20 Regional HRH Goals agreed upon at the 27th Pan American Sanitary Conference have served as a guiding framework for defining the HRH work agendas of health systems in the region, based on the principles of the renewed primary health care (PHC) and the achievement of universal health coverage. The Call to Action and the Regional Goals have made it possible to create a shared platform for work, and have created incentives for collaborative actions among the region’s countries.

The process of measuring progress toward the regional goals was a concrete activity aimed at mobilizing the commitments that had been made, making it possible to articulate efforts with intra-sectoral actors and bring in external stakeholders, particularly in the area of training. It also helped to generate, systematize, and disseminate information, knowledge, and experiences. In addition, it encouraged the development of a culture of accountability in government policies, by incorporating a concrete proposal for evaluation, and a method designed specifically to monitor the evolution of HRH policy.

Use of PAHO’s methodological proposal, with a standardized Handbook on Measurement and Monitoring of Regional Goals, served to gain important information that allowed each country to assess its own performance and progress. The need to be flexible in applying the measurement process, and the attendant adjustments made by the country teams, provided a source of additional learning.

¹ PAHO/WHO. Toronto Call to Action: 2006-2015. Towards a Decade of Human Resources in Health for the Americas. Regional Meeting of the Observatory of Human Resources in Health, 4-7 October 2005.

² PAHO/WHO. Regional goals for Human Resources for Health 2007-2015, in: 27th Pan American Sanitary Conference; 59th session of the Regional Committee (CSP27/10). Washington, DC. 2007.

³ For information on the country measurements [in Spanish only], see: www.observatoriorh.org.

Measuring progress toward the goals is the culmination of extensive work that will give the region's countries greater knowledge on issues requiring attention in the coming decade. It also opens up a new space for negotiation, with technical cooperation from PAHO and WHO, to drive and support work on the important issues in HRH.

II. Looking to the future

The decade of human resources work that participants at the Toronto meeting called for is in its final stage, and coincides with the challenge of moving decisively toward universal health coverage. This juncture places new demands on health systems; the availability of trained human resources, appropriately distributed and committed to health objectives, is key to achieving this objective.

These needs were discussed at PAHO's 52nd Directing Council. They were promoted through the Resolution, "Human Resources for Health: Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems,"⁴ and were addressed at PAHO's 53rd Directing Council, through approval of the "Strategy for Universal Access to Health and Universal Health Coverage,"⁵ as well as at the Third Global Forum on Human Resources for Health, hosted jointly in Recife (Brazil) by the Government of Brazil, WHO, PAHO, and the Global Health Workforce Alliance.⁶

The 52nd Directing Council Resolution reiterates the need for national plans and policies on human resources to increase access to health workers, with special emphasis on underserved areas, by strengthening national HRH planning units and enhancing their links with the training sector, professional associations, and the community, as well as with other relevant stakeholders. The Resolution also recognizes the importance of multidisciplinary collaborative care teams as the basis for a PHC-oriented system, and urges countries to institute systems of incentives to attract, develop, and retain health workers. Finally, it stresses the need to promote the social mission of health-related institutions, the training of HRH, and the strengthening of training in family health.

The 53rd Directing Council Resolution proposes four strategic lines of action by which the Member States can strengthen their health systems, with a view to achieving universal health access and universal health coverage. These strategic lines of action are designed to: increase equitable access to comprehensive, quality health services centered on people and communities; strengthen leadership and governance; increase and improve equitable and efficient funding, moving toward the elimination of direct payment systems; and reinforce intersectoral coordination to address the social determinants of health. The Resolution urges Member States to: improve the capacities of human resources at the primary care level by increasing employment opportunities, and providing incentives and attractive working conditions, especially in underserved areas; consolidate multidisciplinary collaborative health teams; ensure the teams' access to health information and telehealth services (including telemedicine); and introduce new professional and technical profiles, while strengthening existing ones, based on the care model to be implemented, with the aim of achieving universal access to health and universal health coverage.

The policy declaration of the Recife meeting on HRH was, above all, a commitment to universal health coverage, in light of the fact that enjoyment of the best possible health is one of the fundamental rights of all human

⁴ PAHO/WHO. Human Resources for Health. Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems. 52nd Directing Council, 65th session of the Regional Committee. Resolution CD52.R13.

⁵ PAHO/WHO. Strategy for Universal Access to Health and Universal Health Coverage. 53rd Directing Council, 66th session of the Regional Committee. Resolution CD53/5. 2014.

⁶ WHO. Recife Political Declaration on Human Resources for Health: Renewed commitments towards universal health coverage. Third Global Forum on Human Resources for Health. Recife, November 2013.

beings, without distinction of race, religion, political ideology, or social or economic condition, and the fact that that poor health is one of the principal causes of vulnerability and poverty, while, conversely, poverty, inequality, and social exclusion contribute to health problems. The Recife Call to Action seeks to encourage the collaboration needed, at all levels, to achieve the common objective, namely, that “all people, wherever they live, should have access to qualified, motivated, and properly supported health workers, in the framework of a sound health care system,” for which purpose a number of measures have been proposed. The Recife declaration calls on the Director of WHO to develop a global HRH strategy, so that the organization’s Member States can examine it at the 69th World Health Assembly in May 2016.

The debate initiated by WHO regarding the establishment of a Global HRH Strategy⁷ points to the need for guidelines that effectively improve the capacity of health workers to meet health priorities in the new, post-2015 development framework. In this context, human resources are not conceived as the problem, but rather as a fundamental part of the solution for achieving universal health coverage.

Experience in formulating, advocating for, measuring, and analyzing regional HRH goals, along with the guidelines established at the 52nd and 53rd Directing Councils and at the Recife meeting, combined with recent debates on the global strategy put in place by WHO, have created a favorable environment for beginning a participatory process to identify the priority issues that must be addressed in defining a post-2015 HRH development agenda.

Based on the outcome of the Decade of Human Resources for Health 2005-2015, work has aimed at identifying the main problems that remain despite the efforts made, as well as at addressing the emerging HRH challenges in light of increasing citizen demand and active commitment by the States to move toward universal health coverage.

Among the experts who participated in the last round of discussions, there is agreement that a new agenda must be built, in part, on the basis of the experience gathered during the ten-year period now ending, and in part on the basis of emerging challenges, in a context in which the goal of universal health coverage and movement toward citizens’ right to health care figure prominently. Making these two perspectives compatible will require consideration of how to preserve accumulated experience, recognition of the continuing importance of the Toronto challenges, formulation of specific development strategies to address unsolved problems, and acknowledgement of the importance of identifying new challenges in a timely fashion.

Since early 2014, PAHO has outlined a program for working with groups of national and international experts to analyze progress and findings from the recent ten-year period by creating a Regional Advisory Group on Human Resources for Health. The group’s first meeting was held in Santiago, Chile in May 2014⁸, and was devoted to discussing the results of a decade of work on the Toronto challenges and the Regional Goals for Human Resources for Health, existing and emerging problems, and the matter of defining the next agenda. The first draft that emerged from this meeting has been discussed and enriched at subregional forums in Central and South America and at a second meeting in Buenos Aires. The main contents of these discussions formed the basis for a consultation among Latin American countries⁹ that involved over 150 key stakeholders from a range of sectors related to the field of HRH. The main objective was to initiate a participatory process of identifying priority issues; the principal findings and conclusions are incorporated in the present discussion document. A separate consultation for the English-speaking Caribbean countries is pending.

⁷ WHO. A Global Strategy on Human Resources for Health: Health workers from here to 2030. Draft document for consultation, June 2015.

⁸ PAHO/WHO. Relato de la reunión del Grupo asesor Regional: Elementos para una nueva Agenda de RHS: Insumos de la Reunión del Grupo Asesor Regional de Recursos Humanos para la Salud, Santiago de Chile, April 2014.

⁹ Abramzón M. et al. Consulta Regional Agenda de Recursos Humanos en salud post 2015, June 2015. Document produced by PAHO.

The present working document covers the main conclusions arising from this process, and includes a preliminary identification of priority issues for consideration in formulating the new HRH agenda. Its purpose is to contribute to the discussion and to foster agreement with the region's human resources officials regarding strategic approaches and important issues for a regional agenda, taking into account the various global resolutions on health, the Recife Declaration, and the WHO draft proposal for a global HRH strategy.

III. Preliminary proposal on strategic approaches and priority issues for the new agenda

The various consultations and debates that have occurred in the course of one year demonstrate the continued timeliness and value of the Toronto challenges and of many of the Regional Goals currently in place in the region's countries. The results of the last two measurements and of the above-mentioned debates point to there being progress, to greater or lesser degrees, in addressing pending challenges, though much greater progress is needed in some areas. Of special note are the adjustments and commitments in human resources required to address the challenges of universal health coverage.

As has been shown by work carried out during this debate process, advances on various aspects of human resources are needed if health systems are to enjoy greater equity and increase the availability, distribution, and skills of their workers. The set of issues that has been posed has given rise to three broad strategic approaches, encompassing the issues widely recognized as priorities by the various participating stakeholders. These fall into the categories set forth below, and are summarized in a table at the end of the document.

1. Strengthening the capacity for leadership and governance in national HRH authorities

There is consensus among stakeholders participating in the first round of consultations that the leadership and governance capacity of national HRH authorities is a key factor in defining HRH policies and plans. These attributes also have a cross-cutting dimension that runs through all of the strategic approaches, since they involve an articulating, directing, and leadership role for health authorities, i.e., a leadership role by the State in regard to health. The function of leadership and governance is to be understood within an intersectoral dynamic and linkage of public policies, since the field of human resources is composed of a variety of institutions with differentiated functions in various sectors.

A national HRH policy, as part of a national health policy that sets health objectives based on a particular care model, makes it possible to define the type, quantity, composition, and distribution of human resources needed. At the same time, it orients strategies for training, recruitment, skills development, incentive mechanisms, and relationships among the different stakeholders, needed to attain the objective.

In this context, HRH planning requires the formulation of appropriate management plans and strategies, in order to ensure sufficient personnel to meet the population's current and future health care needs. This requires proper leadership and adequate technical capacity, along with a strategy and planning unit with the necessary skills and ability to manage the information needed for decision making. This is only possible with the political will of the authorities and the necessary financial support.

The semi-structured surveys featured in the consultative process, conducted with Latin American stakeholders in the field of human resources, show that "it is necessary to reactivate the leadership role of the State in the field of human resources."

Of those surveyed, 65% recognize the existence, in their country, of a national entity for the coordination of HRH information with regard to the training, work, and number of personnel. This point is of particular interest in formulating policies and interventions, since it is a good indicator of the levels of visibility that these coordinating bodies have, in each country, for the various stakeholders.

However, 44% of those surveyed stated that the initiatives undertaken in their countries during the last ten years did not constitute progress in strengthening a planning system, because of the absence of a comprehensive model that would allow for long-range planning, and a directionality and orientation for adopting the appropriate operational and policy measures. This shortcoming, exemplified by the absence of a national coordinating body, and by contingency-based decision making dependent on current circumstances, is seen by those surveyed as undermining efforts to identify, determine the scope of, and address the population's needs. In addition, respondents stated *that budget deficits make interventions difficult, and that HRH planning is not a national priority*. Moreover, the lack of resources cited by those surveyed is associated with a lack of political will and decision making needed to make HRH a priority issue and strategic area within the health arena.

With regard to leadership and governance issues within the health authorities, some respondents agree that a primary care-based model should determine the definition, implementation, and evaluation of HRH policies, and should be the paradigm for effective health practices.

The following priority issues emerge as challenges in the context of this strategic approach:

1.1 HRH information systems

Reliable data on health personnel and the distribution of workers are vital in formulating and monitoring policies and programs to reduce inequalities of access to trained health personnel. Many of the region's countries reveal a fragmentation of information, a scattering of data-gathering responsibilities among different public entities, insufficient human resources to manage the information, and a lack of technological infrastructure.

These realities limit the capacity to obtain and analyze data. Moreover, where sufficient data are available, their application to public policy formation is limited, because of the absence of appropriate indicators, and due to a lack of definition regarding the classification of occupations. Addressing and solving these informational weaknesses is essential if better mechanisms for planning are to be established and HRH decision making improved.

Although some views expressed during the consultation highlight weaknesses in the process of developing information essential to health planning, a number of those surveyed felt that their countries have advanced in this respect. Thus, certain local HRH policies and interventions have been aimed at strengthening information systems and at improving the quantity, relevance, and reliability of available data. This progress is seen as strategically important for ongoing and effective improvement in HRH decision making, evaluation, and planning.

Nearly 70% of those surveyed during the consultation believe that the human resources at the institutions where they work possess the training needed to manage and process HRH information. Over half of the responses indicate that the necessary technological equipment is in place. Thus, these two types of resources do not appear to be a limiting factor in processing HRH information. At the same time, 56% of respondents

believe that advances have been made in strengthening planning systems during the last ten years, a figure that rises to 67% among respondents who work at training institutions. This may reflect the fact that actions taken in this area have gained greater visibility. Among those who state that there has been progress, 76% believe that it was due to the participation of a variety of stakeholders and, to a lesser extent, to the development of information systems and the increased availability of trained personnel.

Recognizing the advances made during the ten-year period, and the information systems present in some countries, supported by the Human Resources Observatories, suggestions with respect to specific areas include the following points:

- Harmonization of nomenclature and methods for registering health professions and occupations, based on the experience of international organizations such as ILO, WHO, OECD, MERCOSUR, etc., along with the establishment of regional agreements.
- Development of strategies to strengthen capacities for designing and implementing information systems and registries of health professionals, as part of South-South cooperation.

1.2 Methodologies for estimating personnel gaps

The countries of the region have made efforts to estimate, with varying degrees of precision, the gaps in health personnel. Despite advances in this area, the countries frequently request technical and methodological support for objectively determining personnel needs, in order to more accurately estimate existing gaps.

Most available practical experience gives priority importance to determining the needs of specific groups of health professionals, particularly physicians and nurses. This view needs to be broadened to produce methodological designs for estimating existing gaps, taking into account the multidisciplinary nature of health teams at the different care levels that make up the integrated network of health services, as conceived in care models based on the renewed PHC.¹⁰

Although those surveyed regard the actions carried out and planned at the local level as “incipient” in terms of actual results, a number of those commenting on the issue stated that one feature of these actions makes them strategically significant: they reveal, and make it possible to qualitatively and quantitatively assess, the personnel gaps and health needs of the population most in need of attention in HRH planning. In other words, the policies and interventions of the countries are not only recognized as “indispensable” for optimizing and adapting the training, distribution, and number of health personnel based on the population’s health needs and demands, but are also seen as a “means” (technically, operationally, and in terms of policy) of detecting gaps, deficits, and needs to guide future interventions.

If HRH are essential for the proper functioning of health systems, and are critical in addressing the challenge of universal health coverage, it follows that it is also important to have tools to estimate and validate gaps in health personnel, tools that are flexible enough to be adapted to different local realities. This is an important regional challenge, and is an area of development that should be incorporated in the new HRH agenda for the next ten years.

¹⁰ PAHO/WHO. Renewing Primary Health Care in the Americas. Position paper of the Pan American Health Organization/World Health Organization. Washington, D.C.: PAHO, 2007

Progress on this challenge would help improve HRH planning, and would facilitate a better match between human resources trained by universities and those that the health sector needs to function properly, thus enhancing the link between these two sectors.

Suggestions for addressing these issues include the following points:

- Identification and sharing of practical experiences with designing and implementing methodologies for estimating HRH gaps.
- Definition of essential variables to consider in designing gap-estimation models, which countries should develop based on their particular realities (e.g., disease burden, productivity levels, care models, composition of the health care network and its level of integration, availability of technology, etc.).
- Development of strategies to strengthen the capacities of HRH management teams in using methodologies to estimate HRH gaps.

1.3 Strengthening HRH planning systems

As indicated above, HRH planning requires the formulation of appropriate management plans and strategies, in order to ensure that sufficient personnel are available to meet the population's current and future health care needs. In the framework of universal health coverage as an objective, and a health system based on primary care, planning processes appear limited and sporadic, and are complicated by the conflicting interests of the health and education sectors.

Responses to the survey conducted during the consultation point to the lack of a “comprehensive model” as a significant shortcoming, which hinders long-range planning. Those surveyed referred to a lack of leadership and guidance for indicating the path forward, in both operational and policy terms. This deficiency, seen in the absence of a national coordinating body, as well as in contingency-based decision making dependent on current circumstances, is seen as undermining efforts to identify, determine the scope of, and address the population's needs. Respondents also stated that budget deficits make interventions difficult, that HRH planning in their countries is not given high priority, and that there is a lack of coordination among the various stakeholders.

Appropriate human resources planning requires leadership, articulation, and adequate technical capacity to address the challenges posed by the care model and by the diversity of stakeholders. This in turn requires a strategic planning unit with the capacity for articulation, and with varied and integrated technical capacities, along with the ability to drive progress toward a comprehensive model conducive to long-range planning.

Suggestions for addressing these issues include the following points:

- Strengthening of HRH planning capacities in the management teams of health ministries and in other bodies, through training and sharing of experiences.
- Development of comprehensive planning models that link the various stakeholders and that take into account the different professions, with special attention given to the combination of abilities and to geographical balance.

1.4 Strengthening governance and leadership capacities

Developing human resources requires specialized knowledge of planning, training, and management, as well as the ability to integrate these elements in long-term policies.

Proper HRH governance and leadership depends, among other things, on developing a “mentality” that allows for optimal management of information and that enhances the knowledge required for decision making. This involves promoting research, information analysis, and evidence-based practices as a basis for HRH decisions and investments.

In this connection, the opinions of those surveyed varied with regard to planning. There was a general belief that a lack of political decisiveness hobbled decision making and interventions, while opinions differed as to whether a lack of information hindered decisions on the supply and distribution of HRH.

Respondents also believe that in some contexts, given the characteristics of the countries’ health systems, State participation is needed not only for guiding the entire process, but also for establishing timeframes for hiring health personnel, even in fragmented health systems.

Suggestions for addressing these issues include the following points:

- Development of the capacities of HRH management teams to analyze available information.
- Conducting of research and generation of new knowledge on HRH to guide policy and technical action.

2. Improving the availability and distribution of qualified, relevant personnel

One important conclusion drawn from measuring progress toward the pre-established goals is that although the participating countries show advances in the overall availability of basic personnel, and while the number of countries with critical deficits has decreased, problems remain with regard to the distribution of human resources. This particularly affects rural and less accessible areas. The inequity in distribution is a crucial obstacle in working to achieve the objective of universal coverage and access. Addressing this problem requires developing strategies to ensure adequate numbers of health workers in underserved areas, as well as implementing effective systems of incentives to build a loyal cadre of health workers.

All of the analyses and discussions on HRH point to the problem of numbers and distribution of personnel, particularly physicians and nurses. This was corroborated in the quantitative stage of the survey: the findings showed that the majority of those questioned stated that their countries had an insufficient number of physicians (68%) and nurses (77%). Thus, the lack of nurses is greater than the lack of doctors. The qualitative questions re-examined this dimension of the analysis, exploring how informants regarded the problem of the quantity and distribution of professionals in rural and vulnerable areas, and at the primary care level.

According to some of the stakeholders consulted, the issue of distribution reflects a tension between the centers and the periphery. The centers offer greater opportunities for training, income, and consumption, while the peripheries are seen as inhospitable, insufficiently contained environments that lack a State presence. In this regard, one of the alternatives suggested by some informants for achieving better distribution is to decentralize training and create educational institutions in underserved areas.

There is broad agreement that the labor market is one of the fundamental aspects to consider in analyzing the supply and distribution of human resources, since pay and working conditions largely determine the availability of personnel, especially at the primary care level. In the view of some respondents, unfavorable working conditions, which discourage training in certain specialties, are also associated with the lack of a health career path that is governed by appropriate legislation and precise rules.

Improvements also need to be made in the scope of practice of all health team members, by facilitating collaborative work and greater flexibility to encourage innovation and enhance efforts to adapt to local needs and circumstances. The development of multidisciplinary health teams is indispensable in improving the population's access to health professionals.

In regard to the challenges entailed in this strategic approach, the following priority themes emerge:

2.1 Incentive mechanisms to cover underserved areas

One of the greatest challenges that has emerged during the recent ten-year period is that of achieving adequate and ongoing availability of trained HRH in traditionally underserved areas, where the situation is hindered by conditions of isolation, or by geographic, economic, social, or cultural marginality. This challenge is one of the major issues for HRH administrators, particularly in the public sector, which acts as the sole health care provider in most of these localities.

The need to consider underserved areas emerged during the consultation as a major concern. In the view of those surveyed, the distribution of HRH is dependent on a broad range of working conditions. While economic incentives for professional development in remote or vulnerable areas is needed, institutional support also needs to be provided, in the form of both infrastructure and equipment, and with regard to personal support, since people who decide to work in these areas will face major changes in their social environment.

With regard to the geographical distribution of physicians, 92% of those surveyed believe that it is poor or fair, while 84% believe that the distribution of nurses is poor or fair. Fifty-three percent of respondents indicate that there have been initiatives in their countries to place and/or retain doctors in underserved areas, though the corresponding figure for nurses is only 30%. The recognition that these initiatives exist is significantly higher among informants from health ministries; this could indicate that such actions are of limited visibility for other stakeholders.

Among those who recognize the existence of initiatives to retain doctors and nurses in underserved areas, most believe that such actions entail pay differentials. In the case of nursing, greater professional and work opportunities also play a role.

It will be important to identify what strategies are successful in addressing this challenge in the various contexts. This requires studies that explore, in depth, the specific interests of each group of professionals, looking at different variables, in order to design multiple differentiated strategies to attract, develop, and retain personnel employing a variety of incentives.

Suggestions for addressing these issues include the following points:

- Development of systems of incentives to attract personnel to underserved areas.
- Conducting of studies to increase knowledge about the interests, motivations, and working conditions required by health professionals to work in underserved areas.
- Identification and sharing of practical experiences with systems of incentives to attract and retain HRH in

underserved areas.

2.2 Development of multidisciplinary primary health care teams

The points discussed above concern the availability and distribution of health workers, and have traditionally been seen as central aspects of HRH management, involving both planning and strategies to attract and retain workers. They therefore occupy privileged places on the agendas of most countries in the region. Both of these issues have been oriented primarily to the professions, particularly physicians. In the framework of strategies for renewing PHC, and given the types and complexity of today's health problems, multidisciplinary care teams whose combined skills provide a comprehensive way of addressing health problems need to be established. This means adjusting HRH development policies and strategies to new criteria aimed at integrating the various disciplines.

Sixty-nine percent of respondents stated that health care in their countries is organized around multidisciplinary teams. In responses from those working at health ministries, this figure was 80%. However, in only four countries is there unanimity of opinion on this issue. At the same time, 44% of respondents stated that there are no regulations on professional practice in their countries governing the establishment of multidisciplinary health care teams, while the figure among members of professional associations and institutions was 74%.

The model for organizing work is a particular challenge, and provides a useful strategy for determining the potentials of each professional, working in an articulated manner, and for establishing how his or her individual skills, applied in various contexts, could help expand the coverage and quality of care provided by health systems. This involves knowing and documenting work experiences that demonstrate complementarity between nurses, midwives, or other professionals, and physicians, or between physicians who are generalists and those who are specialists. Strategies are needed to optimally deploy their respective skills, with suitable arrangements for coordination and supervision.

Suggestions for addressing these issues include the following points:

- Reviewing of professional practice regulations from the perspective of providing up-to-date legal frameworks that reflect new models for organizing work.
- Improvements in HRH management schemes to meet the requirements of organizing work based on multidisciplinary health teams.
- Development of telemedicine and learning networks.

3. Reorienting the education of HRH professionals toward PHC

There is increasing consensus on the importance of ensuring that the supply and skills of health workers are consistent with the population's current and future needs. This means having qualified, effective health personnel who are capable of responding to defined health needs.

The development of HRH in the region is not yet in harmony with the needs of a PHC-based health system. The challenge of universal health care has not yet permeated academic training institutions, nor has it led to significant curricular changes at these institutions. Thus, a profound paradigm shift is needed in health sciences education. This, in turn, requires strengthening State leadership and bolstering its role in regulating training, and promoting articulation and ongoing dialogue between national health authorities and academic training institutions.

The role of the State, and its regulatory role in regard to training, is an issue that figures repeatedly in the opinions of those surveyed. In many cases, respondents indicate that such a role is practically “nonexistent,” a circumstance almost always related to weakened public capacity to orient educational offerings and deal with market pressures. A number of respondents feel that the State “surrendered” its leadership role, or that it has lost control over training. Such comments could be construed to mean that the State must, or should, at some point assume that responsibility. There is a belief that market logic will dictate that universities operate either as a kind of “shopping center” or in a way that only serves academic or professional interests. It is the State that must be the arbiter of the interaction, so that training institutions take account of social needs, and so that professional profiles, the type of specialties developed in the country, the characteristics of residency offerings, and the number of specialized areas of study created are not determined by the profit motives of the educational marketplace.

Universities need to work to define a new social mission for all of their health sciences schools, with a serious commitment to instill a comprehensive vision in training health professionals, involving a commitment to the health of the neediest, and a strong emphasis on primary health care services and underserved areas.

The following priority issues emerge in the context of this strategic approach:

3.1 Reorientation of undergraduate training programs

Ensuring the presence of high-quality trained professionals who are committed to health objectives continues to be one of the main strategies for ensuring that the population’s health needs are met. Training needs to be based on competencies; on establishing programs and processes for interdisciplinary learning; on designing flexible and modular curricula and innovative teaching; and on strengthening teaching capacities through the adoption of new teaching models. One problem that has been cited is that training programs are concentrated in hospitals. Settings where learning takes place must be diversified, and training must be extended to all levels of the care network, with particular emphasis on the methods for learning used, from the start of health sciences studies, in primary care medicine, within communities, and in rural areas.

Respondents in the consultation cite the need to deepen the relationship between training and PHC, with the aim of defining the professional profiles that each country needs and determining the skills required. A number of informants point to the lack of specialties related to family and community medicine. In this regard, one of the principal failures of training mentioned by informants from universities is the poor linkage with health services. The need to move toward a comprehensive approach is highlighted by some stakeholders, who cite a lack of articulation between training institutions and employers, calling for arrangements involving joint intersectoral efforts to adjust training models to epidemiological profiles.

The State needs to incorporate legal frameworks and take a leadership role regarding the type of training needed, the broad content of curricula, and accountability mechanisms for schools, students, and graduates, to encourage professional values and principles in training that instill greater commitment to communities. In short, there is agreement on the need for health sciences schools, and medical schools in particular, to adopt a newly defined *social mission and responsibility*.^{11 12 13}

Suggestions for addressing these issues include the following points:

¹¹ Beyond Flexner: Social Mission of Medical Education. Conferencia de Oklahoma, 2012 y New Mexico 2014.

¹² PAHO. Educación médica hacia la APS renovada y libros de texto. Informe reunión de escuelas. Buenos Aires, Argentina. 3-5 December 2012.

¹³ PAHO. Relato de la reunión sobre la Misión Social de las Escuelas de Medicina para alcanzar la equidad en salud realizada en Manaus en 2014.

- Training focused on primary health care (PHC) and on strengthening social mission and responsibility.
- Integrated curricula, with early insertion of students in the primary health care network.
- Development of the problem-solving capacity of generalist physicians.
- Interdisciplinary training of the care team.

3.2 Strengthening systems of planning for graduate and post-graduate studies

The countries have expressed a number of concerns about their systems for training specialists, particularly with regard to residencies in medical specialties.¹⁴ The problems cited include: imbalances in the availability of specialists between different regions; lack of certain basic specialties, particularly family medicine; the need for new specialists in the wake of social, demographic, and epidemiological transition; the difficulty of finding specialists to employ in various fields of knowledge; and the absence of policies and plans regarding the numbers and types of specialists needed by each country's health system.

The supply of HRH results from the intersection of two processes: training and employment. The absence of a sufficient dialogue between the institutions that train and the institutions that employ is seen as a fragmentation, which can lead to gaps in some specialties, migration of human resources, failure to adequately serve certain areas, and professional profiles that are not aligned with social needs. There is criticism of the lack of specific regulations to develop curricula at the undergraduate and graduate levels, where curricula often are not oriented to the care model; training of professionals often leaves graduates unable to address the priority health problems of the society, with specialties for which there is insufficient demand in the labor market.

The inadequate distribution of specialist training programs and positions within health systems, the poor quality of training, and the concentration of these processes exclusively in hospitals are among the issues of concern to the region's countries.

Systems that are attempting to move toward universal care also need to analyze and encourage the training, employment, and functions of generalists within the health systems of each country. There also needs to be increased opportunities for training and employment in specialties such as family medicine.

Suggestions for addressing these issues include the following points:

- Planning of graduate training (residencies) on the basis of identified gaps.
- Increased training in family medicine.
- Strengthening of capacities for training specialists.

3.3. Strengthening mechanisms to regulate HRH training

Educational quality is achieved through a permanently established process, one that combines strategies and seeks consensus regarding the profiles and educational mechanisms necessary to improve training. Some of the region's countries have begun procedures for accreditation and professional certification, particularly in medicine, while others have incipient processes in place for the other health sciences professions. The instruments for evaluation and accreditation do not yet include adequate indicators for measuring the social commitment of schools and the incorporation of principles and content oriented to primary health care.

¹⁴ PAHO. Medical Residencies in Latin America. Series: Renewing Primary Health Care in the Americas. Vol. No 5. 2011.

The region's countries have a large number of health sciences training programs and schools. The deregulation of education several decades ago has spawned a disorderly process for establishing the profiles of the professionals needed. Many of the programs within countries are not harmonized, while subregional policies, where they exist, are poorly harmonized between countries. Thus, new methodologies need to be established to harmonize programs and degrees within and between countries.

Suggestions for addressing these issues include the following points:

- Accreditation of training programs, with an orientation toward PHC.
- Harmonization of degrees.

As the above discussion indicates, progress on each of the issues involved in the three strategic approaches requires the State to take a strong leadership role and to articulate the different sectors, both within and outside government. To the extent that the field of human resources intersects with various sectors whose institutions and actors have differing areas of action, leadership and governance requires an intersectoral approach to public policy. As a result, institutional mechanisms must be developed and strengthened to coordinate with key government sectors – in particular, education, labor, and finance – promoting a culture of dialogue and mutual learning between these sectors, with a view to shared responsibility for public health policy. In this way it will be possible to move toward implementing comprehensive long-term policies that provide the region's countries with human resources of adequate quantity, distribution, and quality to address the challenge of universal health coverage.

ANNEX 1

Priority Issues for a Post-2015 Human Resources Agenda

Strategic approach	Priority issues	Proposed interventions
1. Strengthen the leadership and governance capacity of the national HRH authority.	1.1 HRH information systems	Harmonize nomenclature and modalities for registering health professions and occupations.
		Strengthen capacities for designing and implementing information systems and registries of health professionals.
	1.2 Methodologies to estimate personnel gaps	Use practical experiences in designing and applying methodologies to estimate HRH gaps.
		Take into account essential variables in designing models to estimate HRH gaps.
		Enhance the capacities of HRH management teams for applying methodologies to estimate HRH gaps.
	1.3 Strengthening of HRH planning	Establish policies and strategies to reduce HRH gaps, applied in the countries.
		Enhance the planning capacities of management teams
1.4 Strengthening of governance and leadership capacities	Establish comprehensive planning models.	
	Make advances in analytical capacity.	
2. Improve the availability and distribution of qualified and relevant personnel.	2.1 Mechanisms of incentives to cover underserved areas	Conduct research and generate new HRH knowledge
		Develop incentive mechanisms.
		Determine the interests, motivations, and working conditions required by health professionals to work in underserved areas.
	2.2 Development of multidisciplinary primary care teams	Use practical experiences with systems of incentives to attract and retain HRH in underserved areas.
		Implement regulation of professional practice to take advantage of the potentials of health professionals and technicians.
		Organize work based on multidisciplinary health teams.
3. Reorient the education of HRH professionals toward PHC	3.1 Reorientation of undergraduate training programs	Develop telemedicine and learning networks
		Establish training focused on primary health care (PHC) and on strengthening social responsibility.
		Provide integrated curricula, with early insertion of students in the primary care network.
		Develop the problem-solving capacities of generalist physicians.
	3.2 Strengthening of systems for planning graduate and post-graduate training	Provide interdisciplinary training.
		Plan post-graduate studies (residencies) on the basis of identified gaps.
		Increase training in family medicine.
	3.3 Strengthening of mechanisms to regulate HRH training	Strengthen the capacity to train specialists
		Accredit training programs with a PHC orientation.
		Harmonize degrees.