31st of January, 2015

Feedback on global strategy on human resources for health synthesis document

We appreciate the effort of putting the synthesis paper together, including recommendations provided through the public consultation process.

However, if this is the basis for a new global HRH strategy, we feel that it lacks the spirit of radical reform and change it is aiming for.

The paper is in our view very much a summary of all papers it is based on – and the call to action doesn't include issues necessary for radical reform and change that might be referred to in the overall text.

We argue that the capacity for individual states to provide a sustainable health workforce (especially in times of crisis) is closely linked to the much more political issue of their capacity to claim and define fiscal space for health both in national and in regional negotiations, as a condition of advancement along the path of Universal Health Coverage. The paper refers to the influence of the International Monetary Fund to relax policy conditionality to allow greater investments in the social services but in the call to action (par 6.1. and 6.2) this could be stronger expressed.

Public sector and international financing is not only required for a productive investment in the workforce, to meet health care needs and unleashing economic growth. It is also a basic requirement to meet the **social and economic rights** of populations, especially the **Right to Health**. Although there is reference to human rights and international solidarity in par. 2.7 and 2.8, this is not translated into the governance paragraphs in part 5, or the call to action. The human rights framework is not only an underlying principle and belief for action, but also an extensive international legal institutional mechanism with duties by states to fulfill, protect and respect economic, social and cultural rights (and monitored via the ECOSOC council and the UN Human Rights Council Universal Periodic Review). We advise that a global governance for HRH mechanism builds on, and works in close coherence with these existing human rights institutions and frameworks. This is closely aligned with the UN framework on achieving universal health coverage and access to essential services.

the paper doesn't include one of the biggest challenges: it doesn't tackle **corruption, tax avoidance, capital flight etc. (both an national and international levels)** issues that undermine governance and accountability.

We think that there is still a need and role for international solidarity: The funding balance of development aid needs to be adjusted to concentrate more on building general health systems in poor countries so they can withstand health crises like Ebola **- and avoid vertical programmes**. The WHO Code stresses integration of aid on HRH through national health programmes.

Paragraph 4.4 talks about funding mechanisms, and even refers to **a multi-lateral funding facility to support international investment in health systems**. Par 5.1 then

talks about the transnational challenges. There is a crucial contradiction and ambiguity in international governance mechanisms for health (not only the workforce). One recognises more and more the ***transnational*** elements and interrelatedness of global health challenges (eg potential pandemics, health inequities, epidemiological transitions and integrated health systems) which also includes the health workforce. At the same time strategies and programs are rooted via ***national*** programs. In the 21st century there is a need of moving beyond this principle of national sovereignty and responsibilities. The world requires supranational mechanisms to address global challenges and produce global public goods. Health services and the health workforce is one of them.

A mere health labour market analysis and corrective intervention at national levels is hence ***not sufficient anymore***. There is a need for new supranational institutions and financial, political, democratic mechanisms to secure access to global public goods for health for all, based on universal, cosmopolitan values. The philosophic basis for such a supra-national mechanism can already be traced back to ***Social Contract*** theory, e.g in the work by Rousseau, Kant in the 18th century and more recently Rawls and Pogge. These political theories have contributed to the establishment of nation states and eventually their welfare mechanisms. It is now time to seriously consider them ***beyond*** the nation states. This is of course not only related to the health workforce or health services but part of broader social protection & rights, its regulation and related legislation.

Practically, it would be useful to learn how welfare states have developed in industrialized Western-Europe and the United States since mid-19th century[1]. We should then consider how this would apply to supranational level. This happens already to an extent in the European Union and ASEAN region, but notably health, education, pension benefits etc. remain ***national competencies and policies***. This is understandable, because if it would be a ***transnational responsibility*** it would include considerable resource transfers, fiscal reforms and a more radical wealth redistribution than is currently the case. This is politically a very though objective (and not acceptable by mainstream political actors, is the European lesson from the last decades).

But from a sustainable development -, human rights-, reducing global inequalities and securing stability perspective, we think there will be a trend towards and momentum to create and think of such proposals and mechanisms[2].

For the health workforce, one could think of global or regional (financing) mechanisms, institutions, perhaps a solidarity fund to finance health care and the recurrent costs for health workforce salaries to guarantee universal access to basic health services. Models

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[1] See eg. Abraham de Swaan (1988) *In Care of the State: Health Care, Education, and Welfare in Europe and the USA in the Modern Era* . New York: Oxford University Press, 1988.

[2] See eg GASPP, Globalism and Social Policy Program. (2004) Policy Brief *Copenhagen Social Summit ten years on: The need for effective social policies nationally, regionally and globally.* https://bib.irb.hr/datoteka/191427.policybrief6.pdf . The concept of **'three R's'** became the leading framework for the Globalisation Knowledge Network final report to the commission on social determinants of health (2007): http://www.who.int/social_determinants/resources/gkn_report_06_2007.pdf

and scenarios for such a mechanism have been discussed over the last years.[3] It is time now also to include this thinking and models in a global human resources for health strategy for 2030. As Albert Einstein said 'We cannot solve our problems with the same thinking we used when we created them'. This is also the case for health workforce development and retention. Merely enabling economic incentives and improved labor market conditions will not be sufficient. We need a more structural change in the global HRH governance and how to guarantee workforce development.

Another issue that is relatively lacking in the synthesis paper is the **equity concern** and access to a skilled workforce. Including more equity objectives in the different elements of health workforce development is of importance to ensure that there won't be a **two-track development of health systems**; a formal educated, well trained, workforce for the middle- and upper-class, and an informal sub-standard community health workforce for the lower socio-economic parts of society. We have to be very conscious about the risk of divergence. Integrated approaches, based on universal principles should guide the HRH policies.

Finally: there is still the aspect of **Policy Coherence for Development** and the debate around **free trade agreements** and their effects on the mobility of the workforce. Although this is mentioned in Box 3, we urge to including this into the call to action. We recommend GHWA/WHO to clearly state, in the Global HRH strategy, that health workforce and their services are excluded from trade agreements as they provide a public service, a common good that should be in the realm of policy space by states to guarantee basic services to their citizens.

Thank you for the attention, and we hope that some of the issues addressed above can be considered in the further development of the global strategy on HRH.

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[3] See eg. Workshop reader. *Financing Social Protection – Moving from charity to solidarity* (2012) international seminar on financing for health and social protection. Edited by Jens Holst, on behalf of Medico International and Helene de Beir foundation. http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=36208