Draft Global Strategy for Human Resources in Health: Workforce 2030

Submission to the World Health Organization

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Contact

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ONLINE CONSULTATION ON THE WHO DRAFT GLOBAL STRATEGY ON HUMAN RESOURCES IN HEALTH: WORKFORCE 2030.

http://www.who.int/hrh/resources/online_consult-globstrat_hrh/en/

1. Do you have any comments on the vision, overall goal and principles?

***Vision**: Accelerate progress towards Universal Health Coverage and SDGs by ensuring equitable access to a skilled and motivated health worker within a performing health system.*

Comment:

1.1 We suggest that the vision should encompass the end goal rather than progress towards it, and should identify the relationship between the health system and the health worker. Barriers to health workers within functional health systems have been well identified, particularly in primary health care; access to a skilled health worker may not accelerate progress to UHC and SDGs unless the health system has the systems and necessary funding/investment to educate, train and support health worker(s) to deliver appropriate care or treatment. For similar reasons we suggest the vision should have a workforce rather than individual health worker focus eg "to ensure that the right quality, quantity, mix and distribution of health personnel are available to meet health care needs in an environment that supports effective and safe practice". (International Council of Nurses, Health Human Resources Development, 2007.)

1.2 Without a qualifying adverb "performing" is too vague – the system needs to be performing well. We would prefer "effective" to performing since the focus of the former is on good health outcomes, rather than functioning systems.

1.3 We suggest that it is unnecessary to qualify access with the term "equitable", because the principle of equity is embedded in the UHC and SDGs. Moreover, in this global context, this may invite comparison within and between countries that could lead to action/inaction that undermines the global vision. Eg many high income countries have equitable access in principle, but in practice, structural discrimination is often a barrier as indicated in, for example, the Aotearoa New Zealand Human Rights Commission's discussion paper A fair go for all: addressing discrimination in public services, 2012.

1.4 The purpose of the workforce i.e. enabling people to optimise their health potential, could be included, as well as eradication of legislative barriers to workforce flexibility.

Overall goal: To ensure availability , acceptability and quality of the health workforce through adequate investments and the implementation of effective policies at national, regional and global levels for ensuring healthy lives for all at all ages, and promoting equitable socio-economic development through decent employment opportunities.

Comment:

1.5 The sentence is somewhat convoluted; the goal should be clear and unambiguous.

1.6 While we strongly support the principle of decent employment, we do not support the second clause "promoting equitable socio-economic development through decent employment opportunities" as an overall HRH goal. Socioeconomic development may underpin, but is not the primary goal of the development of human resources for health and wellbeing. We suggest there is a significant risk of dissipating energy and focus if we lose sight of the main objective which is about the sustainable development of workforce capacity and capability to meet population health needs. We explore this further below, in the context of using health workforce development to improve employment prospects for women.

1.7 We suggest that self-sustainability must be part of the workforce goal, in the light of wealthier nations consistently relying on immigration to fill workforce gaps through lack of investment in their own workforces. In this context we draw your attention to the International council of Nurses suite of HRH position statements, including the previously cited Health Human Resources Development, (2007), for example on Ethical Nurse Recruitment (2007) Nurse Retention and Migration (2007).

1.8 We suggest that "cultural competence" better expresses the intent of "acceptability".

The Principles:

- *Support governments to build optimal health workforce models for the provision of people-centred integrated health services, responsive to patients' sociocultural expectations, and empowering and engaging communities to be active participants in the health care production process.*

- *Guarantee the right of health workers to be free from gender discrimination and violence in the work place, and ensure 'decent work for all'.*

- *Facilitate the integration of health and social care services through a holistic approach centred on population needs.*

- *Promote international collaboration and solidarity based on mutual interest and shared responsibility, and ensure ethical recruitment practices.*

- *Mobilize political commitment and foster collaboration across sectors and constituencies (including public and private) for effective HRH action.*

- *Ensure WHO support on normative aspects and technical cooperation is coherent and integrated at all levels of the organization.*

Comment:

1.9 A critical omission is the absence of reference to the rights and role of indigenous peoples in the development of health workforce and systems that support their health. This must be added to the principles.

1.10 We suggest the first principle needs simplifying as it covers several areas i.e. workforce models (which should stem from models of care); responsiveness; people centred, integrated health services; and empowerment and some of these are duplicated.

1.11 Responsiveness to health needs, rather than "socio-economic economic expectations" is fundamental and should be explicit. We note that this is referred to obliquely as part of Principle 3 "Facilitate the integration of health and social care services through a holistic approach centred on population needs", but believe that developing the workforce capacity, capability and flexibility to respond quickly, safely and appropriately to health needs is a HRH priority.

1.12 We suggest "sociocultural expectations" is too broad and propose an alternative: inserting the words "culturally safe" before "people-centred integrated health services".

1.13 "the health care production process" is an unduly mechanistic description of the complex, organic processes that contribute to health status. While community engagement in developing local systems is essential, it should be clear that the principle is not about producing healthcare or building models (or employment, socioeconomic goals, or implementing particular economic models), but about facilitating health/wellbeing as intended through UHC and SDGs.

1.14 We suggest that "uphold" rather than "guarantee" freedom from gender discrimination would be more a credible and active aim for Principle 2, though we applaud the principle. The nominal 'guarantee' offered by equal opportunity and employment legislation in many countries is not supported by strategic action to close the gender gap; substantial disparities still exist, and indeed, in some countries like Aotearoa New Zealand, are increasing, despite the expectation of equal participation in the workforce.

1.15 We strongly agree with the principle of ensuring violence-free workplaces.

1.16 We support an holistic approach to population needs but believe the principle should focus on appropriate/integrated workforce development for health and social care services, not the integration of services as such.

1.17 NZNO strongly endorses principle 4 "Promote international collaboration and solidarity based on mutual interest and shared responsibility, and ensure ethical recruitment."

1.18 We see no reason or need to specify "public and private" collaboration in Principle 5. Opportunities will vary from country to country; nations must be free to choose collaborations for effective HRH that are available, appropriate, and relevant, without having to commit to a principle of "public and private" collaboration which may or may not be relevant, available, or desirable. The inclusion of a key aspect of a particular economic and political model in the fundamental principles guiding the GSHRH is concerning, particularly since, in some high-income countries at least, public private partnerships have had adverse health consequences and undermined public services including those supporting HRH. See for instance Why Private-Public Partnerships don't work: the many advantages of the public alternative (David Hall, Public Service International 2015). We strongly recommend the words in parentheses are deleted.

1.19 We support Principle 6 which underlines WHO's substantive leadership role in assisting the systematic national and international development of sound health workforce systems.

2. Does the "overview" well articulate the arguments in support of the objectives of the GSHRH? (Pages 4-6)

2.1 In general yes, but it also reflects omissions such as the need to target a substantial increase in the recruitment, development and training and retention of the HRH to support indigenous populations in a countries, not just "developing countries, especially in the least Developed Countries and Small Island Developing States" as articulated in Section 3. This section should be amended accordingly.

2.2 We note that, unlike the MDGs which included several specific health goals, the SDGs have only one 'umbrella' health goal (Goal 3: to ensure healthy lives and wellbeing for all) supported by other goals focusing on the determinants of health. We support this approach, which is articulated in some sections of the overview and Objective 1 of the GSHRH.

2.2 The overview accurately identifies the unacceptable inequity associated with health workforce migration, where developed countries are failing to sustain HRH to meet their population health needs and provides the labour market context for the GSHRH global targets.

2.3 Similarly, it provides an HRH context for primary health care, linking HRH investment in training and education, and employment to models of care that

encompass “promotive, preventive, curative and rehabilitative services”. However, we strongly challenge gender-based health workforce development being used as a proxy for economic development in low and middle income countries! The dominance of women in poorly paid health care and support industries is a significant contributor to entrenched and inequitable economic outcomes for women in high income countries. Eg the nursing workforce is overwhelmingly a female-dominated occupation in Aotearoa New Zealand, with around 93 percent of registered nurses being female; as well as pronounced income disparities for females, the disproportionate under-representation of males may negatively impact male health.

2.4 A similar imbalanced gender profile may be evident in the global health workforce and this needs to be acknowledged to prevent and address structural gender discrimination in all countries. The health workforce must reflect the gender and ethnic composition of the population it serves and the focus of health workforce development must be on meeting population health needs; it is population health which underpins socio-economic development, not the health workforce. Gender bias undermines the universalism of the SDGs, and human rights principles.

2.5 The overview foreshadows increased HRH demand due to aging populations, and increased population and economic development, but does not identify decreased HRH and health demand due to technical innovation, eg medicines, digital communications. We suggest that this is a critical factor in ensuring wise investment in a fit for purpose workforce, and avoiding market pressures that may privilege certain roles, or reduce health workforce quality or efficiency through substitution/duplication.

3) The GSHRH presents four objectives with proposed global targets

Objective 1 - To implement evidence-based HRH policies to optimize impact of the current health workforce, ensuring healthy lives, effective Universal Health Coverage, and contributing to global health security (Page 7).

Objective 2 - To align HRH investment frameworks at national and global levels to future needs of the health systems and demands of the health labour market, maximizing opportunities for employment creation and economic growth (Page 11)

Objective 3 - Build the capacity of national and international institutions for an effective leadership and governance of HRH actions (Page 15)

Objective 4 - To ensure that reliable, harmonized and up-to-date HRH data, evidence and knowledge underpin monitoring and accountability of HRH efforts at national and global levels (Page 18)

a. Please provide your comments on the listed objectives:

Objective 1

3.1 We suggest using the term "evidence-informed" rather than "evidence-based". Policy is based on a number of factors, including, but not exclusive to, evidence. Evidence, even when it is available, varies in quality. Policy makers must consider the applicability of scientific, statistical, anecdotal etc. evidence with a range of social, economic and political factors in developing effective workable policies. We recommend to your attention a report from the Chief Science Advisor, Aotearoa New Zealand: *The role of evidence in policy formation and implementation* (Office of the Prime Minister's Science Advisory Committee, 2013).

Objective 2

3.2 We suggest objective 2 should refer to current as well as future needs.

3.3 We believe the objective should be to improve fair and sustainable employment.

3. 4 We do not see "maximising opportunities for employment creation and growth" as an appropriate high level HRH objective. Indeed, in some cases, employment creation and growth has led to adverse HRH and quality outcomes. For example, developed countries' disproportionate use of health workers from developing countries who have trained health workers to work overseas (mainly for remittances to repay international debt) has negatively impacted employment opportunities and conditions, particularly for new graduates, in those countries, and has undermined planning and investment in sustainable HRH. Similarly, education programmes aimed at developing countries have been advanced in favour of less lucrative 'return to work' programmes, and contribute to the continued loss of skilled workers from countries which need them, downward pressure on employment conditions and opportunities in recruiting countries, and global inequalities in HRH.

3.5 Many qualified migrant health workers work in different, less qualified roles in high income countries eg doctors working as nurses and caregivers, while failure to achieve registration and to keep up with practice requirements can have lifelong negative employment consequences for individuals, and is a poor use of HRH. There has been significant "employment creation and growth" in the HRH industry and in some areas of health, eg residential aged care in high income countries, but the economic benefits have gone to health and education *provider*s, and HRH for health have been undermined rather than enhanced. Many of these providers are multi-national corporations, whose responsibility to their shareholders dictates their objective of profit and growth. The GSHRH objective is to improve HRH.

Objectives 3 & 4

3.6 We support both of these objectives.

b. Please provide your comments on the proposed global targets.

Target 1.1 *By 2030, 80% of countries have halved current levels of disparity in health worker distribution between urban and rural areas*

3.7 We support the target, and tentatively suggest adding "and access to public health services" to acknowledge the opportunities that telehealth provides for more complex and specialised services health that rural populations lack.

Target 2 .1 *80% countries allocate at last X% of GDP to health worker productions.*

3.8 No comment

Target 2.2 *High & Middle income all countries meet at least 90% of their health personnel needs.*

3.9 We strongly support this target which sets a meaningful, achievable and sustainable goal.

Target 2.4 *High income countries – ensure that by 2030 all OECD can demonstrate allocating at least 25% of all development assistance for health to HRH*.

3.10 We applaud this bold target which acknowledges the pivotal role of health workers and gives substantial support to a primary health care approach. I.e. utilising the expert knowledge and skill of health workers to improve health literacy and self management; to report accurately; advocate wisely; refer appropriately etc. We also hope that it may improve the one-way movement of health workers from low to high income countries.

Target 3.1 *By 2030 all countries have an institutional mechanisms in place to effectively steer and coordinate and inter-sectoral health workforce agenda*.

3.11 This is a very useful target which sets a clear challenge, for high income countries at least, to address the obsolete health workforce hierarchies and narrow medical focus that are a barrier to integrated healthcare.

Target 4.1 *By 2030, 90% of countries have established mechanisms for HRH data sharing through national health workforce accounts and on a yearly basis report core HRH indicators to WHO Secretariat and publish them.*

3.12 We support this target in principle, but believe that annual reporting is unnecessary, burdensome and may be counterproductive if countries saw it as too onerous to comply. We suggest a period of between 2- 5 years would be sufficient for the purpose of HRH data sharing and HRH reporting to the WHO.

c. Is the evidence adequate in support of the proposed objectives?

3. 13 Not in all cases, and we are concerned that much of the narrative is driven by a narrow political and economic perspective, that is misplaced in a global strategy for HRH. Eg While we believe that there is evidence to support Objective 1 Section 13 (*Dramatic improvement in efficiency can be attained by strengthening **national institutions** to enable them to devise and implement more effective strategies and appropriate regulation for the health workforce),* we do not agree that there is evidence indicating that "harnessing the full potential of collaboration with the **private sector**, incentivising and aligning its operations to public sector health goals" is necessary to achieve that objective (emphasis added). Indeed, in terms of regulation, we would argue that private sector alignment with public sector goals is the outcome of a strong, well-purposed regulatory regime.

3.14 Similarly, in s16, the purpose of "introducing competency-based national licensing and relicensing assessment for graduates" is to build quality and capacity through regulation and accreditation authorities; adding "from both private and public institutions" reveals a bias towards a strategy based on neoliberal principles which are not relevant/applicable to, and should not be imposed on sovereign nations.

3.15 S29 We do not believe there is evidence that high-income countries are "struggling" to match supply and demand of health workers, as the volatility of labour market swings in HRH supply and demand in many countries indicate. 'Struggling' is a subjective perception, as is "existing affordability and sustainability constraints"; either could be characterised differently using a different political lens. Eg high-income countries are failing to match HRH investment with their needs, or have chosen not to prioritise HRH. The outcome – a continued overreliance on importing foreign trained health personnel - is correctly identified and evidenced.

3.16 While there is evidence of the increasing role of women in the health workforce and that there are opportunities for women in health workforce education and employment (s32), we disagree that that is because those opportunities are 'gender neutral'. Women (and indigenous peoples, migrants and other vulnerable groups) are more likely to be in low paid employment in the health sector, as elsewhere, because of entrenched structural and cultural discrimination. As such, health employment does not represent a pathway to equality, or to equitable growth and prosperity. HRH must be developed to reflect the populations they serve; the GSHRH must not be gender-directed.

3.17 Evidence supporting targets 3.1 (s 45- 47) and 4.1 (60 and 61) is well articulated. We agree that there is a need for a global approach to HRH, not only

in supply and demand, but also to assure consistent protection of public safety and improvement of population health across borders, disciplines and sectors.

4. For each objective, the GSHRH proposes a number of policy options organized according to target countries. Please provide your comments on the policy options

a. All countries

Objective 1

4.1 We suggest inserting "long term" before the words "national health policies and strategies" in s14; short term strategies such as meeting health workforce skills gaps with increased immigration already exist in many high income countries. It is long term planning that is needed, particularly given the lead-in time needed for some specialty areas of practice.

4.2 We support, in general, the policy options outlined in s14 *Strengthen contents and implementation of HRH plans as part of national health policies and strategies* i.e. overcoming entrenched rigidities that hinder fair employment, good working conditions and career structures, and building positive practice environments. Again, however, we must challenge the inference implicit in "entrenched rigidities in **public sector** rules" (emphasis added). Nurses' long experience in all health settings indicates that there are 'entrenched rigidities' throughout the health system. Some public sector rules, such as good employment legislation/collective agreements, quality regulation, etc. enhance HRH, and some private employment practices, such as zero hours contracts, inadequate job security, safety and income, undermine HRH. If the policy option is intended to support the former and prevent the latter, that needs to explicit. We note, however, the same anti-public sector bias is implicit in s15 which refers to accountability only in relation to the public sector and to a specific problem faced by some countries i.e. to "excising ghost workers from the public sector payroll".

4.3 Accountability is essential for *all* employers, providers and health workers, regardless of whether the domain public, private, community, NGO. One could equally say that private employers who use state trained health workers but contribute nothing to education, should be accountable for part of that cost; or that private health service contractors must be fully accountable for all outcomes of services they have been publicly funded to provide. We are unaware of the extent of the problem of 'ghost workers', but we suggest that corruption and illegal, unethical and greedy behaviour is not confined to the public sector; global policy options for HRH should be broadly based on establishing the right environment for quality workforce development, not pinpointing a specific practice.

4.4 We have commented on s16 above and support the policy options of s17-19 i.e. Optimising health worker satisfaction, retention and performance; harnessing ICT where feasible; and building resilience and self-reliance in communities. We suggest strengthening s18 by inserting “and protects” after “workforce data that respects [and protects] confidentiality requirements”.

Objective 2

4.5 There is strong supporting evidence for the well-articulated policy options to build forecasting and planning capacity to improve HRH (s32), to catalyse multi-sectoral action on health workforce (s33) and to invest strategically through long-term (10-15 years) public policy stewardship and strategies in decent conditions of employment (s34). We suggest that two timeframes should be identified in the latter: a medium term of 10-15 years, and a longer, generational term of 25-30 years.

4.6 We warmly applaud the explicit reference to the provision of a living wage as a minimum.

Objective 3

4.7 We suggest a business case for HRH (s48) is only one necessary component of establishing a rationale for investment in HRH. Establishing the national (or regional) context i.e. historical, social, legal and cultural objectives, public expectations, international obligations, and principles etc. is of primary importance, because that sets the agenda for what the business case should deliver. Without a clear understanding and consensus as to what needs to be delivered there is a risk of misaligning funding and policy goals. In Aotearoa New Zealand, for example, national development of HRH *must* encompass Māori-specific HRH because of the relationship between Māori and the Crown established by Treaty of Waitangi and the policy and business model may differ substantially from the ‘standard’ model. Similarly different models would be required depending on the mix of private and public provision of health and education services.

4.8 The increasing gap between rich and poor, both within and between countries, is a stark reminder of inherent imbalances of power and the failure of globalisation to deliver the benefits of gains in productivity, knowledge, technologies, etc. fairly or equitably. It is critical to avoid imposing models and business cases on nations which may limit their capacity to develop culturally appropriate health systems to meet their population health needs, or restrict opportunities to utilise learning opportunities from others - eg Proven models such PHARMAC, Aotearoa New Zealand’s public pharmaceutical purchasing agency, which has saved billions of public health dollars and ensured access to affordable medicines. In this context, we note that PHARMAC is under threat from provisions in an international trade agreements which would significantly affect

their operating model by delaying market entry of generic medicines. The international implications for health are significant if this model is destroyed are enormous.

4.9 While s 50 supports the Objective 3 and Target 3.1, we suggest that the efforts of the health and social service workforces need to be aligned rather than linked (as per s51). In high income countries, the rapidly increased training and employment of workers in a wide range of care and support roles, some of which replace and/or overlap traditional clinical roles, has been associated with adverse consequences in some areas, such as mental health and aged care, where there has been inadequate provision for clinical assessment and oversight. The provision of health and social services may be integrated, but there are human resource requirements specific to each.

4.10 The workforce focus is somewhat lost with the second part of s50 – the wider social determinants of health and the partial list of the conditions that people need to live, grow and thrive

Objective 4

4.11 The policy options are well articulated though, as previously stated, we are concerned that data collection and reporting requirements may be overwhelming. We suggest that it should be explicit that information is only to be collected and shared where there is a specific rationale and demonstrable benefit for doing so and that blanket statements such as "all workforce data (respecting personal confidentiality) should be treated as a global good" should be avoided.

b. High-income countries

Objective 1

4.12 S20 (Correcting the configuration and supply of specialists and generalists) must refer to primary health care (PHC) and the nursing and midwifery workforces, not just general practice and family medicine; there is overwhelming supporting evidence for PHC.

4.13 We support having mechanisms to improve health workforce quality performance and distribution (s21). We suggest evidence supports the inclusion of mechanisms for ethical recruitment and transition programmes for new graduates as well as "adequate deployment and retention". We also suggest it would be useful to identify examples of supportive practices such as first entry to practice placements, voluntary bonding schemes etc. These have been recently introduced and evaluated in Aotearoa New Zealand with positive outcomes. Eg Voluntary bonding Scheme. Nurse entry to practice and Advanced Choice of Employment schemes, Ministry of Health.

Objective 2

4.14 s35 (investing in the production, recruitment deployment and retention of health workers to meet its needs through domestically trained health workers) is supported by evidence. We suggest training and education should replace "production" (of health workers).

Objective 3

4.15 S 51 *Develop capacity to align incentives for health workforce education and health care provision to public health goals.*

No comment

Objective 4

4.16 Applying big data approaches to gain a better understanding of the health workforce (s 66) is a sound policy opinion but consent of health workers to collection of personal health workforce data must be explicit.

5. For each objective, the GSHRH proposes responsibilities of WHO Secretariat, please include other responsibilities (if any) that the WHO secretariat would need to assume to support implementation of the GSHRH? (Kindly make reference to the related objective in your response)

Objective 1 S26 *Develop normative guidance, support operations research to identify evidence-based policy options and provide technical cooperation*.

5.1 We suggest changing evidence-based to evidence informed as described above**.**

Objective 2

5.2 S40 No comment

Objective 3

5.3 S56 and 57 the responsibility of the Secretariat for "fostering technical cooperation and capacity building", and to "implement the trans-national HRH agenda" should explicitly include the responsibility to privilege national population health interests above international or transnational corporate interests. In particular, the GSHRH should not be a vehicle for the imposition of commercially driven international education and standards which conflict with cultural safety, or undermine the development of national HRH tools. The IELTS, for example, is largely accepted as the international gold standard for English language competence by health regulatory authorities, but is, in fact, neither culturally nor occupationally relevant in many countries, and there is no evidence that it is fit for purpose. Sharing information about the development of culturally safe, cost effective tools for HRH purposes to foster cooperation and build capacity is useful; facilitating the expansion of business interests (from high-

income countries) without protecting sovereign and cultural interests is not. In this regard the tobacco industry's disgraceful record and the increasing encroachment on regulation in multilateral trade agreements such as the Trans Pacific Partnership and Trade in Services Agreement are indicative of the risk that powerful commercial 'stakeholders' pose.

Objective 4

5.4 s70-72 **–** these responsibilities are appropriate ad well defined.

6. For each objective, the GSHRH proposes recommendations to other stakeholders and partners.

a. Based on the proposed policy options, please provide your suggestions (if any) on these recommendations in the appropriate field.

Objective 1

6.1 S27 *education institutions to adapt institutional set-up and modalities of instruction to respond to transformative needs*. While we agree that harmonisation of quality standards across private and training institutes is necessary and that there are advantages in internationally consistent standards and "modalities of instruction", we do not believe these should be at the expense of local institutes. This should be explicit.

6.2 S28 We strongly challenge the feasibility of, and need for, accreditation and regulation processes for cadres of health workers other than currently regulated clinicians. Regulation exists to protect public safety; it applies to health practitioners whose scope of practice encompasses the potential for harm. Other cadres of workers do not have this potential and do not need to be regulated. Regulation and accreditation is an expensive and resource intensive process. Care and support workers do need to be trained and we support nationally consistent training and qualifications. Regulation of the non-clinical health workforce is unnecessary, and can give rise to duplication, confusion - including between state and private education institutes - and unfair and unrealistic expectations of remuneration. In the same section, we suggest that practitioners should be not only competent to practice lifelong, they should be fit to practice, as articulated in Aotearoa New Zealand's excellent Health Practitioners Competence Assurance Act 2003.

Objective 2

6.3 The health workforce is productive in the sense of adding value, but its potential to "create millions of new jobs" is the outcome of improving population health. S41 currently endorses the business of health itself. We believe a more circumspect approach is necessary in view of the plethora of medications,

treatments and procedures that are available and profitable to providers in many high-income countries, but which are of limited, or even negative, health value. The GSHRH should encourage the IMF, World Bank and others to recognise investment in the health workforce as a key to productivity; enabling people to reach their full health potential will "unleash sustained opportunities for economic development", not the health workforce per se.

6.4 We support the recommendations in Ss42-44

Objective 3

6.5 We support the recommendations in Ss58 and 59.

Objective 4

6.6 We support the recommendations in Ss73 and 74

7. Please provide any general comment on the draft GSHRH

7.1 We see nursing as central to a global strategy on human resources for health designed to address universal health coverage and SDGs. We suggest that there is an opportunity to elevate this within the global strategy on human resources for health as nursing is the largest workforce in health globally. There could be potential in developing a specific action which advances the issues for nursing. Nursing scopes of practice have been shown time and time again, to be amenable to change based on population and patient health needs and nursing has been particularly successful in delivering health care to the most vulnerable and hard to reach populations.

7.2 We recommend:

Regulation: establish a contemporary regulation system for healthcare professionals
Legislation: improve legislation and remove barriers to enable healthcare professionals to improve access to health care for vulnerable populations
Primary Health Care: ensure healthcare workers are adequately prepared to meet the health needs of the population under the supervision and with the support of healthcare professionals
Education: support for articulated learning systems/ career laddering /multidisciplinary teams
Sustainable production of healthcare workers: countries should be self-sufficient in the production of healthcare workers needed in their country
Responsible migratory practices: to ensure the ethical recruitment of healthcare workers

7.3 We welcome the opportunity to comment on this document which is global in nature and is not limited to low and middle income countries. We note

that many of the objectives and statements in the document have been articulated and presented for decades with limited or frustratingly slow progress.

7.4 We urge the need for explicit and concrete targets to monitor progress and advance Universal Health Coverage and health workforce development.

7.5 We look forward seeing the Annexes referred to in the document in due course.

END