

**4<sup>th</sup> AAAH Conference:**  
***Getting Committed Health Workers to the Underserved Areas:***  
***A Challenge for Health Systems***

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Keynote Address  
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**OPENING WELCOME**

This Conference is a milestone event, important for Asian and global health. One hundred and fifty (150) participants – multi-sectoral and multi-stakeholders -- from more than a dozen countries are being brought together by an impressive array of partners. We acknowledge the hospitality of our Vietnamese hosts who have teamed with the dynamic AAAH network. Here, I convey my admiration for Dr. Suwit of Thailand who has tirelessly and adroitly built the regional trust and solidarity that characterizes AAAH. Asia, of course, is one key region in a series of alliances linked by the Global Health Workforce Alliance, represented here by Executive Director, Mubashar Sheikh. GHWA's Kampala Declaration confers legitimacy and adds impetus to this event, aiming "to assure adequate incentives and an enabling and safe environment for effective retention and equitable distribution of the health workforce." Last but not least is WHO – global in Geneva, Southeast Asia in Delhi, and Western Asia and Pacific in Manila. I salute Dr. Manuel Dayrit, the Department Director, who has demonstrated exemplary leadership in advancing WHO's normative, technical, and convening roles; I especially want to thank WHO's Dr. Carmen Dolea for enabling me to see the recent work of the WHO Expert Group. Finally on behalf of the China Medical Board, a private American foundation committed to professional education and research in Asia, I want to extend a special welcome to our Southeast Asian and Chinese collaborators.

Our purpose at this Conference is clear – how to get trained health workers into underserved, backward, disadvantaged areas. This equity mission recognizes the special disadvantage of peoples, often minority or indigenous populations, living in rural areas, areas of conflict or crisis, and more recently urban slums. To understand the whys, whats, and hows for achieving this mission, we will examine evidence, share our experiences, and network for future action. There will not be simply "talking!" We also have an opportunity to help craft "global recommendations" for a launch during the May 2010 World Health Assembly, at the same time when deliberations on a global code of practice on international recruitment may take place. Building on two earlier WHO Resolutions on human resources -- WHA 57.19 on migration and WHA 59.23 on scaling-up of trained workers, the 2010 recommendations will be drafted by a WHO Expert Group that will feed our AAAH conference deliberations into their meeting immediately afterwards.

### **THREE BASIC POINTS**

It is never repetitive to underscore the huge importance of access to skilled and motivated health workers for achieving good health equitably shared. Despite an upsurge in rhetoric, human resources remains a neglected, under-appreciated, and under-financed engine for health improvement. Shortage is a key constraint, but the shortages are often due to -- or exacerbated by -- severe mal-distribution. In other words, the problem may be less the total number of trained workers but more what types of workers are trained, where they are located, and what they actually do! Severe mal-distribution, it should be noted, harms not just the disadvantaged populations but also well-to-do groups. A converse of low density is the other-side: excessive concentration of overly specialized (and highly paid) professionals which can cause unnecessary tests and procedures, over prescription of drugs, iatrogenic diseases, and wasted higher costs – plaguing the rich and poor alike!

Secondly, mal-distribution is a commonly shared problem in all countries -- but each country is also unique. All market-based economies have labor markets where professionals and other workers have occupational mobility. (Only one or two authoritarian regimes today dictate exactly where each worker must work!) We have to acknowledge that most professionals (including most of us here) seek urban-based middle-class professional work and lives. There is nothing wrong about these personal and professional preferences. What need fixing are the biased institutions, inequitable policies, and perverse public subsidies that worsen health imbalance and inequity?

Even though problems may be shared, each country has its own unique national legacy. Some problems come from deep historical processes, like leftover colonial practices and structures. In many countries, remote regions also contain ethnic and cultural minorities who retain traditional health beliefs and practices. Due to historical forces, these peoples have been pushed into remote mountains, hills, arid lands, and recently into urban slums – that are further handicapped by weak economic and infrastructure bases. In some cases, the challenge may be less “retention” where some people never had trained health workers to lose and more training local workers or incentivizing urban workers for rural service. Moreover, today’s worker situation reflects past educational investments; workforce development has a long lag time of about one generation. From a menu of strategies each country may chose options that suit its situation. The approach cannot be “one size fits all.” But the approach also cannot be “any size will do!” To craft successful policies for specific national contexts, the sharing of experiences is invaluable: “better to learn from somebody else’s mistakes than your own!”

In parallel with in-country mal-distribution are imbalances across nations. Whereas European and North American countries enjoy more than 10 doctors-nurses per 1,000, some of the poorest countries with higher burdens of disease may not have even 1 doctor-nurse per 1,000. This global inequity is magnified by the migration of skilled personnel from poorer to richer countries. Mal-distribution within and across countries can be seen as an inter-linked continuum. Ironically, the importation of foreign workers in some rich

countries, like the USA, is due to its desire to cover its own disadvantaged populations – fixing one problem to create another or the international transmission of workforce problems!

Thirdly, what to do, I would argue, is mostly known. The challenge is how to do it successfully in specific contexts! The WHO Expert Group has developed four categories of strategies: education, regulation, financial incentives, and management and social systems support. These are based on the commonly accepted framework of “push-pull” factors. Workforce strategies aim to dampen the “push” out of and to enhance the “pull” into remote areas.

To assess national situations, I have developed a “10-point equity check list” for problem diagnosis and solution options:

Some are *educational policies*:

- (1) Are training institutions located in disadvantaged regions?
- (2) Are student admissions and graduates from these communities?
- (3) Is the training curriculum appropriate in theory and practicum?
- (4) Is there compulsory rural service (admission, subsidy, specialty training)?

Some are *health policies*

- (5) Does the worker mix match practitioner skills with the desired deployment?  
What about nurse practitioners, physician assistants, community workers?
- (6) Does country import foreign workers to cover its disadvantaged populations?
- (7) Are rural workers accorded professional status and career development?
- (8) Is rural service promoted through incentive salary payments?
- (9) Are there family benefits, e.g. schooling, housing, transport, city visits, etc?
- (10) Are rural workers supervised and backed-up, including IT linkages?

## CALL FOR ACTION

I look forward to the many contributions at this Conference through the sharing of experiences to improve the “global recommendations.” The four categories by the WHO Expert Group of education, regulation, incentives, and systems support offer a good framework upon which to build. To stimulate conference exchange, I would call for three actions.

**Getting the skill-mix right!** The skill-mix or composition of health professionals, shaped by medical education, is probably the most powerful long-term driver of worker-population match. Educating more will not necessary solve the problem of mal-distribution. Countries like India, China, Mexico, and many others suffer from acute shortages in disadvantaged regions while unemployed graduates languish in the cities. According to Dartmouth’s David Goodman in the United States, only 1 physician settles in a low density area for every 4 physicians who concentrate in high density areas. For many disadvantaged populations, the training a local worker is probably the most practical immediate solution. Deploying a highly skilled professional to these

communities, while desirable, requires powerful public policies and significant public financing to swim against the tide of the professional “middle-class” syndrome.

We must become more adroit at understanding the skills and capabilities of different workers, matched to a country’s epidemiology and social economy. Some have argued for task shifting, community health workers, or health teams. These over-simplify the core challenge of the skill-mix. Most crash programs with local workers “crash.” Some basic functions (e.g. immunizations and DOTs) can be handled by briefly trained worker if backed by strong supervision and support. Such vertical systems I call “directive systems” because they direct communities to only a few selected beneficial technologies and services. Integrated health systems that respond to a range of patient complaints require workers with more education because these professionals must use more sophisticated skills to navigate a more diverse range of complaints. The late Jose Luis Bobadilla labeled some of these professional functions as “clinical overhead” – diagnosis, referral, problem-solving, and palliation that require skill, time and costs. Such horizontal systems I call “responsive systems” because they must respond to diverse presentations. An optimal balance of these directive and responsive systems will change with a country’s epidemiology and social economy. The role of medical education is to anticipate its skill-mix production to feed properly the workforce pipeline for the future.

**Advancing research, monitoring, and evaluation** – To succeed, we must be able to diagnose the real problems and accelerate effective solutions. The 1990 Commission on Health Research Development described research as performing four health functions: (1) to understand the true nature of the changing problem; (2) to develop tools and technologies; (3) to accelerate interventions; and (4) to advance basic knowledge. An example of properly diagnosing problems was reported in the last October Lancet Series on human resources in China. Most recognize that China’s mal-distribution problem is severe across China’s major provinces -- Eastern coastal better off than Western provinces. While this is true, the Lancet analysis showed that 80% of China’s inter-county inequality in the distribution of doctors and nurses comes from *within* the provinces, not *across* provinces. Just producing more workers in provincial capital cities cannot solve China’s mal-distribution problem; critical are intra-provincial deployment policies. A partnership must be developed between central and provincial governments so that provincial policies fulfill national health goals. In human resources, our evidence base for this type of research is very thin. Also under-developed are M&E metrics. Without tracking progress, we have no idea of what is working and what is not working. And gaining credible evidence will not be easy. The problem is that the Cochrane criteria developed from clinical trials are not entirely relevant for the study of interventions in free-living populations. These invariably require quasi-experimental designs that cannot (and should not attempt) to achieve the scientific rigor based on the natural sciences. Parenthetically, I was pleased to learn that WHO has established a “Guideline Review Committee” to grade the quality of evidence in all of its recommendations.

**Strengthening the health system** – My final point is obvious but nevertheless worthy of highlighting. Solving the workforce challenge should be measured by the overall performance of the health system. The workforce is an exceptional systems input, as

human agency controls and modulates all other health system inputs – financing, information, technology, operations, and infrastructure. In the health system, the health worker is a necessary but alone insufficient condition to improved systems performance. The WHO Expert Group recommendation, therefore, that its strategies not be viewed singly, but rather as “bundles” for long-term sustained improvements of the health system. In workforce improvements, patience and persistence are essential because of the lagged pipeline effects of medical education and training. There are also plenty of opportunities to leverage workforce improvements as part of national health reform. While health reform mostly focuses on financing, workforce is an equally important dimension. Indeed, some have suggested that national reforms cannot succeed without workforce reform. There are strong arguments for establishing national health workforce commissions as focal points of intelligence, promotion, and the convening of stakeholders involving membership of diverse constituencies, including government departments (health, education, and finance), professional associations, the academy, and non-governmental organizations. Finally, it should not be forgotten that health workers are the twin parts of the human agency of health systems. Julio Frenk has underscored that people or communities play at least five roles in the health system -- as patients, consumers, financiers, citizens, and co-producers. So community participation in worker selection, training, and support are critical human interfaces. In these interactions, workers should not be viewed simply as “functionaries,” dutifully conducting their assigned tasks. Health workers are people, who properly trained and motivated also drive health systems as innovators, educators, motivators, and leaders.

These calls for action – skill mix, research, and health systems – will not have much effect without strong political commitment. Implementing a bundled set of strategies will require strong political commitment to engage stakeholders, incentivize the key actors, to overcome vested interests, and to address what Manuel Dayrit has called “the bigger picture” of human resources, health systems, social determinants, and multi-sectoral and multi-stakeholder engagement. Coming out of this conference, each country will carry forward its own action agenda as part of a global movement. But let’s together exploit the opportunity for a global movement. When delegates praise the recommendations and the possible Resolution on the global code of practice at the May 2010 World Health Assembly, I would like to hear: “Oh yes, that happened because of Hanoi!”

I look forward to exciting exchanges at this Conference. Thank you.