Preface

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When they met in Annecy, France, in December 2000, the authors of the papers presented here did not fully realize they were initiating a discussion that would become increasingly crucial to the future of the health sector, whose ability to meet growing challenges was increasingly being questioned. The HIPC programme[1] launched by the multilateral financial agencies in 1996 to alleviate the debt of poor countries, was still in its starting phase, and the Millennium Development Goals Declaration, had been adopted a few weeks before by the United Nations General Assembly[2]. These two topics were hardly mentioned at Annecy, but what was discussed is now proving highly relevant to the implementation of these two major agendas.

The HIPC process is making fresh resources available to the under-financed health sector, as it requires that some 20% of resources made available to the eligible country be directed to the health sector. For example, this has meant an increase of 60% in the health budget of Mauritania in 2001. But these new resources will not be translated into more and better services—and eventually to better health outcomes—if the recipient countries cannot count on a workforce sufficient in numbers, well educated and trained, adequately deployed and managed, and motivated to provide services of good quality.

Similarly, the health-related MDGs[3] will not be achieved if countries cannot successfully address the issues of (1) lack of qualified health personnel, due to a limited capacity to produce them and to retain those who have been trained, and in the case of Africa to loss due to AIDS; (2) irrelevant and outdated education mechanisms and content; (3) poor

[1] The Heavily Indebted Poor Countries Initiative, launched by the IMF and the World Bank in 1999 and supported by most bilateral donors (see http://www.worldbank.org/hipc/)

[2] United Nations Millennium Declaration, 5 September 2000, resolution 53/239 (see http://www.un.org/ millennium/).

[3] The health-related MDGs are to do the following: (1) reduce by two-thirds, between 1990 and 2015, the under-five mortality rate; (2) reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; (3) have halted by 2015 and begun to reverse the spread of HIV/AIDS; and (4) have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

capacity to regulate professional practice; and (4) insufficiently attractive incentive systems and ineffective management policies and practices. Access to services of good quality is crucial to the attainment of most of the MDGs, and this, in turn, requires adequate human resources.

The HIPC and MDG processes have highlighted what many students of the health sector have been saying for many years: the performance of the health sector will be only as good as the performance of the men and women who provide the services—from the admissions staff to the most specialized health personnel. Why this has long met with systematic neglect by policy-makers and managers would be an interesting topic for students of the policy process. Whether the explanation lies in their complexity, their multisectoral nature, their political content or the lack of ready-made solutions, the fact is that health workforce issues have been overlooked by countries and by the international community until now. This oversight is less and less justifiable.

Indeed, since Annecy, health workforce issues have become more prominent on the agenda of many agencies, beginning with the World Health Organization, which has developed a full work programme to produce and disseminate sound policy advice. In early 2001, WHO's Regional Office for Africa joined forces with WHO headquarters, the World Bank, the International Organization for Migration (IOM) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) to convene a "Consultative Meeting on Improving Collaboration Between Health Professionals, Governments and Other Stakeholders in Human Resources for Health Development" in Addis Ababa, which brought together 17 countries and a score of international agencies[4].

As a result of this meeting, many actors have engaged in advancing the HRH agenda, and a series of initiatives have been developed. The most significant has been the "Strategies on Human Resources for Health and Development—A Joint Learning Process" launched in 2002 by the Rockefeller Foundation, in which a number of multilateral and bilateral agencies and professional leaders and experts from many countries are now participating.

[4] Report available at http://www.whoafr.org/hrd/consultative_meeting_report.pdf

The papers presented here cover the main dimensions of HRD in health: planning and managing the workforce, education and training, incentives and working conditions, managing the performance of personnel and policies needed to ensure that investments in human resources produce the benefits to which the investing populations are entitled. Authors write from diverse professional, regional and cultural perspectives, and yet there is a high degree of consistency in their diagnosis of problems and proposals for strategies to address them. They all agree on the multidimensionality of problems and on the need for solutions that take into account all dimensions. They also agree that if problems tend to be similar in nature, they take forms that are time- and context-determined.

This set of papers raise questions and give insights into strategies that are relevant to developed and developing countries.

For example, all countries experience imbalances in the geographical deployment of health personnel, but causes and avenues of solutions vary from one country to another, according to historical, economic, organizational and cultural factors. This leads the authors to also agree that HRD is a process, not a blueprint, and will be successful only if the main stakeholders participate in it. Top-down policy development simply does not work in this area, where professionals not only value their autonomy, but have the social and political capacity to defend it. Countries that have succeeded in adjusting their workforce to the health and service needs of their population have done so through a long and difficult process of planning and continuing negotiation with providers, educators and managers of health services. This seems a heavy price to pay, particularly to those who look for immediate benefits, but the long-term reward of a health workforce that does the right things—and does them well—is likely to be well worth the investment.