Meeting Report

Workshop on Strengthening Governance Capacities for Human Resources for Health in the Western Pacific Region

Manila, Philippines
18–20 September 2013

World Health Organization
Western Pacific Region

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REPORT

WORKSHOP ON STRENGTHENING GOVERNANCE CAPACITIES FOR HUMAN RESOURCES FOR HEALTH IN THE WESTERN PACIFIC REGION

Convened by:

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines

18 to 20 September 2013

Not for sale

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NOTE

The views expressed in this report are those of the participants in the meeting and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office in the Western Pacific for those who participated in the Workshop on Strengthening Governance Capacities for Human Resources for Health in the Western Pacific Region which was held in Manila, Philippines from 18 to 20 September 2013.

EXECUTIVE SUMMARY

While the imperative to move towards universal health coverage is gaining greater international attention, scaling up human resources for health becomes a challenge faced by most countries in ensuring equitable access to services, especially developing health workers responsive to the health systems and population needs. The HRH strategic leadership and governance capacity in the health sector is one of the key factors in addressing the HRH challenges and in implementation of HRH policies and strategic plans. It is thus critical that countries have adequate governance capacities to tackle the HRH challenges.

The Human Resources for Health Action Framework (2011-2015), supported by Member States in RCM 62, guides the activities planned to scale up human resources for health in the Region. A major component of the HRH Action Framework is Health workforce governance, leadership and partnerships for sustained HRH contributions to improved population health outcomes.

A "*Workshop on Strengthening Governance Capacities for Human Resources for Health in the Western Pacific Region*," was convened in Manila, Philippines, on 18 to 20 September 2013. The aim of the Workshop was to contribute to building both individual and institutional capacity in strengthening human resources for health governance in the countries, especially in the HRH units of MoHs. It was attended by participants from Cambodia, the Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines, Vanuatu and Viet Nam.

The governance on HRH Western Pacific regional meeting closed with unanimous agreement on the need to strengthen the HRH regional network in order to push the HRH agenda forward at country level. HRH can be a bottleneck that needs to be strengthened in order to improve access to and the quality of services. Thus, effective HRH policies and HRH management are of fundamental importance in achieving universal health coverage. The challenges affecting HRH are the quantity, distribution, skill mix and quality of human resources. Then there is the added factors of demographic and epidemiologic changes, globalization, and communities' changing expectations of health providers. Increasing noncommunicable diseases also affect the need for and skill mix of HRH. Given this context, another pressing need is to build capacity of HRH managers.

To this end, the importance of and need to share experiences and technical cooperation between countries was emphasized. The WHO Regional Office for the Western Pacific can play an important role in facilitating cooperation and moving the agenda forward.

Other activities that can be useful in improving national systems include liaising with other countries in the region to learn from their experiences, and aligning curricula development for short health professions courses.

ABBREVIATIONS

HRH	Human resources for health
MoH	Ministry of Health
MoU	Memorandum of Understanding
WHO	World Health Organization

CONTENTS

Keywords

Health manpower – organization and administration / utilization / Capacity building / Manpower planning

1. INTRODUCTION

The meeting on Governance of Human Resources for Health in the Western Pacific Region was hosted in Manila, Philippines, from 18 to 20 September 2013. It was attended by participants from Cambodia, the Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines, Vanuatu and Viet Nam. A list of participants is given in Annex 1.

The participants shared their experiences on the governance of human resources for health (HRH) and discussed the pressing issues affecting the Region. Professor Thomas Bossert (Harvard School of Public Health) and Dr Gülin Gedik (HRH Team Leader, WHO Regional Office for the Western Pacific) facilitated the discussions. Annex 2 includes the agenda of the meeting.

1.1 Objectives

The objectives of the meeting were to strengthen governance capacities for HRH development by:

(1) building awareness on the national and international HRH challenges;
(2) building capacity on policy options and actions to address HRH issues and countries' challenges in the context of universal health coverage; and
(3) identifying areas for technical cooperation and follow-up actions.

2. PROCEEDINGS

2.1 Human resources for health (HRH) challenges in the Western Pacific Region

Countries in the Western Pacific Region face a number of HRH challenges. Those common to most countries include geographical imbalances in the distribution of HRH, increasing inequalities, fragmented and inadequate information collection, weak evidence bases, and concerns for the quality and relevance of health professional education. Some countries experience critical shortages of health workers, whilst others are heavily reliant on migrant health workers. Some countries have skill-mix imbalances and shortages in specific categories, while there is an oversupply in some other categories with absorption capacity leading to unemployment.

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Globalization, urbanization, technological advance, and changes in consumer demand and in the demographic composition of the population will bring new challenges to future health workforce requirements. Heavier workloads and changing needs will require a larger health workforce with new skill mixes. In addressing these challenges, governments will need to ensure that there is national capacity to regularly collect, collate, analyse and share data to inform policy-making, planning and management as well as to design and implement HRH policies. Additional capacity will also be needed to negotiate policies and investments in health systems and health workforces.

The participants briefly shared the main HRH challenges they face in their respective countries:

The **Lao People's Democratic Republic** HRH strategy runs until 2020. The country has one university – the University of Health Sciences, belonging to the Ministry of Health (MoH) – that is responsible for the education of medical doctors, nurses, pharmacists and other health professionals, such as radiologists and laboratory workers. Apart from this university, there are also three colleges and five other schools training nurses and midwives.

The HRH difficulties faced in Lao People's Democratic Republic currently are:

- the quality and quantity of training, as well as in-service training and the development of training institutions (teacher training, curriculum, etc.);
- recruitment – although approximately 2000 students graduate in health professions annually, less than half are recruited;
- shortage of health workers in rural areas – a decree was adopted in 2010 which introduced three-year compulsory rural area service for new graduates; and
- new staffing norms are being adopted with the goal of reaching five to seven health workers per health centre – at least one medical assistant, two midwives and one nurse.

In **Cambodia**, low salaries and insufficient numbers of health professionals are the consequence of the MoH's financial constraints. A lack of resources is limiting attempts to reduce maternal mortality and morbidity.

In **Viet Nam**, medical and nursing education reforms have been introduced recently, and there is a move towards a competency-based curriculum. Currently, the number of nurses in the country is insufficient. For decades, nurses have been considered as doctors' assistants, although the understanding of the roles and responsibilities of nurses is gradually improving. It is also planned to introduce licensing and accreditation to improve the quality of service. Discussions on the reform of the health system are underway. To this end, the challenge is to adapt the health workforce and health professional education to the new system.

In **Malaysia**, the government provides 60–70% of health services, particularly in rural areas. There are 33 medical universities and colleges training medical doctors (two of which are private), 12 training dentists (six private), 17 training pharmacists, and 19 training nurses.

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The number of doctors is sufficient, but there is a shortage of specialist doctors. The latter tend to move from the public to the private sector once they have gained experience in the public sector. The challenge is to retain these specialists in the public sector. The country already produces approximately 5000 new nurses per year, but as with specialists, governmental hospitals still have a shortage of nurses. The public sector is unable to hire more nurses due to financial constraints. The result is that increasing numbers of nurses are working double shifts.

The MoH of Malaysia has not been able to keep up with the growth in hospitals and facilities, partly due to financial constraints. A particularity of Malaysia is that the West coast of the country has more resources than the East coast. The government is addressing this gap by planning an effective policy of incentives because most HRH personnel come from the West coast and do not want to work on the East coast.

There is an urgent need for evidence-based, well-informed HRH planning in **Papua New Guinea**, which includes the need to audit all public and private institutions producing health workers and ensure appropriate accreditation mechanisms. The data on HRH is fragmented and incomplete. Although the need for a HRH policy has been recognized in the country since 1997, it was not until 2013 that the government endorsed and approved a national HRH policy. The delineation of health workers' roles and responsibilities is ongoing.

The **Philippines** adopted a HRH master plan in 2006, since which significant efforts have been made in communication and dissemination. However, it is recognized that these efforts have so far only focused on the central level, whilst the local level has lagged behind. This implies the need for a local-level communications system in the future. In ensuring stakeholder coordination, the HRH stakeholders' network was institutionalized in 2006. Currently, the network is awaiting legislation to fully incorporate it into the health system. It is actively involved in the development of the current HRH strategy. Since the creation of the network, HRH has focused on building institutional capacities. It is now considering the expansion of the capacities of its personnel (in macro planning for HRH skills, etc.). As universal health coverage is a health policy vision, the availability and accessibility of the health workforce is becoming a major challenge, especially in rural areas. It is also critical to influence the financial sector to increase investment in the health workforce.

In **Vanuatu**, budgetary constraints are limiting HRH planning. A significant number of health workers have reached retirement age and replacing them is proving particularly difficult. The shortage of nurses has been alleviated somewhat by recruiting them from the southern islands but their number is still insufficient, and the number of graduates being produced locally is limited. The challenge is in finding a way to make the scarce resources reach the community level.

2.2 Projecting supply and demand for HRH strategic planning

It takes time to see the results of HRH interventions, especially in the quantity and quality of health workers. It is essential, therefore, to develop long-term strategies and plans to address HRH challenges.

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The purpose of workforce planning projections is to:

- contribute to evidence-based, rational decisions when formulating national HRH policies and strategies;
- rationalize policy options based on a (financially) feasible picture of the future in which the expected supply of HRH matches the requirements for staff within the overall health-service plans; and
- identify short- and long-term actions for achieving longer term objectives.

Projections are useful for policy- and decision-making. They enable governments to deal with uncertainties and to estimate HRH requirements taking into consideration different scenarios based on the range of assumptions.

Various methods can be used to make projections of HRH supply and demand, each of which has its advantages and disadvantages. The choice of the method is influenced by various factors such as the size of the system and the needed HRH changes, the number of cadres to be projected, data availability, especially on staffing patterns, costs, productivity, geographical and functional distribution, and the level of 'precision' sought. The projections can develop alternative scenarios of a future health-care system, providing different visions of what might take place based on specified assumptions. These scenarios assist in the planning process by showing the potential consequences of different assumptions about the future.

The *Workload Indicators of Staffing Need* (WISN) method allows health managers to determine how many health workers are required for a given workload in a given facility. It is being widely used in identifying staffing needs at the level of a facility.

The Lao People's Democratic Republic provided an example of estimated needs for health workers for the next 10 years using a service-target approach. Staffing gaps for health facilities based on staffing standards and assumptions were estimated. Accordingly, the total and annual training requirement was calculated with cost of employment and production of staff. These projections have helped the MoH to negotiate with the government and improve the quotas for health facilities.

The discussions highlighted the fact that projections are particularly useful in exploring various scenarios and helping in decision-making, but they are used more in large countries. However, it is worth noting that the traditional projection methods do not take into account the health labour market dynamics. This is particularly the case in the private sector, which is more responsive to labour market.

2.3 Educational and management capacity for HRH

Human resources management and capacity development is linked to organizational performance which is determined by: organizational and managerial incentives; managers' attitudes, values, skills and beliefs; managers' authority; incentives for workers; and works' attitudes, values, skills and beliefs.

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In general, civil service rules are rigid and difficult to change given the limit ability of most managers to motivate and provide incentives. They usually cover the public sector and therefore require a cross-sector initiative to produce change. Incentives for public service workers can include the creation of transparent 'merit-based' hiring and firing, and a promotion system in the civil service. Management capacities may be improved if managers were trained not only in new skills but also in values and attitudes.

In assessing and planning HRH management capacities, interventions can be considered at macro (policy context, HRH stewardship), meso (administration of human resources) and micro (institutional environment, facility practice) levels. Management capacity raises different issues at various levels of the system.

Education capacities for HRH can be assessed both quantitatively and qualitatively. Looking at the education funnel – pool of potential applicants, application rate, institution acceptance rate, student acceptance rate, success rate, and entry into workforce rate – provides a framework for assessing the attractiveness of health professions, alternative opportunities, student quality, education quality, and academic support systems.

The World Federation of Medical Education (WFME) Standards for Quality Improvement can help in assessing the quality of education. Quantification of the different stages of the HRH education funnel is often possible and provides initial insights into the potential for policy intervention. Quantification of the different dimensions of HRH education quality is usually difficult, but qualitative assessments of structural and procedural education quality are often possible and useful, despite limitations.

The experience of Cambodia in introducing national exit examinations was shared with the participants of the meeting. The Sub-Decree 21 on education for health introduced national exit examinations with the objective of improving the quality of health education at public and private universities. It includes criteria for passing the university graduation examination and completing the thesis, as required. It was pointed out that the pertinence of an entry/exit examination was based not only on theoretical knowledge but also on practical skills.

The discussions highlighted the fact that while programme accreditation is a challenge, the accreditation of health facilities themselves is also important. Identifying the appropriate level for institutions to reach and the standards that can realistically be expected of them are of central importance. There is agreement on the need for a strong central regulatory body to manage health professions education, particularly where there is a strong private sector. At the same time, there has to be a distinction between licensing and accreditation processes.

In Viet Nam, the government involves medical associations in policy dialogue, and in the Philippines they created their own accreditation body in 1976, but it did not finally start to function until the 1990s.

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In the Philippines, the increased number of private nursing schools has augmented the number of nursing graduates, but there are quality concerns as a significant number of graduates fail the national examinations. Some other career opportunities are offered to unlicensed graduate nurses, such as further study opportunities as phlebotomists or physiotherapists. However, the nurses do not welcome this approach as they consider it downgrades their profession.

The Philippines is moving to outcome-based education. Malaysia has moved to a more sustainable health workforce by increasing the number of health workers produced.

2.4 Financing the health workforce

In many countries, health workforces suffer from long lasting under-investment. It is usually difficult to track HRH expenditures; however, the level of health spending can be a proxy for HRH expenditures. Government and private spending for health in the Western Pacific Region varies between countries. Apart from domestic sources, external funding from other countries and organizations is also a source to fund HRH. However, external funding is unpredictable and, ideally, should be aligned with government strategy. Data suggest that 20–25% of development assistance for health goes to HRH. However, the investment is not always aligned with government strategies, mostly because funds are allocated to in-service training and programme management. Pre-service education does not usually benefit from external sources of funding and allocations to additional health-worker recruitment are limited due to sustainability concerns.

Salaries constitute a major part of HRH expenditure. While wages are an important element driving HRH availability, they are not the only one. There are other elements, such as education, benefits, etc.

For instance, in Mongolia, the total health expenditure comprises state budget (70–80%), health insurance (17–20 %), and out-of-pocket payments (OOPs) (2–3%). Although out-of-pocket expenditure in Mongolia is only 2–3% of the total, informal OOP payments are not included in the overall budget and it is, therefore, difficult to calculate.

Approximately 40–60 % of the total budget is allocated to salaries. The salary structure for the public sector comprises basic salary plus ad hoc salary plus bonuses plus allowances plus incentives. The basic salary is defined in the job description for the position. Ad hoc salary (which should not exceed 40% of the basic salary) is given for: performing double tasks; replacing other employees who are temporarily unavailable; performing tasks not specified in the job description; working during holidays or working without holidays (double the daily pay for the days worked). Bonuses are provided for the years served (if served above a certain number of years), academic degrees, skills (according to professional degrees and other certified skills, etc.).

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The health sector has a payroll scheme that is separate from the general civil service payroll scheme. In 2007, a government resolution approved the separate classification and ranking of health workers. This was a result of a High-level Committee for HRH established in 2007 and headed by the Prime Minister of Mongolia. The Committee facilitated the signature of a Memorandum of Understanding between eight government ministries and agencies, and eight donor organizations to work together in developing HRH in Mongolia.

Despite the sector's efforts, the country's economic status and low HRH budget make that salaries are not sufficient to cover costs of living. Currently, the challenges being faced by Mongolia are the non-comprehensive performance-based payment mechanism, which has led to inequality in income levels and workloads, and an informal payments system.

The experience of Viet Nam in introducing new incentives to recruit health workers in rural areas was presented to the meeting. Health workers who rotate for 6 to 12 months to rural facilities are offered allowances and an additional 50% in addition to their usual salary. New graduates are also recruited in rural areas for two to three years.

Inequalities in the income of health workers employed by different sectors were discussed in plenary. For example, the health workers employed by the church in Papua New Guinea earn less than those in the civil service. On the other hand, churches provide almost half of all the health services. Regulation of these services remains a challenge. In some countries, for example, in the Lao People's Democratic Republic, salaries comprise the majority of the health budget.

2.5 Improving health workforce performance

There is not sufficient evidence on how to induce workers to improve their productivity and performance. Currently, satisfaction and motivation theories are used mostly in performance research and studies. The theories on satisfaction and motivation focus on internal drivers, external drivers, and a combination of the two. By understanding these drivers, policy-makers can implement the following actions to boost performance:

- recruitment based on individual differences;
- job descriptions;
- environmental contexts;
- contracts and compensation;
- goal and objective setting;
- changing organizational culture; and
- capacity building for management and leadership.

Motivation and satisfaction were complex and may have different consequences for performance. Thus, there is a need to develop multiple policies to match the external and internal drivers. There is evidence for some combinations of incentives that seem to work by improving motivation and performance but there is need for much more research.

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Recently, there have been a number of research studies that have used the discrete choice approach in exploring health workers' preferences. The Lao People's Democratic Republic applied this tool to study the feasibility of retention policies in the health sector in three provinces. In this study, 15 different intervention packages were introduced for a sample of 1454 health workers and medical students. The package that included promotion to a permanent post, transport for official and personal use, a scholarship after a year's study, and housing, was the health workers' preferred choice. Obtaining a permanent civil servant post stood out as the most preferred incentive.

To solve the problem of scarcity of health workers in certain geographical areas, the Government of Viet Nam implemented the Human Resources Rotation Policy, focusing on sending young graduate doctors to work for a period of two to three years in these areas. In return, they were able to work for tertiary hospitals after finishing the rotation. For experienced health workers, the rotation period is six to 12 months with an allowance of an extra 50% in salary. This strategy is new and its effectiveness has not yet been proved. Regarding Viet Nam's experience, concerns were raised about the quality of services that new graduates could provide, as they would naturally lack practical experience. The Philippines shared the experience of implementing a similar intervention, which was initiated two years ago. No complaints about the service provided have yet been received. It was considered important, however, that support and supervision mechanisms be in place.

It was noted during the discussions that adding more incentives did not increase performance significantly after a certain amount of incentives were in place.

2.6 Political feasibility and strategies

The effective implementation of HRH strategies depends heavily on an understanding of the political structure. Politics has its own rationality and HRH is always competing with other interests and other rationalities for access to government, community and international resources. The proposed policies may not be feasible in certain governance structures and political contexts.

There are some tools that can help political analysis: when decisions are made (policy process sequences); how decisions are made (decision-making models); and who makes decisions (stakeholder analysis). Each context will be different so differences in social, economic, and political institutions should be considered when developing strategies.

As an example, the experience Papua New Guinea in HRH policy development was shared. HRH has been a challenge for many years, and although the development of a HRH policy and strategy was on the agenda for more than a decade, a policy was only adopted this year. HRH is one of the seven health priorities included. The HRH policy aims to strengthen primary health care to reach rural and urban marginalized and disadvantaged populations. The plan focuses on filling the gap and supplementing the workforce, increasing training capacity, and improving HRH management.

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2.7 Priority setting and sequencing

As resources and capacities are limited, it is critical to prioritize the interventions and actions as part of strategic planning. First, the strategic planning process is important and it emphasizes interactive involvement in order to gain information and commitment. Priority setting is only part of that process and it is a logical consequence of evidence-based decision-making. This also helps to determine the sequence of actions.

Five steps in priority setting and sequencing were introduced:

1) problem identification;
2) development of criteria for prioritizing;
3) HRH reform policies;
4) sequencing of HRH reform policies; and
5) assessing the political feasibility of reform policies.

2.8 Labour market approach in HRH management

In many developing countries, there are fewer health workers than needed to deliver key health services. In other countries, there are too many health workers. Other key health workforce issues include geographical distribution, skill mix, productivity, quality of care, and level of care (clinic versus hospital). Traditional health workforce planning processes tended to focus on determining the health workforce level and skill mix required to meet the needs of the population. Once this level was determined, policy-makers adjusted training capacity and assigned staff as needed, with minimal regard for labour market dynamics. However, this approach ignores important behavioural characteristics of health workers (supply side) and employers (demand side).

Health workers respond to economic incentives that are unrelated to the health-care needs of the population. The way they respond depends on individual characteristics (e.g. age, single doctor versus doctor with school-age children).

Employers respond to economic, social and political incentives unrelated to the health-care needs of the population. There is a need to distinguish between needs-based employment levels (the number, skill mix, distribution of health workers required to meet the health needs of the population or existing infrastructure) and the demand for health workers (the number, skill mix, distribution of health workers all employers are willing to hire – i.e. funded positions). The demand for health workers may depend on government budget (public sector), household budget, insurance coverage (private sector), donor aid, nongovernmental organization (NGO) activity (public and private sector), health sector wages and political environment.

Therefore, it is essential to understand the health labour market dynamics and develop appropriate strategies on areas that require intervention.

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The importance of understanding health labour market dynamics is evidenced in the case of the Philippines, where, in the last decade, globalization and the global shortage of health workers increased the outflow of nurses. The rapidly increasing number of nursing schools, mostly in the private sector, reflected the demand from the international labour market. However, this had an impact on the quality of graduates and the success rate in licensing examinations decreased significantly. When overseas employment opportunities recently declined, the country was not able to absorb all the graduates, which resulted in nurses being unemployed or underemployed. The number of nursing schools has also started to decline mainly due to the decrease in demand.

2.9 Monitoring the health workforce

The monitoring of the health workforce is important and a framework based on health workers' working lifespan is proposed. However, challenges are faced with HRH information systems and scientific evidence needed to facilitate health workforce monitoring. Scarcity and fragmentation of HRH data in many countries is coupled with the challenge of timely access to and use of data to support evidence-informed decision-making. It is difficult to capture either the range of HRH occupations and activities (e.g. optometrists, health information technicians, medical teachers) or some dimensions (e.g. unemployment, migration). Thus, it is necessary to use different data sources, but the capacities for analysis and synthesis of HRH data across multiple sources (e.g. use of standard classifications) need to be strengthened.

There have been efforts to improve HRH information collecting in countries of the region. The Lao People's Democratic Republic shared its experience and challenges in developing an HRH database at the MoH. It captures data and reports regularly on public service employees. It has helped the government to understand the HRH situation better. However, there is still need to strengthen capacities at provincial and local levels to improve data collection, reporting and analysis capacities. In the Philippines, there is a MoU for developing an information system where workforce data can be shared. A mapping of available data has already been prepared and six organizations have been identified to provide the data. However, the first challenges to data collection appeared at the outset concerning confidentiality and usability. Efforts are being made to ensure that these institutions agree to work together.

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3. CONCLUDING REMARKS

The governance on HRH Western Pacific regional meeting closed with unanimous agreement on the need to strengthen the HRH regional network in order to push the HRH agenda forward at country level.

While universal health coverage will be central to the agenda after 2015, HRH can be a bottleneck that needs to be strengthened in order to improve access to and the quality of services. Thus, successful HRH policies and good HRH management are of fundamental importance in achieving universal health coverage.

The challenges affecting HRH are the quantity, distribution, skill mix and quality of human resources. Then there is the added factor of communities' changing expectations of health providers.

In the current regional context, it is important for HRH to focus on noncommunicable diseases (NCDs) and integrated health care. These concerns should be included in HRH plans' educational and training framework. Given this context, another pressing need is to train HRH managers.

To this end, the importance of and need to share experiences and technical cooperation between countries was emphasized. The WHO Regional Office for the Western Pacific can play an important role in facilitating cooperation and moving the agenda forward.

Other activities that can be useful in improving national systems include liaising with other countries in the region to learn from their experiences, and aligning curricula development for short health professions courses.

ANNEX 1

LIST OF TEMPORARY ADVISERS, RESOURCE SPEAKER AND SECRETARIAT

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ANNEX 1

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ANNEX 1

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2. RESOURCE SPEAKER

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ANNEX 1

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ANNEX 2

WORLD HEALTH ORGANIZATION | **ORGANISATIONS MONDIALE DE LA SANTE**

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

WORKSHOP ON STRENGTHENING HEALTH WORKFORCE GOVERNANCE CAPACITIES IN THE WESTERN PACIFIC REGION

WPR/DHS/HRH(03)/2013.1
16 September 2013

Manila, Philippines
18 to 20 September 2013

ENGLISH ONLY

PROVISIONAL AGENDA

Wednesday, 18 September 2013

08:30–09:00	Registration
09:00–10:30	Welcome and Opening
	Objectives and scope of the meeting
	Introductions by participants
	Overview of HRH challenges in Western Pacific Region
	Gulin Gedik, Team Leader, Human resources development, WHO Regional Office for the Western Pacific

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ANNEX 2

	Panel discussion: HRH challenges at country level
	Dr Sing Menorath, Director of Education and Research for Health Personnel Department, Ministry of Health, Lao PDR
	Dr Sing Menorath, Director of Education and Research for Health Personnel Department, Ministry of Health, Lao PDR *Dr Nguyen Cong Khan, Director General, Administration of Science Technology and Training, Ministry of Health, Viet Nam* *Dr Nooraini bt Baba, Director, Planning Division, Ministry of Health, Malaysia*
	Group photo
10:30–11:00	Break
11:00–12:30	Assessment of capacities for human resources for health strategic planning
	Thomas Bossert, Harvard School of Public Health
	Panel Discussion: HRH challenges at country level *Dr Kenneth G. Ronquillo, Director, Health Human Resource Development Bureau, Department of Health, Philippines* *Dr Enkhtsetseg BANDIKHUU, Division of Human Resources Development, Department of Public Administration and Management, Ministry of Health, Mongolia* *Dr Varage John LAKA, Manager, Workforce Standards and Accreditation Medical Standards Division, National Department of Health, Papua New Guinea* *Mr Gaviga Jonas Arugogona, Senior Policy Monitoring and Evaluation Officer – Health, Department of Strategic Policy, Planning and Aid Coordination. Office of the Prime Minister, Vanuatu*
12:30–13:30	Lunch
13:30–15:00	Projecting supply and demand for HRH strategic planning *Gulin Gedik*
	Projecting health workforce needs for future in Lao *Dr Khampasong Theppanya, Deputy Head, Personnel Division, Department of Organization and Personnel, Ministry of Health, Lao PDR*
	Discussion

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15:00–15:15	Break
15:15–16:15	Assessing educational and management capacity for HRH *Thomas Bossert* Introduction of national exit exam and faculty development in Cambodia *Dr Sokneang Touch, Deputy Director, Human Resources Development Department, Ministry of Health, Cambodia* *Professor Duong Dararith, Vice Dean, Faculty of Medicine, University of Health Sciences, Cambodia*
16:15–17:15	Group Work: Assessing education and management capacities

Thursday, 19 September 2013

08:30–10:00	Financing health workforce *Gulin Gedik* Paying health workforce in Mongolia *Dr Enkhtsetseg BANDIKHUU, Division of Human Resources Development* *Department of Public Administration and Management, Ministry of Health, Mongolia*
10:00–10:15	Break
10:15–12:00	Improving the health workforce performance *Thomas Bossert* Discrete choice experiment and introduction of incentives for health workers in Lao PDR *Dr Khampasong Theppanya, Deputy Head, Personnel Division, Department of Organization and Personnel, Ministry of Health, Lao PDR* HRH for hardship areas: new policy/ intervention in Vietnam *Mrs Nguyen Lan Huong, HRH Expert, Department of Manpower and Organization* *Ministry of Health, Viet Nam*

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ANNEX 2

12:00–13:15	Lunch
13:15–14:45	Political feasibility and political strategies for human resources for health policy developments *Thomas Bossert*
	HRH policy development in PNG *Mr Joseph Kembu Lipu, Manager, Human Resource Management, National Department of Health, PNG*
14:45–15:00	Break
15:00–16:00	Priority Setting and Sequencing *Thomas Bossert*
16:00 – 17:00	Group Work: Assessing financing capacities and political feasibility

Friday, 20 September 2013

08:30–10:00	Labour Market Approach *Marko Vujicic (through web connection), Managing Vice President, Health Policy Resources Center, American Dental Association*
10:00–10:15	Break
10:15–12:00	Monitoring health workforce *Gulin Gedik*
	Health labour market in Philippines *Dr Christine Joan CO, Chief, Planning and Standards Division, Health Human Resource Development Bureau, Department of Health, Philippines*
12:00–13:30	Lunch

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ANNEX 2

13:30–15:30	Presentations - Group Work
15:30–15:45	Break
15:45–16:30	Future actions and collaboration Closure

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