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HRH 2018-30

Pakistan: Human Resources for Health Vision

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Human Resources for Health Vision
2018-30

Ministry of National Services,
Regulations & Coordination

Pakistan: Human Resources for Health (HRH)
National HRH Vision (2018-30)

Produced by:
Ministry of National Health Services, Regulations & Coordination

In partnership with:
Department of Primary and Secondary Healthcare, Punjab
Department of Specialized Healthcare and Medical Education, Punjab
Department of Health, Sindh
Department of Health, Khyber Pakhtunkhwa
Department of Health, Balochistan
Department of Health, Federally Administered Tribal Areas
Department of Health, Azad Jammu & Kashmir
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JOINT MESSAGE

FROM FEDERAL, PROVINCIAL/ AREA MINISTERS OF HEALTH

Human Resources for Health (HRH) is pivotal for any meaningful improvement in the health status of people of Pakistan. A well-trained and motivated health workforce forms the basis for achieving Universal Health Coverage (UHC) and is a key to the attainment of the Pakistan Vision 2025, the National Health Vision (NHV) 2025 and the Sustainable Development Goals (SDGs) 2030 agenda.

The health workforce in Pakistan is the backbone of health systems and economic growth. Well-functioning health systems ensure healthy societies which then become an engine for economic development. A sick society never comes out of the vicious circle of poverty. Investments in health workforce and related professions have also produced millions of decent job opportunities in the country, which continues to contribute in the economic development.

However, the grave shortage of qualified health professionals and workers has restricted the progress in the health sector and is one of the main reasons for poor health outcomes and consequential poverty.

It is, therefore, our responsibility to take corrective measures to deal with the HRH related challenges. We, the Ministers of Health, gathered and discussed the issue in a meeting of Inter-Ministerial Health & Population Strategic Forum held on 16 December 2017 and decided to develop a unified National HRH Vision followed by development of Provincial/ Area HRH strategies and implementation.

It is very heartening that the first ever National HRH vision has been developed in Pakistan with a great deal of dedication and through an inclusive consultative process. We congratulate the Federal Ministry of National Health Services, Regulations & Coordination (M/o NHSR&C), other ministries, provincial/ area departments of health, regulatory councils, academic health institutions, private sector, civil society organizations, development partners and other stakeholders.

A unified HRH vision, yet ensuring provincial autonomy and diversity, will further strengthen health related coordination and coherence among stakeholders. Considering increasing population and emerging health needs, it is our priority to increase the number of hospitals by three folds in the public and private sector to achieve the SDG3/ UHC targets. This will create job opportunities for all types of health workforce. However, a pre-requisite for this reform is addressing workforce shortage with quality production, equitable distribution, enhanced productivity and an improved working environment.

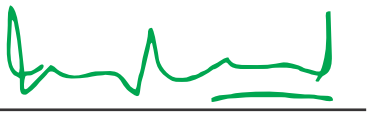
Pakistan cannot afford an exclusive curative health care model. There is no other option but to strengthen our primary, preventive and promotive health care system, for which the need for well-trained community based and multipurpose health workforce with support systems is critical. This will also ensure provision of essential health services at the door step of communities.

Pakistan cannot afford an exclusive curative health care model. There is no other option but to strengthen our primary preventive and promotive health care system, for which the need for well-trained community based and multipurpose health workforce with support systems is critical.

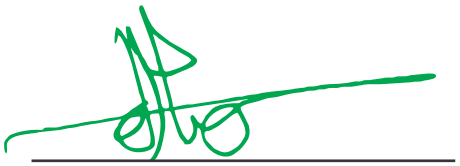
Today is just the starting point. The political health leadership not only commits the finalization of all provincial/ area HRH strategies as early as possible but also ensures that the required financial allocations for successful implementation of HRH strategies are made available.

We appreciate the efforts and leadership of the Secretary and Director General (Health), M/o NHSR&C in completing the task of developing this vision on time.

Now, this is the time for us to move forward with full force. Let us make use of this historic opportunity, with a shared vision for a better future for Pakistani people especially women, children and the poor.



Syed Murad Ali Shah
Chief/Health Minister, Sindh



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Chief/ Health Minister, Gilgit Baltistan

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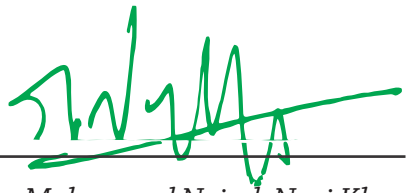

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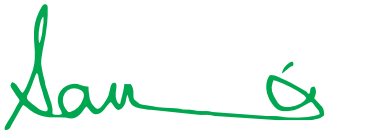


Saira Afzal Tarar, Federal Minister

FOREWORD

With the 18th constitutional amendment and devolution of health as a subject to the provincial governments, the federal government is the main interface with the international community and instrument for discharging constitutional federal health functions including regulations and coordination.

The Ministry of National Health Services, Regulations and Coordination since its creation in 2013, is making all possible efforts in providing common strategic vision to guide the health sector according to the Government of Pakistan's Vision 2025, which is to achieve universal health coverage through efficient, equitable, accessible and affordable health services to its entire populace; to coordinate public health and population welfare at national and international levels; fulfill international obligations and commitments; and provide oversight to health regulatory bodies.

Following the National Health Vision (2016-25), the National Human Resources for Health (HRH) Vision defines common national priorities and guidance about the most important pillar of the health system in Pakistan. However, to implement the same we need to revisit our structures at the national, provincial/area and district level and make early corrective measures to deliver the best possible results.

The ministry and provincial departments of health are currently receiving a record allocation of development and recurrent budget. Of this, a major chunk is allocated for HRH related activities. The rationale for the investments is that these directly impact key health indicators. Pakistan Vision 2025, clearly commits enhanced investments in the social sector including health as a top priority for the Government of Pakistan.

Role of the private sector cannot be ignored at all for ensuring universal health coverage in Pakistan. This demands a strong partnership not only in service delivery but also for the development, absorption and improvement in skills of HRH.

On behalf of the federal and provincial/ area governments, it is a call for all the relevant public and private sectors stakeholders, civil society organizations, non-governmental organizations (NGOs), United Nations agencies and development agencies to extend their full support to the implementation of this vision and actively engage in the HRH development process.

I appreciate the dedication and commitment of the National HRH Task Force and National HRH Working Group and all those who have contributed to the creation of this vision. However, their task is not over yet and they have a long road to travel for successful implementation and monitoring of the vision.

Naveed Kamran Baloch,

Secretary M/o NHSR&C

FOREWORD

ACKNOWLEDGEMENTS

ACKNOWLEDGEMENTS

The National Human Resources for Health (HRH) Vision (2018-30) reinforces the commitment of the government for creating a meaningful improvement in the health status of the people of Pakistan. The National HRH Vision provides a way forward for strengthening the most important pillar of the health system and to achieve the goals set in the National Health Vision 2025 and Pakistan Vision 2025.

The work for the development of HRH strategies actually started way back in 2009 with the support of Global Health Workforce Alliance and WHO. However, efforts were interrupted in 2011-12 mainly as a result of the 18th constitutional amendment and abolishment of the Ministry of Health.

Federal and Provincial Health Ministers in a meeting of the Inter-Ministerial Health & Population Strategic Forum held on 16 December 2017 expressed their concern on the grave situation of HRH in the country and took time bound decisions to develop a common HRH vision document at the national level followed by strategies at the provincial levels. Encouragement of the Federal Minister, Saira Afzal Tarar was instrumental in initiating the process.

My gratitude is due to Provincial Secretaries of Health, Directors General Health Services, the Regulatory bodies and the development agencies in identifying focal points to constitute a National HRH Task Force and a National HRH Working Group. Support from Academic Institutes and Regulatory Councils involved in the process is valuable and commendable.

I am grateful to Dr. Mohammad Assai Ardakani, WHO representative and his team especially Dr. Jamal Nasher, Coordinator Health System Development in providing technical inputs, all possible support to successfully complete the consultative process and organizing a WHO-Eastern Mediterranean Regional Office (EMRO) mission on a very short notice. Special thanks are due to Dr. Zafar Mirza and Dr. Gulin Gedik from WHO EMRO for providing support and guidance.

I am thankful to all members of the Taskforce and Working group and all those who participated in a series of meetings, consultations, consolidating data and analyzing the same to suggest common strategic areas for the vision document. This document could not have materialized without their inputs. It is worth mentioning the coordinating efforts of the Health Planning, System Strengthening and Information Analysis Unit (HPSIU) under the leadership of Dr. Malik Muhammad Safi, technical support of Dr. Raza Zaidi and other members of the team.

Many more individuals and organizations gave their time and suggestions to create this document and I am thankful to all of them.

In the end, I call upon all stakeholders for the implementation of this vision and achievement of targets.

Dr. Assad Hafeez, Director General (Health)

Contents

ACRONYMS

Acronyms

AJK	Azad Jammu and Kashmir
BSN	Bachelor of Nursing
CSO	Civil Society Organizations
CPSP	College of Physicians and Surgeons Pakistan
CMW	Community midwifery
CPD	Continuous professional development
CCF	Country Coordination and Facilitation
DOH	Department of Health
DHDC	District Health Development Centre
EMRO	Eastern Mediterranean Regional Office
FWW	Family Welfare Workers
FATA	Federally Administered Tribal Areas
GB	Gilgit Baltistan
GHE	Government Health Expenditure
GDP	Gross Domestic Product
HPSIU	Health Planning, System Strengthening and Information Analysis Unit
HRH	Human Resources for Health
IMR	Infant Mortality Rate
ICU	Intensive Care Unit
IHR	International health regulations
KP	Khyber Pakhtunkhwa
LHV	Lady health visitor
LHW	Lady health worker
MPH	Master in Public Health
MSN	Master of Nursing
M/o NHSR&C	Ministry of National Health Services, Regulations & Coordination
NHV	National Health Vision
NGO	Non-governmental organizations
PNC	Pakistan Nursing Council
PHDC	Provincial Health Development Centre
PMDC	Pakistan Medical and Dental Council
SDG	Sustainable Development Goal
THE	Total Health Expenditure
UK	United Kingdom
US	United States
UHC	Universal Health Coverage
WHO	World Health Organization

Preamble

Adequate numbers, quality and well-performing health workers are crucial for effective functioning of health systems. Through an effective and efficient health workforce, Pakistan aims to successfully implement the agenda of right to health wellbeing and to ensure economic and social development of its people. In this regard, **Pakistan Vision 2025** is a reflection of the government's commitment, in which investment in the social sector including health is a top priority. Aligned with the Pakistan Vision 2025, the **National Health Vision (NHV; 2016-2025)** was also endorsed by the Federal and Provincial health ministers in August 2016, as a unified common health vision for universal health care, especially for women and children of Pakistan. Formulation of Pakistan's Human Resources for Health (HRH) vision is a key action under Pillar IV of the NHV.

Human resources for health underpins the health goal of the **Sustainable Development Goals (SDGs)** as health systems can only function with a health workforce fully geared towards meeting the contemporary challenges. Importance of health workforce is evident as HRH is not only a specific SDG3 target (SDG3c) but is important enough to merit inclusion in the universal health coverage (UHC) index (SDG3.8.1) and also as one of the thirteen core competencies for the international health regulations (IHR) index (SDG3.d.1). Health workforce has impact beyond SDG3 - it is an integral part of achieving several SDGs, including Goals 1, 2, 4, 5, 6, 8, 10, 11 and 17, thus contributing significantly towards making health a strong leverage point in the overall SDG schematic. The contribution of health workers thus needs to be seen in a wider context of its role in the larger economy of the country than merely achieving SDG3.

Pakistan has one of the lowest densities of health workers in the region and globally, with an essential /skilled health professional (physicians including specialists, nurses, lady health visitors (LHVs) and midwives) density of 1.4 per 1,000 population[1], which is much below the indicative minimum threshold of 4.45 physicians, nurses and midwives per 1,000 population[2] necessary to achieve universal health coverage. For sustainable development, it is not only the adequate numbers, which is needed but also a well distributed workforce with appropriate skills mix to provide quality services.

This HRH Vision 2018-30 provides guidance for deploying strategic measures and suggests linkages along with the scope of work for the national and provincial health systems, thus allowing all to plan their own agendas, albeit with some principles and strategic choices that are common and mutually agreed upon.

Pakistan has one of the lowest densities of health workers in the region and globally, with an essential health professional density of

[1]WHO, 2017; World health statistics: Monitoring health for the Sustainable Development Goals
[2]WHO, 2016; Global strategy on human resources for health workforce 2030

Context

In Pakistan the demand for and size of HRH are forecasted to grow substantially as a consequence of population growth, combined with epidemiologic and demographic transitions

Globally some 234 million workers are working towards the achievement of health targets such as universal health coverage (UHC). This number includes 27 million doctors and nurses and other workers in health occupations employed in the public and private sector. This include the 57 million unpaid workers and another 45.5 million often low paid workers in jobs lacking decent working conditions, mainly in the areas of maintenance, administrative support and informal care.[3] The world is facing an estimated shortfall of up to 18 million health workers by 2030, primarily in low and lower-middle income countries.[4]

In Pakistan, the demand for and size of HRH are forecasted to grow substantially as a consequence of population and economic growth, combined with epidemiologic and demographic transitions. There are significant mismatches in the needs of, demand for and supply of health workers leading to inequitable distribution and deployment of health workforce.

Pakistan is going through slow and interconnected epidemiological and demographic transitions. **Epidemiological transition** data shows that the burden of communicable diseases in the country is gradually declining as a result of developments in modern healthcare & medicine, increased public awareness and reduction in poverty, while the burden of non-communicable diseases is on the rise.[5] In the communicable disease group, the leading burden of diseases (BoD) is related to neonatal conditions, followed by infectious & parasitic diseases (including diarrhea) and respiratory infections. In the non-communicable disease group, the leading diseases are cardiovascular & diabetes, followed by malignant neoplasms and mental/ substance use disorders. Unintentional injuries are more prevalent than intentional injuries.

A slow **demographic transition** is observed with a decline in the burden of communicable diseases that is contributing to a reduction in the crude death rate, followed by a slow decline in the crude birth rate. This is leading to a continuously increasing youth age group along with a more recent and gradual increase in the proportion of old age group.[6]

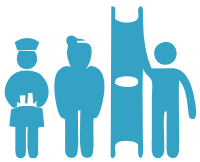
Health status as indicated by life expectancy for both sexes has improved from 33.8 years in 1951 to 68 years in 2015. Infant Mortality Rate (IMR) declined significantly from 177 in 1950-55 to 65.8 deaths per 1000 live births in 2015. However, decline in neonatal mortality is comparatively very slow at 45 per 1,000 live births in 2015. The fertility decline in Pakistan started only in the late 1980s and later gained momentum in the 1990s. Pakistan still has a very high fertility rate i.e. 3.8 children per woman (in 2012-13), with a much higher fertility in rural areas compared to urban.

[3] International Labour Organization, 2016; Health workforce: A global supply chain approach
[4] www.who.int/hrh/en/
[5] WHO's Global Burden of Disease (BOD) data for Pakistan, 2000, 2005, 2010 & 2015
[6] https://www.un.org/development/desa/ publications/world-population-prospects-the -2017-revision.html

Review of **burden of disease, demographic data and population projections** are critical to estimate the number and types of health workforce required to deal with the challenges. As per Census 2017, the population of the country is 213.7 million, including Azad Jammu & Kashmir (AJK) and Gilgit Baltistan (GB) and is expected to rise to approximately 282 million by 2030.

HRH is intrinsically linked to the **economy** of the country, which continues to maintain its growth momentum above 4.0 percent for the 4th year in a row with highest growth at 5.28 percent in 10 years in 2017.[7] According to the World Bank, the country's long-term growth depends on this investment in its people - this is what will make growth matter for Pakistanis. The government's next challenge will be to invest in health, education and nutrition.[8]

The National Health Accounts (2013-14) indicate that the Total **Health Expenditure** (THE) was US$7.72 billion (3 per cent of the Gross Domestic Product (GDP)) and US$39.5 per person per year. Share of the Government Health Expenditure (GHE) was 31.4 per cent of the THE and less than 1 per cent of the GDP. Federal and provincial health expenditures increased from Rs.42.09 billion in 2010-11 to Rs.225.33 billion in 2015-16 with a share of 34.5 per cent and 65.5 per cent respectively for the development and current expenditure.[9] In health 50 to 70 percent of the development expenditure and sometimes more than 90 per cent of the current expenditure is HRH related.



Situation of Human Resources for Health

One of the major challenges for health sector in the country is related to HRH, i.e. severe shortage of health workforce especially nurses, midwives and lady health workers (LHWs), imbalanced geographical distribution of health workforce including between urban and rural areas, imbalanced skill mix, inadequate skills acquired by the health workforce, poor job satisfaction & work environment and out-migration.

Reliable information about the number of health workers actively working in the country is not available. A summary of registered physicians including specialists, nurses, midwives, community midwives and LHVs along with their density per 1,000 population in 2017 is as following:

Imbalanced geographical distribution, poor job satisfaction, and out-migration characterize some of the challenges facing the health sector in terms of workforce

[7] Ministry of Finance, 2017, Economic Survey of Pakistan
[8] World Bank, Nov 2016; Pakistan Development Update- Making growth matter
[9] Ministry of Finance, 2017;Pakistan Economic Survey

Table 1: Registered Selected Health Workforce by the end of 2017

	Physician and Specialists	Density per 1,000 population	Nurses, Midwives and LHVs	Density per 1,000 population	Total	Density per 1,000 population
Punjab +ICT +AJK+GB	97,866	0.83	65,990	0.56	163,856	1.39
Sindh	74,166	1.55	21,644	0.45	95,810	2.00
KP(Including ex FATA)	26,963	0.76	13,672	0.39	40,635	1.15
Balochistan	6,157	0.50	2,740	0.22	8,897	0.72
PAKISTAN	205,152	0.96	104,046	0.49	309,198	1.45

By the end of 2017, there were 107 registered medical colleges in the country - 41 in the public sector (including the Armed Forces) and 66 in the private sector. Registered medical colleges in 2017 were having an annual production capacity of approximately 13,900 to 16,000 doctors.

College of Physicians and Surgeons Pakistan (CPSP) is fetching world-wide recognition for its qualifications (73 fellowship and 22 membership programs). According to the database of CPSP, the College had produced a total of 29,558 **Specialists** (9,010 membership and 20,548 fellowship) by the end of December 2017, with an annual production capacity of more than 1,900 specialists.

A number of physicians have received specialist education from abroad. By the end of 2017, a total of 40,328 specialists were registered by the Pakistan Medical & Dental Council (PMDC) with a density of 0.19 per 1,000 population.

Diploma nursing programmes offered in the country include General Nursing, LHVs, Licensed Practical Nursing, Midwifery (4th year), Community midwifery (CMW) and Family Welfare Workers (FWW). Degree nursing programmes include Bachelor of Nursing (BSN), Bachelor of Nursing (Post RN BScN) and Masters of Science in Nursing (MSN). By the end of 2017, the number of nurses with the above qualifications and registered with Pakistan Nursing Council (PNC) was: 3,331 BSN, 2,413 Post RN BScN, 202 MSN and 48 Master in Public Health (MPH).

Approved nursing and midwifery institutions in the country were 215 by the end of 2017, out of which 145 were in the public sector (including the Armed Forces) and 70 in the private sector (including missionary). Production capacity of all nursing institutions was 9,728 in 2017.

There were 5,058 registered **dentists** in 2002, which increased to 18,723 general dentists and 1,836 dental specialists in 2017. The density of dentists however still remains as low as 0.1 dentists per 1,000 population (one dentist per 10,000 population) with the highest density in Sindh and the lowest in Balochistan. By the end of 2017, there were 49 registered dental colleges in the country - 14 in the public sector and 35 in the private sector.

Community based health workers in Pakistan primarily include LHWs and Community Midwives (CMWs), vaccinators, malaria supervisors, etc. LHWs play a critical role by bridging the gap between health facilities and the community. About 102,000 LHWs and 12,000 CMWs were deployed in their communities. The role of LHWs and CMWs becomes significantly important in Pakistan due to shortage of physicians and nurses, especially in rural, hard to reach areas.

The role of LHWs and CMWs becomes significantly important in Pakistan due to shortage of physicians and nurses, especially in rural, hard to reach areas

Table 2: Number of Lady Health Workers in 2017[10]

	Number of LHWs	Density per 1,000 Population
Punjab	**44,497**	**0.41**
Sindh	**21,358**	**0.45**
Kp(Including ex FATA)	**15,930**	**0.76**
Balochistan	**6,400**	**0.52**
Islamabad	**309**	**0.15**
AJK	**2,990**	**0.74**
GB	**1,465**	**0.81**
Total	**92,949**	**0.43**

LHW is an effective approach to address the equity and gender challenges in the health sector while ensuring availability of primary, preventive, promotive and some curative care services at the doorstep of community. Currently, the number of LHWs is on the decline, whereas less than 60 per cent of the targeted population (100 per cent rural areas and 30 per cent urban areas mainly slums/ densely populated areas) is covered by LHWs.

Number of registered degree holder **pharmacists** in the country was 33,455 by the end of 2017, with a density of 0.16 per 1,000 population. There were 39 Pharmacy institutes (17 in public and 22 in private sector) offering degree programmes (B and/or D) for registration in register 'A' in 2017.

There were 158,767 registered **homeopathy practitioners** in the country[11] by the end of 2017, with a density of 0.74 per 1,000 population. The number of registered ***hakims*** was 62,540[12] with a density of 0.29 per 1,000 population. 139 registered Homeopathy colleges[13] and 34 registered *Tibb* colleges & 4 *Tibb* Universities[14] and other institutions in the country are playing a critical role in producing health workforce, which offers *unani, ayurvedic, hikmat*, traditional and alternate options for health care to the people.

[10] Data of Lady Health Workers' Programme, 2017
[11] National Council for Homeopathy, 2017; Registration data
[12] National Council for Tibb, 2017; Registration data
[13] National Council of Homeopathy, Pakistan, 2017; Registration data
[14] National Council of Tibb, Pakistan, 2017; Registration data

In the absence of a regulatory body for allied health workers, information about training institutions and number of **allied health workers/ paramedics** is not fully available. Allied health staff includes laboratory health workers, laboratory scientists, assistants, technicians, radiographers and related occupations. Similarly, information regarding environment and public health workers including officers, technicians, sanitarians, hygienists, public health inspectors, food sanitation and safety inspectors and related occupations is not readily available.

Table 3: Other health works in 2017

	Number	Density per 1,000 Population
Dentists including specialists	**20,559**	**0.10**
Pharmacists	**33,455**	**0.16**
Lab works	**14,959**	**0.07**
Hakims	**62,540**	**0.29**
Homeopathy Practitioners	**158,767**	**0.74**
Traditional Birth Attendants	**29,445**	**0.14**

Other health workers include a vast cadre of health service providers such as medical assistants, dieticians, nutritionists, occupational therapists, medical imaging and therapeutic equipment technicians, optometrists, ophthalmic opticians, physiotherapists, personal care workers, speech therapists and medical trainees.

This category of **health management and support workers** includes other health systems personnel, such as managers of health and personal-care services, health economists, health statisticians, health policy lawyers, medical records technicians, information technicians, ambulance drivers, building maintenance staff, and other general management and support staff.

Purpose

The purpose of this document is to provide an overarching national HRH vision and a common direction that harmonizes provincial and federal efforts including public sector, regulatory bodies, academic institutions, private sector and civil society organizations in line with international commitments.

The word 'national' depicts common political aspirations of the provincial and the federal governments and is an account of strategic directions to achieve a common vision and a guideline for provinces/ areas to develop their respective strategies.

Vision

"Accelerate progress towards universal health coverage, sustainable development goals and economic growth by ensuring equitable access to a quality health workforce within a resilient, responsive and strengthened health system"

Goal

"To ensure a flexible, responsive and sustainable health workforce that is of sufficient size, quality, capability and distribution to deliver on Pakistan's sustainable development goals, provide universal health coverage, and equitable access to health services for all"

Principles

1. Promote the **right to enjoyment of the highest attainable standards of health**
2. Provide **standardized, integrated, people-centered health services** devoid of stigma and discrimination
3. Uphold the personal, employment and professional rights of all health workers, including safe and decent working environments and freedom from all kinds of discrimination, coercion and harassment
4. Ensure **equality of access to leadership positions** based on merit and required qualifications
5. Ensure **ethical recruitment practices** through selection of right person for the right job and **equitable distribution** of health workers
6. Implement standardized mechanisms of **accreditation, accountability**, reward & recognition

7. Mobilize and sustain **political and financial commitment** and foster **inclusiveness** and collaboration across sectors and constituencies including private sector

8. Promote **innovation and the use of evidence** through research, HR information systems and knowledge hubs

9. Promote **collaboration and solidarity** with the private sector, civil society organizations and other stakeholders in alignment with national, provincial/area and district health goals and priorities

10. Build effective collaborative **partnerships and coordination** mechanisms engaging local **community, national** and **international** stakeholders and pursuing the **aid effectiveness** approaches

Objectives

1. To establish a national and provincial health workforce planning and development capability that provides the necessary tools **(strategies, governance mechanism, legislation) and resources** to deliver a health workforce of sufficient size, composition, capability and distribution to meet the health needs of the population

2. To align **investment in human resources for health labor market with the current and future needs** of the people and health system to address shortages and improve distribution of quality health workforce, so as to enable maximum improvements in health outcomes and poverty reduction

3. To build the **capacity of institutions** at district, area/ province and national levels for effective and quality pre-service & in-service training and leadership of actions on human resources for health

4. To strengthen **data collection, processing and dissemination of information** related to human resources for health for monitoring and ensuring accountability at different levels

Strategic Directions

1: Strategies, Governance and Legislation/Regulation

Challenges

- **Political will** at various levels of decision making is not strong enough to be **translated into adequate material resources** for the health workforce agenda.

- The thought process in the health sector, related to the 2030 agenda of SDGs and UHC, has not been reflected in the **HRH related strategic work.**

- **Health workforce governance structures** lack the development, implementation and monitoring of relevant strategies and multi-sectoral coordination mechanisms.

- There are a number of challenges associated with the design and operation of Pakistan's health workforce regulatory regime:
  - the **legislative HRH framework** is out of date, fragmented and does not equip regulators with the tools they need to assure health workforce quality
  - the **governance of regulators** is fragmented, the model of governance is out of date (relying on elections rather than direct competency based appointments by the government), and Council members' conflicts of interest at times compromise the decision making of the Councils
  - the **regulatory powers are insufficient** to enforce standards and lift workforce quality, or generate sufficient resourcing to monitor compliance with standards and undertake enforcement
  - **data quality is insufficient** to support workforce planning, risk management or health system improvement

Strategic Vision

- **Ownership of the HRH strategies at the highest level of political leadership** with regular monitoring of budgetary allocation and expenditure for HRH production, induction and development. Enhanced employability in the public and private sector will be the outcome of interest.

The legislative framework needs reform Enactment of a single umbrella law under which all the councils are established and operate

- Provincial/area departments of health to finalize their **HRH strategic plans** in 2018, while developing linkages with each other and the national HRH vision.
- Strengthening of institutional capacity by establishing **HRH units** with adequate capacity, authority, financing and accountability with a well-defined functions encompassing HRH strategies, planning, governance, implementation, monitoring and generation of HRH related evidence. The units will be responsible in ensuring **vertical and horizontal coordination** of the public health offices by engaging other public sector offices, development partners, academic institutions, civil society organizations, communities and private sector.
- Strengthening of current **regulatory councils** and enactment of new councils for allied health workers etc. The legislative framework needs to be made effective, flexible and responsive to emerging challenges. Enactment in Pakistan of a single 'umbrella' law under which all the councils are established and operate will be explored. Having all the councils under the single umbrella law, would provide greater economies of scale in the regulation of the professions. Before expanding the scope of regulation, a 'regulatory impact assessment' is required to provide the best evidence to the government for achieving HRH regulations' objectives.

2: Investing in HRH Labor Market

Challenges

The country faces the **critical shortage** of all cadres of health workers, especially the **skilled / essential health workforce** (physicians, nurses, LHVs, midwives) and community based workers, even to deliver basic and primary health services and UHC.

Table 4: Required number of Physicians including Specialists Expected Gaps

	Required minimum number in 2030 (@1.11 per 1,000 population)	Registered stock in 2017	Minimum production capacity 2018-30	Expected gap in 2030, assuming 60% attrition of the 2017's registered numbers and 15% attrition in new registered number during 2018-30
Punjab + ICT	159,866	93,287	7,600*13	29,243
Sindh	70,310	74,166	3,500*13	Likely to exceed the threshold
KP(Including ex FATA)	54,958	26,963	2,050*13	18,824
Balochistan	20470	6,157	300*13	14,077
AJK + GB	8,566	4,579	400*13	1,857
Pakistan	**314,170**	**205,152**	**180,700**	**57,999**

Table 5: Required number of Nurses and Midwives and Expected Gaps

	Required minimum number in 2030 (@3.34 per 1,000 population)	Registered stock in 2017	Minimum production capacity 2018-30	Expected gap in 2030, assuming 60% attrition of the 2017's registered numbers and 15% attrition in new registered number during 2018-30
Punjab + ICT AJK + GB	505,298	65,990	5,185*13	408,339
Sindh	210,930	21,644	2,993*13	164,008
KP(Including ex FATA)	164,873	13,672	1,330*13	141,792
Balochistan	61,410	2,740	220*13	57,329
Pakistan	**942,511**	**104,046**	**126,464**	**722,655**

Perception of the LHWs' as a liability has gained traction within the health sector as a result the number of LHWs has **declined from 102,000 to 92,949** between 2013-17 with additional challenges related to their supervision, quality of services and changes required in their scope of work.

- Productive **efficiency of health workforce** is critical considering financial constraint environment and need for effective delivery of health services.

- **Attrition rate of health professionals** is very high due to several social, economic and job related factors. A significant number of female Pakistani doctors simply do not join the labor market after getting married due to family reasons. Migration of significant

Attrition rate of health professionals is very high due to several social, economic and job related factors

LHWs are an asset rather than a liability

number of health professionals abroad is another factor contributing to the high attrition rate. According to Bureau of Emigration & Overseas Employment[15], 14,487 physicians and 2,349 nurses were registered for overseas employment mainly to the gulf countries, during 2008-2017. Only in 2017, 1,632 physicians and 293 nurses were registered for overseas employment.

Table 6: Pakistani Health Workforce Stock in UK and North America[16]

Health workforce stock	2014	2015
PakistanDoctors in UK	**5,275**	**5,194** (5,637 in 2016)
Pakistani Nurses in UK	**1,066**	**1,051** (1,031 in 2016)
Pakistani Doctors in Canada	**861**	**897**
Pakistani Nurses in Canada	**220**	**232**
Pakistani Doctors in US	**11,873**	**12,125**

- Level of **job satisfaction** is very low in public and private sector as evidenced by frequent protests of different health workforce professional associations across the country.

Strategic Vision

- **Employability** of qualified HRH in public and private sector is the outcome of interest not only to ensure health wellbeing but also to ensure their contribution to the economic growth.

  The production of **physicians** is by large stabilized, however emphasis would be on their geographical distribution. **Specialization** in areas of RMNCH and Non-communicable diseases would be required in addition to enhancing the numbers of family physicians.

  More production and placement of a **hospital management cadre** in tertiary and secondary hospitals and **public health specialists** as provincial and district managers, replacing the generalists in all provinces/ areas is required.

  Priority would be to more than double the current production capacity of nurses, **LHVs and midwives** by 2023 and then to revisit the target. Investment in increasing the number of good quality nursing tutors would be a pre-requisite.

  LHWs should be viewed as an asset rather than a liability. Priority would be to have renewed strategic thinking of the intervention and especially about the role of LHWs while ensuring maximum possible coverage in the country especially in the rural and hard to reach areas.

[15] http://www.beoe.gov.pk/reports-and- statistics
[16] http://stats.oecd.org/

Even with scaling up the number of physicians, nurses and midwives, the system needs to be made fully functional with proportional increase in the number of **pharmacists, allied health workers/ paramedics, other health workers, management and other support workers** along with enhanced investment in rest of the building blocks of health system.

***Tibb* and Homeopathy practitioners** would be mainstreamed in the primary health care system to tap their potential in delivering UHC.

- **Task shifting** is a promising policy option to be adopted to increase the productive efficiency of the delivery of health care services, increasing the number of services provided at a given quality and cost. Scope of work of community based workers will be re-visited to make them more effective.

- **Reduction in high attrition rate** is to be understood in it's true context. Emigration patterns of the health workforce for employment and training to be monitored closely to make adjustments in the HRH strategies accordingly.

For effective involvement of Pakistani diaspora, experimentation and discussions are undertaken on **Locum.** Locating and empowering a dedicated unit with appropriate authority will enable informed policy decision in this regard.

- Enhancing **job satisfaction** entails adoption of the following measures:

  - Guaranteeing rights to all health workers, including a service structure, safe and decent work environment and freedom from all kinds of discrimination and violence.
  - Address broader societal barriers that prevent women from joining the health workforce. Such barriers include security issues, sexual harassment in the workplace, women requiring permission from family to work and provisions for life course events such as maternity leave.
  - Ensure respect of the health workers, promote better working environments, clear job descriptions/ competencies required, stimulate personal growth and include at the very least a provision of a decent wage and incentives for equitable deployment and retention.
  - Ensure development and implementation of standards (e.g. minimum of one qualified nurse for 3 general hospital beds and minimum of 1 qualified nurse for one ICU bed) through autonomous healthcare commissions both in public and private sector.

- Ensure occupational health and safety, fair terms for health workers, merit-based career development opportunities and a positive practice environment to enable their effective deployment, retention and adequate motivation to deliver quality care.

3: Health Professional Education and Training

Challenges

- The **institutional imbalances and poor quality health professional education** have led to inequity and inconsistency of health professional's availability causing hindrance in universal access to health services.
- The specific challenges related to **governance of institutions** are the number, range and quality of health professional and training institutions, the disciplinary mix, accreditation to maintain educational standards, management of the applicant pool, and retention of students till graduation.
- Lack of regular and structured **continuous professional development (CPD)** assessments and plans across all types and levels.

Strategic Vision

- New **nursing and midwifery schools** to double the production by 2023 with enhanced quality of professional education, is a must for achieving SDGs' targets. Along with public sector, the private sector to be encouraged to invest more in nursing education. Gender equity to be ensured where feasible, while lower nursing diplomas to be phased out gradually. Institutions of higher learning to be established by federal and provincial governments on priority basis.

  For **Medical and dental education,** emphasis should be on quality, rather than opening of new colleges. However, considering geographical imbalance and market dynamics, medical and dental colleges especially in Balochistan and GB may be considered. Enhancing production capacity of specialists along with mandatory working for all formal post-graduate trainees to serve in underserved districts will address the issue of inequity for availability of health professional.

- Professional health training institutes should use a **thinking 'systems'** approach. Health training institutions to strengthen **six key functions:** i) stewardship or institutional governance; ii) provision of educational services considering health needs (demographics, BoD and epidemics); iii) selection and employment of staff members; iv) financing of training; v) development and maintenance of infrastructure and technology; and vi) generation of information and knowledge.[17]

New nursing and midwifery schools to double the production by 2023 with enhanced quality of professional education, is a must for achieving SDGs' targets

[17] http://www.who.int/whr/2006/chapter3/en/

Task shifting as a policy option can be adopted for increasing the productive efficiency of health care delivery

- Training needs to be associated with complementary services from an employability angle including access to capital, finance, access to information and job-matching services.

After establishing HRH cell at provincial level, regular **assessments** to be carried out to produce **CPD plans.** Different options to be explored to ensure in services training for different health care providers:

- Reactivating/ strengthening the system of Provincial Health Development Centres (PHDCs) and District Health Development Centres (DHDCs), where feasible
- Identifying training institutes at district/ divisional level for CPD
- Assigning the task of developing / adopting short and medium term e-learning and distant learning courses, some of which will be made compulsory to ensure continued learning
- Partnerships with development agencies to arrange in service training courses considering needs
- Use of development programmes for in-built in-service and refresher trainings

4: HR Information Systems

Challenges

- Absence of updated and reliable **health workforce information** employed in the public and private health sector.
- The registration **data of the professional councils is not live** and does not provide information on the actual current status.
- **Inadequate research** which is critical for HRH planning, implementation and monitoring

Strategic Vision

- **Define and adhere to an agreed minimum data set for HRH registry**. Start with electronic conversion of HRH related data of the ministries, departments of health and autonomous health institutions/ bodies. The system at a later stage can consider including NGOs, Civil Society Organizations (CSOs) and the private sector HRH data.
- Establish single **health professional and institutions' live registry system for professional councils and linked with the Pakistan Health Information System** Dashboard for consolidating all HRH data at the national level.
- An HRH information system will allow longitudinal **studies** over extended periods to determine the long term cost effectiveness of interventions by providing cost data on the same, while also addressing the concern of whether policies in the health sector are achieving the desired results.

  Joint reviews / assessments with support of development partners will be organized for lesson learning and further reforms.

Establish single live registry system for professional councils linked with the Pakistan Health Information System Dashboard

Implementation Arrangements

The National HRH Vision paves the way to scaling up health workforce with a medium term, long term and uniform strategy in advancing towards Universal Health Coverage and SDGs. The HRH Vision guides the provincial strategies that will enable the implementation of health workforce interventions. It should also be noted that scaling up will go beyond the quantity aspect, addressing the quality, accessibility and performance concerns.

The federal, provincial/area, district governments, public agencies and autonomous bodies, in accordance with the National HRH Vision, principles and measures spelt out in this document, will implement the strategies in partnership with private sector, NGOs, CSOs and communities.

The process will be overlooked by the **Pakistan Health & Population Strategic Forum,** under the leadership of Federal Minister of Health Services, Regulations and Coordination and to facilitate deliberations and coordination of the government's efforts to significantly improve health and population outcomes in Pakistan. The forum will continue to undertake policy and strategic discussions to reach consensus on measures to strengthen Pakistan's health and population sector and to achieve Vision 2025 and international commitments. The forum will work as a high level advisory and approval body with responsibility to guide and inform the HRH development process and will consider the strategic issues raised by the national HRH task force.

Review of available data/ progress on health workforce in Pakistan and setting strategic directions is the responsibility of a high level **National Human Resources for Health Task Force** - a broad-based committee of stakeholders including ministry, departments, regulatory bodies, international partners, private sector, academia and civil society.

To ensure a multi-sectoral participation and collaboration and to warrant that HRH areas are deliberated upon to provide guidance to evidence based policy decision, the **Health & Population Think Tank** will deliberate, analyze and provide policy solutions as and when required.

M/o NHSR&C has formed a **National HRH Working Group** consisting of Director Program, HPSIU, focal points from all provinces/ areas, PMDC, PNC, Health Services Academy, WHO, donor constituency and other co-opted members. The group collated and analyzed the available HRH related data to produce the Pakistan HRH Vision document. The same group will continue to function to monitor the implementation of HRH Vision and provide technical support to provinces/ areas to translate this into provincial strategic plans.

Similar implementation arrangements will be ensured at provincial/area level to produce, implement and monitor provincial HRH strategies.

Monitoring

The Vision will be implemented in two phases:

Phase I: from 2018 to 2022
Phase II: from 2023 to 2030

Implementation of the Vision will be reviewed in 2022 to make further adjustments in the document, if required. Key performance indicators are:

Indicators for Targets (2018-2022)

1. The percentage of provinces/ areas with an HRH unit responsible for developing, implementing and monitoring HRH policies and plans and coordinating with other departments and stakeholders
2. The percentage of provinces/ areas with a health workforce registry collecting agreed minimum set of data and linked to the National Health Information Dashboard to track health workforce stock and distribution
3. A unified registry for health professional councils established
4. Fully functional accreditation mechanism in the country for medical, nursing, pharmacy and other health professionals and their education institutions
5. The percentage of provinces/ areas with a mechanism (health care commissions) to promote patient safety and adequate oversight of the private sector

Indicators for Targets (2018-2030)

6. Number of health workers (physician, specialists, dentist, pharmacist, nurse, midwife, lady health worker) by gender, province/ area and district level
7. Density of health workers (physician, specialists, nurse, midwife, dentist, pharmacist, lady health worker) per 1,000 population by province /area
8. The percentage of provinces/ areas that have achieved at least an 80 per cent student graduation rate across medical and nursing training institutions
9. Attrition rates among health workers by profession and gender
10. Repository of integrated health workforce assessments and information exchange conducted annually

Universal Health Index
Baseline: 40

International Health Regulations Index
Baseline: 53

HRH related SDG3 Tracer Indicators (2016-2030)

3.cSkilled health professionals (registered physicians including specialists, nurses, LHVs and midwives) density (per 1,000 population) - Baseline: 1.4

3.8.1 Universal Health Index - Baseline: 40

- Physicians per 1,000 population - Baseline: 0.8
    - Psychiatrists per 100,000 population - Baseline: 0.3
    - Surgeons per 100,000 population - Baseline: 1.3

3.d.1 International Health Regulations Index (13 core capacities) - Baseline: 53%

- HRH available to implement IHR core capacity requirements
- Field epidemiology training programme or other applied epidemiology training programmes in place
- Health Workforce Strategy available

Annexure A: Process for the development of HRH Vision

The process for the development of a National and Provincial HRH Strategies started in 2009 with support of the Global Health Workforce Alliance and WHO. However, efforts were interrupted in 2011-12 mainly as a result of the 18th constitutional amendment and abolishment of Ministry of Health. Work on the development of Provincial HRH Strategies and Work plans started in 2012 but could not be completed fully. However,

- Health workforce strategy developed in Sindh in 2012 and revised in 2016
- HRH profile developed in Punjab in 2012
- HRH strategic framework developed in Khyber Pakhtunkhawa in 2016

A new environment emerged in the health sector with redefined roles and responsibilities of the federal and provincial governments after the 18th constitutional amendment in 2011. To execute the federal functions, M/o NHSR&C was created in 2013 with the mandate to provide a common strategic vision to guide the health sector.

National Vision 2025 and the SDGs agenda (endorsed by the Parliament in 2016), focus on Universal Health Coverage, Global and Regional HRH Strategies provided a renewed dimension for reforms in the HRH at national and provincial level. M/o NHSR&C approved a concept note & inception report for the development of HRH Vision and Strategies and activated HRH coordination mechanisms in October 2017 by notifying a national HRH Taskforce and National HRH Working Group. Milestones achieved since then were as following:

- Information gathered and collated by the National HRH Working Group on five HRH areas: i) Information related to Epidemiological and Demographic Transitions; ii) Policies, strategies and Legal frameworks; iii) The Health Workforce Labour Market; v) The Health Professional Education; v) HRH Information systems
- A meeting of National Health 'Think Tank' on 8 December 2017 to deliberate upon HRH issues and to suggest strategic direction. The 'Think Tank' identified four medical universities in the country to have further deliberation on specific HRH topics.
- Meeting of the Inter-Ministerial Health & Population Strategic Forum held on 16 December 2017, and the following time bound decisions were made:

- Send a joint request to WHO EMRO for an HRH Mission in January 2018, to suggest HRH policy and strategic options
- Draft National HRH Vision document by the end February 2018
- Draft Provincial Strategies by the end of April 2018

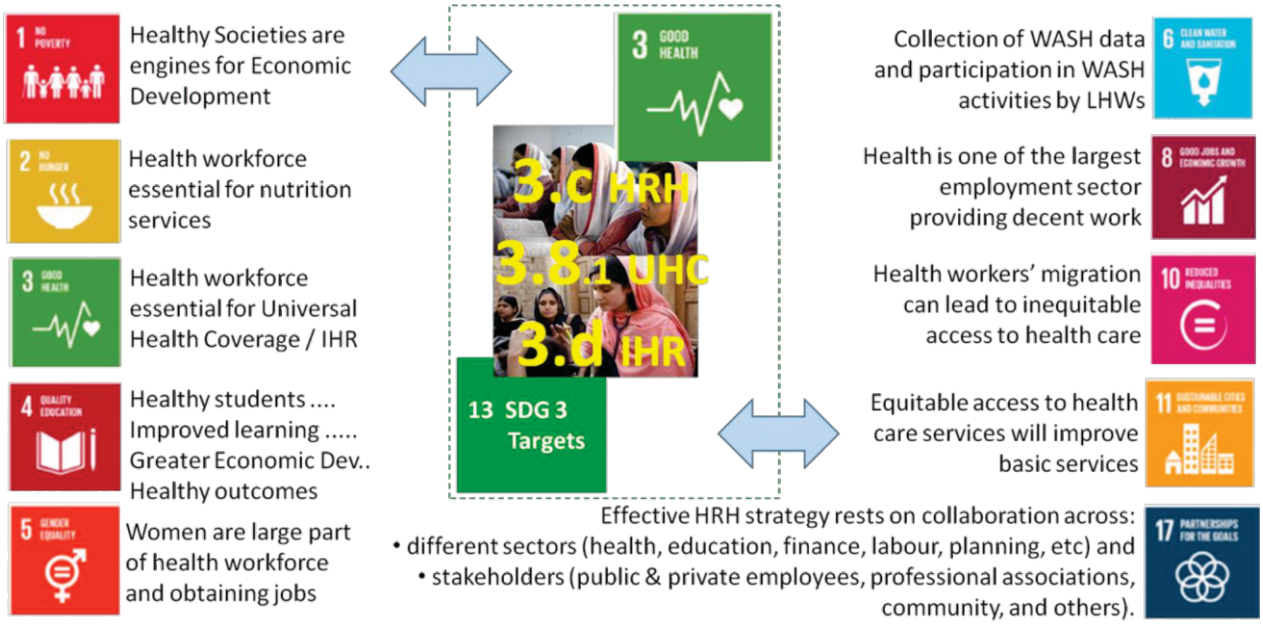
- Meetings of National HRH Working Groups on 22-23 January 2018 and 2 February 2018 to develop consensus on HRH strategic priorities for the draft National HRH Vision and Provincial Strategies
- WHO EMRO mission visited Pakistan 28 January - 2 February 2018 and shared their recommendations on HRH policy and strategic priorities
- Draft HRH Vision developed and shared with stakeholder for review and comments - 26 February 2018
- Joint meeting of National HRH Task Force and National HRH Working Group to review and finalize the HRH Vision - 6 March 2018

The Inter-Ministerial Health & Population Strategic Forum endorsed the National HRH Vision on 4 April 2018. The work on the Provincial HRH Strategies and an assessment to establish standardized HRH Registry has also started.

We salute the health workers who have made the supreme sacrifice by laying down their lives, in the line of duty

Pakistan :
Human Resources for Health

Pivotal for Health Wellbeing,
Economic & Social Development



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