formulating

chapter six
national health workforce strategies

The ultimate goal of health workforce strategies is a delivery system that can guarantee universal access to health care and social protection to all citizens in every country. There is no global blueprint that describes how to get there – each nation must devise its own plan. Effective workforce strategies must be matched to a country's unique situation and based on a social consensus.

The workforce presents a set of interrelated problems that cannot be quickly tidied up or solved by a "magic bullet". Workforce problems are deeply embedded in changing contexts, fraught with uncertainty and exacerbated by a lack of information. Most significantly, the problems can be emotionally charged because of status issues and politically sensitive because of divergent interests. That is why workforce solutions require all stakeholders to be engaged together, both in diagnosing problems and in solving them.

The key is to mobilize political commitment to tackle workforce challenges. But this is difficult because achieving a health impact from an investment in the workforce takes time, extending well beyond election cycles. Disgruntled workers can paralyse a health system, stall health-

sector reform, occasionally even bring down a government. Yet, successful strategies have been demonstrated that can energize the workforce and win public support. The political challenge is to apply known solutions, to craft new approaches, to monitor progress, and to make mid-course corrections.

Previous chapters have focused on dealing with workforce problems through the management of entry, workforce and exit. These aspects determine the performance of a health system and its ability to meet present and future challenges.

However, such problems cannot only be discussed in managerial and technical terms. The perspective of people who use the health care system must also be considered. Their expectations are not about the efficient delivery of cost-effective interventions to target populations; they are about getting help and care when faced with a health problem that they cannot cope with by themselves. In the relationship between individual health workers and individual clients, trust is of paramount importance, and it requires fair governing and effective regulations to build and sustain – which in turn involves leadership, strategic intelligence and capacity building in institutions, tools and training. These essential elements of national workforce strategies are the focus of this chapter.

BUILDING TRUST AND MANAGING EXPECTATIONS

To the general public, the term "health workers" evokes doctors and nurses. While this does not do justice to the multitude of people who make a health care system work, it does reflect the public's expectations: encounters with knowledgeable, skilled – and trustworthy – doctors and nurses who will help them to get better and who will act in their best interests.

Trust is not automatic: it has to be actively produced and negotiated. It is "slowly gained but easily lost in the face of confounded expectations" *(1)*. In many countries the medical establishment has lost its aura of infallibility, even-handedness and dedication to the patient's interests. Fuelled by press reports of dysfunctional health care provision, public trust in health workers is eroding in the industrialized world *(2)* as well as in many developing countries *(3–5)*. Poor people in particular may be sceptical or cynical when talking about their doctors, nurses or midwives: "We would rather treat ourselves than go to the hospital where an angry nurse might inject us with the wrong drug" *(6)*. Trust is jeopardized each time patients do not get the care they need, or get care they do not need, or pay too much for the care they do receive. When patients experience violence, abuse or racketeering in health facilities their fragile trust is shattered.

The consequences of loss of trust go beyond the individual relationship between user and provider. A society that mistrusts its health workers discourages them from pursuing this career. The erosion of trust in health workers also affects those who manage and steer the health system *(7)*. The administrations in charge of the health care system – governments, health-insurance institutions and professional organizations – have to make difficult trade-offs. They have to decide between competing demands: each citizen's entitlement of access to health care goods and services; the need to govern the cost of the uptake of these goods and services; and the needs of the professionals and other human resources who deliver these goods and services. The characteristics of the health sector with its large number of actors, asymmetry of information and conflicting interests make it particularly vulnerable to the abuse of entrusted power for private gain *(8)*. The public no longer takes for granted that these trade-offs are always made fairly and effectively, nor do the front-line health workers.

Strategy 6.1 Design and implement a workforce strategy that fosters trust

The design of a strategy for a national health workforce might include measures actively to produce and negotiate trust in providers and managers of the health system *(9, 10)*. This requires explicit measures that:

- address personal behaviour in the interaction between care providers and patients, between employers and employees, and between managers and institutions (this requires training as well as political leadership, and civil society organizations play a key role);
- set up managerial and organizational practices that give space for responsiveness, caring, interpersonal interaction and dialogue, and support the building of trust;
- take visible steps to eliminate exclusion and protect patients against mismanagement and financial exploitation;
- establish decision-making processes that are seen as fair and inclusive.

FAIR AND COOPERATIVE GOVERNING

Building and sustaining trust and protecting the public from harm require good governance and effective oversight, as well as fair regulation of the operations of health care facilities and the behaviour of health workers. The problem is that, in many countries, the regulatory environment is opaque and dysfunctional. All too often, weak professional and civil society organizations with few resources or little political clout exist alongside an equally weak state bureaucracy that lacks the structures, the people and the political will for the effective regulation of the health care sector.

Self-regulation

In many countries, professional organizations decide who can provide care and how providers should behave. Self-regulation can indeed be effective and positive: professional associations can promote professional ethics and positive role models, sanction inappropriate behaviour, and maintain the technical competence of their members. The way health workers balance their own interests and those of their patients depends to a large extent on what is considered "good professional behaviour" by their teachers and peers. Professional associations can play an active role in shaping that image (see Box 6.1).

Self-regulation by professional associations is not always effective, for a number of reasons. First, unlike doctors and nurses, some categories of health workers are not organized in this way. Second, each professional category tends to have its own organization, which results in energy being wasted in battles over boundaries and in defence of professional privileges. Third, in contrast to Europe and the Americas, where the majority of professional organizations are well established and date back at least 100 years, four out of 10 associations in low income countries are less than 25 years old *(11)*. These younger organizations tend to be under-resourced and less well connected politically, and, crucially, to have less authority over their members.

The professional self-regulation model is also showing signs of strain because employers increasingly override it. This has long been the case where the state is the traditional employer of health workers, but in countries where large numbers of health workers were self-employed and autonomous, most of them now work in an employer–employee relationship. As a result of this "proletarianization" of health workers *(12)*, it is employers and not professional organizations who exert the most influence on professional behaviour. This is the case whether the employer is the state, a not-for-profit nongovernmental organization, a financial corporation or an international organization. This shift to employer-power is so pronounced that, in some countries, health professionals have started to form unions in reaction to employer challenges to their autonomy and income *(13)*. As a result, professional

associations by themselves can no longer claim to provide coherent governance, in the public interest, of the health workforce as a whole.

"Muddling through" and command-and-control

Driven by political pressure for universal access and financial protection, governments have taken an increasingly prominent role in financing and regulating the collective consumption of health care *(14)*. This has overriden the autonomous governance of professional organizations, and self-regulation has been gradually replaced by a more elaborate institutional control by public administration *(15)*.

The way this control operated varied from place to place. In much of Europe and the Americas, where a large part of the workforce was self-employed or employed by private institutions, much of the state's regulatory efforts focused on payment mechanisms and on training and accreditation mechanisms to define the territory of the various health professions. Given the resistance of professional associations to state encroachment on their autonomy, the process of governing health workers was very much a process of "muddling through" a low-intensity conflict *(16, 17)*. There is a tradition, however, of negotiated regulation that has effectively built up the regulatory capacities of state and social security organizations.

In many socialist and developing countries, where a large proportion of health workers are in the employ of government, a more elaborate kind of institutional control has effectively replaced self-regulation. In these countries the public administration tends to rely on a command-and-control approach: the use of hierarchy and administrative rules to govern the health workforce. It is true that a well-functioning command-and-control structure is advantageous in controlling epidemics and responding to environmental catastrophes. As a strategy to regulate and orient the health care market, however, the approach has its limitations.

At worst, when a health system is structurally underfunded or near collapse or the legitimacy of the state is questioned, the command-and-control approach simply does not work. At best, it is ill-adapted to what is expected of health systems today. First of all, administrative rules are a rather blunt instrument to steer the interaction between individual patients and caregivers – particularly when the expectations of the former are rising. Second, such an approach to policy-making and regulation generally focuses on government employees, leaving health workers and institutions

Box 6.1 Self-regulation opportunities

In 2001, a group of national nursing associations, government nurses and regulators from east, central and southern Africa developed and published a prototype regulatory framework and guidance on the accreditation of nursing and midwifery education programmes. As a result, those countries in the region that already had registers have begun moving away from lifetime registrations to ones that require periodic licensure.

In Uganda, the registrar of the Nurses and Midwives Council recently closed down a number of health training schools that did not meet the required standards. These measures were taken despite the fact that some of the schools that were closed, and some of the students who were affected, had powerful connections in political and senior civil service circles.

In Angola, the national nurses associations and the Order of Nurses of Portugal are equipping districts with nursing textbooks.

In Thailand, the Rural Doctors Association has played an important role in ensuring the commitment – and the presence – of doctors in rural and underserved areas.

The "evidence-based medicine" movement is another way of self-regulating the behaviour of health-care providers in a manner that serves the public interest.

outside the public sector to take care of themselves. The regulations that do exist (e.g. prohibiting moonlighting in private practice) are not or cannot be enforced. The failure of the traditional command-and-control approach to stem the unregulated commercialization of the health sector *(18)* has contributed greatly to the erosion of trust in health care providers and in health systems.

Watchdogs and advocates

Civil society organizations that act on behalf of citizens (consumer groups, HIV/AIDS activists, etc.) have gained a large amount of influence in the health sector. These organizations have often had an important role for a long time in resource mobilization and improving health care delivery. In more recent years they have also found many ways to put pressure on providers, professional associations and health care bureaucracies and institutions *(3)*. Some provide citizens with information that puts them in a stronger position when they have to deal with a health care provider. In France, for example, the lay press publishes a ranking of hospitals in the performance of different procedures

Other civil society groups function as watchdog organizations to sound the alarm when citizens are denied their health entitlements or are discriminated against. In Sierra Leone, for example, women's groups demonstrated in the streets of Freetown demanding that the military government guarantee emergency care for all pregnant women, following newspaper reports that women had died after being denied treatment they could not afford. In many countries, civil society groups contribute to priority setting by participating in the planning process, as in Bangladesh *(19)*, or by providing checks and balances on government budgeting, as in Mexico *(20)*.

Consumer defence movements are gaining strength because they can push for mechanisms to be put in place to protect people against exclusion, poor-quality care, over-medicalization and catastrophic expenditures. They can also ensure that procedures are adopted that give people the possibility to redress harm. It is clear that a great many people currently lack such protection. For example, in contrast to industrialized countries, regulation of fees charged by private institutions or self-employed care providers is almost non-existent in most developing countries. Even where regulations exist, governments may have major problems enforcing them *(21)*. There are three results: first, each year approximately 44 million households worldwide are faced with catastrophic health expenditures *(22)*; second, many more people are excluded from access to care; and third, this situation favours supply-induced over-medicalization *(23)*. One example is the high incidence of caesarean sections around the world *(24)*. Within a single country, mothers with the financial means may be subject to an unnecessary and potentially dangerous intervention, while the same procedure is denied to another who needs it to save her life or that of her baby but who cannot mobilize the funds.
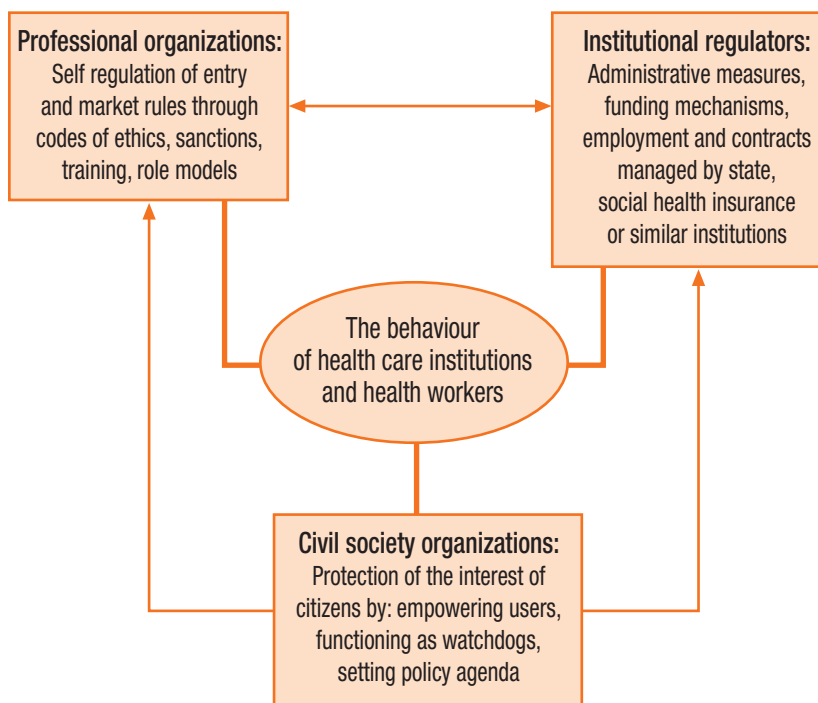
A model for effective governance

None of the models described above – self-regulating professional associations, the command-and-control approach of institutional regulators, and the advocacy of civil society – is sufficient on its own to regulate the behaviour of health workers and institutions. Rather than relying on one single regulatory monopoly, national health workforce strategies should insist on cooperative governing. Regulations resulting from the participation of all three bodies, as well as health care institutions and the workforce, are more likely to generate trust and cooperation.

Strategy 6.2 Ensure cooperative governance of national workforce policies

In order to ensure public safety and good governance of health care providers, capacity building requires investment in the overall regulatory architecture outlined in Figure 6.1. Simultaneous efforts are needed to reinforce the potential contributions of the state and social insurance institutions, as well as those of professional and civil society organizations. This means that, along with the creation of the specific technical bodies for licensing, accreditation and so on, forums must be established that allow for interaction among these various groups, which in turn implies the recognition and support, including financial, of their contributions *(19)*. Ministries of health may be reluctant to strengthen the very institutions that act as checks and balances on their own work, but in the long run it is in their own interest to have a strong system of dialogue and cooperation.

Figure 6.1 Organizations influencing the behaviour of health workers and the health institutions

Professional organizations:
Self regulation of entry
and market rules through
codes of ethics, sanctions,
training, role models

Institutional regulators:
Administrative measures,
funding mechanisms,
employment and contracts
managed by state,
social health insurance
or similar institutions

The behaviour
of health care institutions
and health workers

Civil society organizations:
Protection of the interest of
citizens by: empowering users,
functioning as watchdogs,
setting policy agenda

STRONG LEADERSHIP

Because the health workforce is a domain of many conflicting interests, policy-making cannot be exclusively consensual and sometimes there has to be the possibility of arbitrage. Without strong leadership, national policies tend to flounder in a combination of ad hoc solutions, many of which focus on defending the interests of particular professional categories and create problems of their own. National leadership is necessary to initiate the process, push for breakthroughs, engage key stakeholders (workers, government and civil society), promote the synergistic roles of each, and encourage them to adopt a partnership approach.

The responsibility for that leadership lies with public authorities: the policy-makers and managers of the public and parapublic sectors. In recent years, however, little or no investment has been made in leadership in the public sector. In an environment of widespread scepticism about public sector and state involvement, stewardship functions have suffered from the stranglehold of macroeconomic constraints on public sector development, along with, if not more than, other public health functions.

The need for administrative and stewardship capacities is perhaps most obvious in extreme situations, such as post-conflict reconstruction in Afghanistan or the Democratic Republic of the Congo. It is also evident in many stable countries, where sector-wide approaches or poverty reduction strategies fail to perform as expected for want of leadership capacity, or where the unregulated commercialization of the health sector is undermining both workforce and health system performance.

Leadership is also crucial to deal with competing vested interests and to obtain high-level political endorsement of health workforce strategies. The work of the "change team" that brought about the health reforms in Colombia in the early 1990s exemplifies some of the tactical capacities that are crucial to successful reform *(25)*. At an early stage the team strictly controlled access to the decision-making process, and drew attention away from the health reforms by including proposals in a wider social security reform, the main spotlight of which was on pensions. Nevertheless, the team understood the need to allow certain voices, such as those of senators, to be heard. In working with groups that championed change, they focused their attention on the development of new institutions, such as new insurance agencies, that would take part in the new system. The reform of the old institutions, which would clearly be difficult, was tackled in a later phase.

Developing leadership skills depends on leadership structures and tactical capacities. The lack of both is recognized. The problem is that most people are inclined to believe that political know-how is an innate quality and therefore ill-suited to capacity building. Those who have attempted to develop training courses for leadership have often come to the disenchanting conclusion that they did not make a great deal of headway. There is little empirical evidence on what, if anything, can be done. Interviews with policy-makers, however, show that individual tactical capacities are built through coaching and mentoring, particularly within structured projects, whereas the strongest influence on the creation of the leadership structures comes from the organized sharing of knowledge and experiences with other countries. Coaching, mentoring and intercountry exchange are less straightforward capacity-building tools than training, but they can be organized. If this could be done effectively and on a large scale, it would help remove one of the key constraints to health worker development – the lack of people and structures to provide policy leadership, even in resource-poor or fragile countries.

STRENGTHENING STRATEGIC INTELLIGENCE

In all too many cases, the health workforce information that is available to national decision-makers is extremely poor. Many, if not most, ministries of health, for example, do not know how many health professionals there are in the country, let alone how they are distributed. That major stakeholders have such poor knowledge of their own situation underscores the lack of connection between the acuteness of human resources problems and a coherent policy response.

Strategy 6.3 Obtain better intelligence on the health workforce in national situations

For a thorough understanding of health workforce problems, systematic work is required in four areas: the extent and nature of the problem in the specific national context; what is being done and what can be done; the national politics around the issue; and the potential reactions of health workers and the institutions that employ them.

Extent and nature of the national workforce problem

In most countries, this information is patchy at best. Among others, Malawi has recently demonstrated that a proper understanding of the nature of local health worker problems can help it to make a quantum leap in the formulation of more coherent policies and strategies *(26)*. Accurate information on medical demography, shortages and oversupply is essential, but there is also a need to cover the range of problems that relate to entry, workforce and exit as well as to performance and trust; there is a need to cover the entire range of health workers, not merely doctors and nurses, and not merely the public sector; and there is a need to look at what there is in the field as well as at the expectations of the staff and the public, in the light of the present crisis and the future challenges.

Action taken and further options

This is an area where even less is being done than in documenting the magnitude and determinants of health workforce problems. Much can be learnt from innovation and problem-solving which takes place at the grass-roots level and escapes the notice of policy-makers. Making assessments of actions and options requires specific skills as well as a systematic and institutional approach that involves inventory keeping, monitoring, evaluation, documentation and exchange. Much can also be learnt from experiences in other countries; that assessment, too, has to be carried out in a systematic way, with methodical evaluation, sharing and exchange.

National politics around the health workforce

To build a workable strategy by changing a dysfunctional situation, it is often useful to understand the forces that have created such a situation in the first place: otherwise there is a real risk of making a bad situation worse. Much of the rigidity that characterizes the public sector workforce, for example, comes from attempts to protect the workforce from political interference: ill-thought-out policies to create more flexibility may then introduce opportunities for discrimination and favouritism, which would add to the malfunction. To take another example, if the reason for excessively centralized human resource management is insufficient management expertise or a lack of accountability mechanisms at more decentralized levels, then rapid administrative decentralization may not be a wise choice.

Reactions of health workers and their employers

The good intentions of policy-makers when designing health system structures, processes and reform programmes are often undermined by a failure to consider how health workers are likely to respond. It is of particular importance to understand the reasons for their resistance to change. For example, one would expect staff in a centralized system to welcome the increased autonomy that comes with decentralization. In Uganda and Zimbabwe, however, decentralization was perceived as a threat to job security and raised concerns that the politics of ethnicity would govern both recruitment and personnel *(27, 28)*. Where public services are downsized or shifted to the private sector, health workers can experience the triple stress of fear of job loss, fear of failure to secure alternative employment, and growing workload *(29)*. In other situations, health workers may resist change because they are uncomfortable with the increased responsibility associated with reform proposals. It is possible to prevent many of these problems through a better understanding of the reactions of the different stakeholders. Informal dialogue goes a long way towards achieving such understanding, but it is also possible to organize more systematic exercises in order to appreciate potential reactions *(30)*.

INVESTING IN WORKFORCE INSTITUTIONS

When governments have little capacity for policy design, regulatory measures are easily appropriated by interest groups. Policy-making then becomes ineffective at best and counter-productive at worst. Some countries have done well: Malawi's human resource plan is one example (see Box 2.2). In recent years, however, most countries have not made adequate investments in developing policy-making and regulatory capacities. Indeed, during the 1990s a considerable number of health departments in ministries of health around the world fell victim to public sector downsizing and rationalization.

Building or rebuilding country capacities for policy-making in health care delivery requires much more than just tools and training: there is a hierarchy of tools, people and structures *(31)*. Without the policy-makers and managers who can interpret and contextualize the output of costing and budgeting tools, making such tools available and training staff to implement them will be of little benefit. At the same time, without the institutions, structures and committees that have the authority to make decisions, managers and policy-makers have no way of transforming intellectual exercises into political facts.

National-level health workforce institutions are needed to build public trust, facilitate fair and cooperative governing, produce strong leaders, and gather strategic intelligence. These reasons alone should be enough to justify their financing, but in reality it is not easy for policy-makers to sell the idea that such institutions need to be built and strengthened – if only because of the long time perspective and the lack of visibility of issues such as return on investment.

Since investment in training or tools is more readily accepted and since significant amounts of funding are now being directed towards training, the way forward is probably to link these directly to institution building. The key is to identify specific areas where insufficiencies are greatest and where distinct institutional efforts can yield concrete results.

Some of these efforts have already been discussed in previous sections of this chapter: building capacity for regulation; leadership structures and tactical capacities; and strategic information on core indicators. Two other areas that warrant

highlighting are learning from microlevel innovations and scenario building and planning. Both are explored below; they can best be organized through the creation of national health workforce observatories (see Box 6.2) or by linking ministry of health departments, academic institutions and nongovernmental organizations in learning networks and communities of practice.

Learning from microinnovations

Perhaps nowhere has there been as much creative problem-solving and innovation at the microlevel as in the health workforce. Many examples have been mentioned throughout this report. The idea is to learn from these innovations, encouraging what works and discouraging what does not. Making these assessments requires specific skills as well as a systematic and institutional approach that involves inventory keeping, monitoring, evaluation, documentation and exchange.

An accurate assessment is necessary in order to decide which actions merit inclusion in a national health worker strategy: they must be cost-effective, provide quick results, correct present distortions and prevent further deterioration of health care services *(34)*. One such innovation was a stop-gap solution for a lack of doctors in one area of Mozambique, where *tecnicos de cirurjia*, or assistant medical officers, were trained in surgical skills. Their excellent results led policy-makers to generalize the experiment and today *tecnicos de cirurjia* are a characteristic feature of district hospitals across the country *(35)*.

Box 6.2 Human resources for health observatories in Latin America

National observatories for human resources for health were set up in 22 countries in 1998 as part of an initiative by the Pan American Health Organization (PAHO), WHO's Regional Office for the Americas, to counteract the neglect of health workforce issues in Latin America during the 1980s and early 1990s. PAHO established an Observatory of Human Resources in Health to link these national observatories, which have helped raise the profile of the health workforce agenda, improve the information base, and strengthen health sector stewardship *(32)*. The observatories provide continuity in settings where there may be a significant turnover of decision-makers and policies. Their common characteristic is multiple stakeholder participation involving universities, ministries of health, professional associations, corporate providers, unions and user representatives.

The institutional arrangements, however, are specific to each country. The Brazilian Observatory *(33)* provides a number of important lessons about state–non-state interactive capacity building. It consists of a network of university institutes, research centres and one federal office dealing with human resources for health. There are 13 network "nodes" or "workstations" coordinated by a secretariat staffed by the Ministry of Health and the Brasilia office of PAHO. The Observatory's remit since 1999 has been to contribute to, and inform the development, regulation and management of, human resources in the health sector and related policy areas.

The Observatory has produced much valuable information and analytical work and its capacities have developed considerably. It has built on existing informal networks where managers and academics were motivated by professional interest in investigating the relevance of planning, management and training in human resources for the health sector. Much of the network's success and resilience can be attributed to the initial focus on content as well as to its working style. The focus on content allowed network members to build their technical and professional capabilities in a spirit of intellectual independence and autonomy that continues to characterize interactions today. The style of working is characterized by flexibility, creativity, pragmatism, inventiveness and entrepreneurial spirit . The combination of pursuing technical excellence and informal collaboration resulted in group learning, and consolidated shared ideas.

On this basis the networks were formalized and institutionalized in the late 1990s. This move further enhanced productivity, largely by intensifying exchanges nationally and internationally with the help of a number of personalities in Brazil and in other countries.

The Brazilian Observatory shows that informal networking can develop into more formal structures that produce concrete outputs and outcomes. Within the network there are demands for an intensification of exchanges in terms of content and policy relevance, and for the introduction of monitoring and evaluation mechanisms to ensure quality and relevance of the network's outputs.

Scenario building and planning

Scenario building and planning, which are essential to determine long-term orientations, also require specific capacities that lend themselves to an institutional approach. National strategists have to make fundamental choices that define what the future workforce will look like and how it will relate to the value systems of the society in which it operates. The demands on health workers are changing fast, and one can only guess what they will be in the future, but the time of omniscient professionals working on their own is definitely past. The provision of health care in the future lies in teamwork, with overlapping and complementary skills that constantly adapt to rapid changes in society and technology. At the same time, the health care team will be asked to be much closer to their clients, with a family doctor type of contact point who acts as the hub for the team and as the interface between clients and the health system. The model of separate and independent health care professions will soon be overtaken.

More than a planning problem, preparing for these changes is a matter of organizing a broad discussion around entitlements and scenarios for the future. Such discussions may emerge from the civil society movement as in Thailand *(36)*, from local authorities as in Oregon, United States *(37),* or from the public health establishment as in New Zealand or the Netherlands *(38, 39)*. Debates on scenarios for the future have to take into account the spectrum of drivers shaping the workforce, including changing health needs, demographic trends such as ageing, consumer expectations, growth in private health services, and the global labour market for health workers (see Figure 2 in the Overview to this report). In terms of content, future scenarios are likely to focus on the tensions between commercialization on the one hand and universal access and social protection on the other, and between a technocratic disease orientation and social demands for a more patient-centred approach.

It is the process that is of prime importance. Just as fair governance requires cooperation, so too does planning for the future. Experience from priority-setting debates shows that the legitimacy of the choices that are made is less a function of what is actually decided than the perception of procedural fairness *(40)*. If the way decisions are made is inclusive and transparent, societal support follows. There is a clear association between the intensity of dialogue with multiple stakeholders and the strength and sustainability of the policy choices *(30, 41)*. A failure to be inclusive means that opportunities are missed and resistance and resentment build up.

CONCLUSION

National health workforce strategies must move beyond salary and training in the public sector to strategies for the entire work cycle of entry–workforce–exit in both the public and private sectors. Workforce development is both a technical and political exercise, requiring the building of trust among stakeholders and linking people's expectations with health worker performance.

Whether in fragile states focusing on short-term and medium-term perspectives, or in more stable countries that focus on longer-term strategies that command more resources, the quality and the success of policy-making and regulation depend firstly on the inclusion of key stakeholders. Also crucial are the availability of people and resources to carry out the policy formulation work, and the capacity to base the policy on a proper understanding of the nature of the problems.

All country strategies should prioritize the following actions.

- Build national strategies out of concrete action points that cover management of entry, workforce and exit as well as: building or rebuilding trust; multi-stakeholder management of the regulatory environment; and leadership capacities.
- Pay attention to the process. The choices to be made may be difficult and controversial: it is essential to ensure procedural fairness by being inclusive and transparent, but with the courage to arbitrate when vested interests are taking over.
- Strengthen strategic intelligence, focusing on: (i) understanding the extent and nature of health workforce problems; (ii) evaluating what is being done and determining what can be done; (iii) identifying the political drivers that led to the current situation; and (iv) understanding workers' viewpoints and anticipating their possible reactions to change.
- Build the country's health workforce institutional capacity, with a focus on regulation, leadership and strategic information, including: (i) analysis and evaluation of microinnovations; and (ii) scenario building and planning for the future.

REFERENCES

1. Davies H. Falling public trust in health services: implications for accountability. *Journal of Health Services Research and Policy*, 1999, 4:193–194.

2. Mechanic D. Changing medical organization and the erosion of trust. In: Conrad P, ed. *The sociology of health and illness*, 6th ed. New York, NY, Worth Publishers, 2001:198–204.

3. Van Lerberghe W, Ferrinho P. *Civil society organizations and the poor: the unfulfilled expectations.* Washington, DC, The World Bank, 2003 (background paper 28028 for *World Development Report 2004*).

4. Gilson L. Trust and the development of health care as a social institution. *Social Science and Medicine,* 2003, 56:1453–1468.

5. Jaffré Y, Olivier de Sardan JP. *Une médecine inhospitalière: les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest [Inhospitable medicine: difficult relations between carers and cared for in five West African capital cities].* Paris, Karlhala, 2003.

6. Narajan D. *Voices of the poor: can anyone hear us?* New York, NY, Oxford University Press, 2000:97.

7. Robinson R. Rationing health care: a national framework and local discretion. *Journal of Health Services Research and Policy*, 1997, 2:67–70.

8. Transparency International. *Corruption and health. Global corruption report 2006.* London, Pluto Press, 2006.

9. Benington J. Risk and reciprocity: local governance rooted within civil society. In: Coulson A, ed. *Trust and contracts: relationships in local government, health and public services.* Bristol, The Polity Press, 1998.

10. Taylor-Gooby P. Markets and motives: Trust and egoism in welfare markets. *Journal of Social Policy*, 1999, 28:97–114.

11. Mercer H, Ineson S, McCarty P. *National regulation of medical profession capacities.* Geneva, World Health Organization, 2006 (background paper for *The world health report 2006*; available at: http://www.who.int/hrh/documents/en/).

12. McKinlay JB, Stoeckle JD. Corporatization and the social transformation of doctoring. In: Conrad P, ed. *The sociology of health and illness,* 6th ed. New York, NY, Worth Publishers, 1999:175–185.

13. Krause EA. *Death of the guilds. Professions, states and the advance of capitalism, 1930 to the present.* New Haven and London, Yale University Press, 1996.

14. Frenk J, Donabedian A. State intervention in medical care: types, trends and variables. *Health Policy and Planning*, 1987, 2:17–31.

15. Moran M. *Governing the health care state. A comparative study of the United Kingdom, the United States and Germany.* Manchester and New York, Manchester University Press, 1999.

16. Lindblom CE. The science of "muddling through". *Public Administration Review*, 1959, 19:79–88.

17. Bennet AE, Holland WW. Rational planning or muddling through? Research allocation in the NHS. *Lancet*, 1977, 8009:464–466.

18. Bloom G, Standing H. *Pluralism and marketisation in the health sector: meeting health needs in context of social change in low and middle-income countries.* Brighton, Institute of Development Studies, 2001 (IDS Working Paper 136).

19. Jahan R, Germain A. Mobilizing support to sustain political will is the key to progress in reproductive health. *Lancet*, 2004, 364:742–744.

20. *Dignity counts: a guide to using budget analysis to advance human rights.* Mexico, Fundar, 2004 (International Budget Project, International Human Rights Internship Program).

21. Van Lerberghe W, el Rashidi AR, Sales A, Mechbal A. Reform follows failure: unregulated private care in Lebanon. *Health Policy and Planning,* 1997, 12:296–311.

22. Xu K, Evans D, Carrin G, Aguilar-Rivera AM. *Designing health financing systems to reduce catastrophic health expenditure.* Geneva, World Health Organization, 2005 (Department of Health System Financing, Technical Brief for Policy-Makers, No. 2).

23. Pongsupap Y, Van Lerberghe W. Choosing between public and private or between hospital and primary care? Responsiveness, patient-centredness and prescribing patterns in outpatient consultations in Bangkok. *Tropical Medicine and International Health*, 2006, 11:81–89.

24. *The world health report 2005 – Make every mother and child count*. Geneva, World Health Organization, 2005.

25. Gonzalez-Rossetti A. *Enhancing the political feasibility of health reform: the Colombia case*. Data for Decision-making Project, 2000 (Health Sector Reform Initiative, Paper No. 39; http://www.hsph.harvard.edu/ihsg/publications/pdf/lac/Colombiafinal-pp2.PDF, accessed 22 February 2006).

26. Palmer D. *Human resources for health case study: Malawi's emergency human resources programme*. DFID–Malawi, December 2004.

27. Pangu KA. Health workers motivation in decentralized settings: waiting for better times? In: Ferrinho P, Van Lerberghe W, eds. *Providing health care under adverse conditions: health personnel performance and individual coping strategies*. Antwerp, ITG Press, 2000 (Studies in Health Services Organization and Policy, 16):19–29.

28. Mutizwa-Mangiza D. *The impact of health sector reform on public sector health worker motivation in Zimbabwe*. Bethesda, MD, Abt Associates, 1998 (Partnerships for Health Reform, Major Applied Research 5, Working Paper No. 4).

29. Wiscow C. *The effects of reforms on the health workforce*. Geneva, World Health Organization, 2005 (background paper for *The world health report 2006,* available at: http://www.who.int/hrh/documents/en/).

30. Ammar W. *Health system and reform in Lebanon*. Beirut, Entreprise universitaire d'Etudes et de Publications, 2003.

31. Potter C, Brough R. Systemic capacity building: a hierarchy of needs. *Health Policy and Planning*, 2004, 19:336–345.

32. Rigoli F, Arteaga O. *The experience of the Latin America and Caribbean Observatory of Human Resources in Health* http://www.lachsr.org/en/observatorio.cfm, accessed 22 February 2006).

33. Campos FE, Hauck V. *Networking collaboratively: The Brazilian Observatório on Human Resources in Health. A case study prepared for the project 'Capacity, Change and Performance'*. Maastricht, European Centre for Development Policy Management, 2005 (Discussion Paper, 57L); http://www.ecdpm.org/Web_ECDPM/Web/Content/Navigation.nsf/index2?ReadForm, accessed 22 February 2006).

34. *Rehabilitating the workforce: the key to scaling up MNCH* (*The world health report 2005*, Policy Brief 2). Geneva, World Health Organization, 2005.

35. Vaz F, Bergstrom S, Vaz Mda L, Langa J, Bugalho A. Training medical assistants for surgery. *Bulletin of the World Health Organization,* 1999, 77:688–691.

36. Tangcharoensathien V, Jongudomsuk P. *From policy to implementation: historical events during 2001-2004 of universal coverage in Thailand*. Bangkok, National Health Security Office, 2004.

37. Kitzhaber JA. Prioritizing health services in an era of limits: the Oregon experience. In: R Smith, ed. *Rationing in action*. London, BMJ Publishing Group, 1993.

38. *Core services 1993/4*. Wellington, National Advisory Committee, 1992.

39. *Choices in health care: a report by the Government Committee on Choices in Health Care*. Rijswijk, Ministry of Health, Welfare and Cultural Affairs, 1992.

40. McKee M, Figueras J. Setting priorities: can Britain learn from Sweden? *BMJ,* 1996, 312:691–694.

41. Stewart J, Kringas P. *Change management – strategy and values: six case studies from the Australian public sector*. University of Canberra, Centre for Research in Public Sector Management, 2003 (http://www.dmt.canberra.edu.au/crpsm/research/pdf/stewartkringas.pdf, accessed 21 February 2006).