

CHAPTER 7

COUNTRY PROFILES



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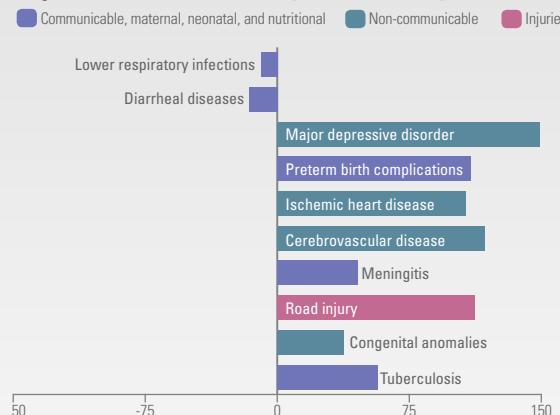
AFGHANISTAN

Approximately 57% of the Afghan population has access to basic health care, although coverage is much lower in hard-to-reach areas. Out-of-pocket expenses account for up to 79% of total health expenditure, despite the abolition in 2008 of formal user fees in public health facilities. There is a high burden of communicable diseases, with limited progress towards achieving Millennium Development Goal 4, and also a high and increasing burden of noncommunicable diseases such as heart disease, stroke and depressive disorders. The availability of skilled health professionals (9.4 per 10,000 population) is low, and mechanisms for accreditation, regulation and licensing require improvement. Planning for human resources for health has therefore been a priority for the government, with the development of multiple policies and collaborative forums, but effective implementation is a challenge. Although the planned development of a five-year strategy for human resources for health is a positive sign, effectively implementing it will require clear resource commitments.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	28.4; 46; 4 (2010)
Average annual rate of population change (%)	2.4 (2010-2015)
Population living in urban areas (%)	24 (2011)
Gross national income per capita (PPP int. \$)	1140 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	9.6 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	16 (2011)
External resources for health as a percentage of total expenditure on health (%)	16.4 (2011)
Life expectancy at birth (years) [all; female; male]	60; 61; 59 (2011)
Total fertility rate (per woman)	6.3 (2010)
Neonatal mortality rate (per 1,000 live births)	36 (2011)
Infant mortality rate (per 1,000 live births)	73 (2011)
Under-five mortality rate (per 1,000 live births)	101 [84-126] (2011)
Maternal mortality ratio (per 100,000 live births)	460 [250-850] (2010)
Births attended by skilled health personnel (%)	36.3 (2011)
Antenatal care coverage - at least one visit (%)	45.5 (2011)
Antenatal care coverage - at least four visits (%)	14.6 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	66 (2011)
Postnatal care visit within two days of birth (%)	23.4 (2010)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Afghanistan. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

1036% increase to meet 22.8/10,000 threshold

1619% increase to meet 34.5/10,000 threshold

2860% increase to meet 59.4/10,000 threshold

FEASIBILITY
POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional)
PER 10,000 POPULATION (Estimated 2010)

ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

0.6
Physicians

NATIONAL AVERAGE

1.9
Physicians

SUB-NATIONAL HIGH

7.2
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).



TO



1
Physician

NO DATA



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

REGULATE:

Dentists	?
Midwives	✓*
Nurses	✓*
Pharmacists	?
Physicians	?

LICENSE/RE-LICENSE:

Dentists	?
Midwives	✓*
Nurses	?
Pharmacists	?
Physicians	?

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?

informed by data and strategic intelligence?

addressing pre-service education?

addressing geographical distribution and retention?

addressing health workforce performance (e.g. competence, responsiveness and productivity)?

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?

For which period? **2012-2016**

Does the strategy/plan account for the financial costs and resource requirements to implement it?

= Yes = Partial = No = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

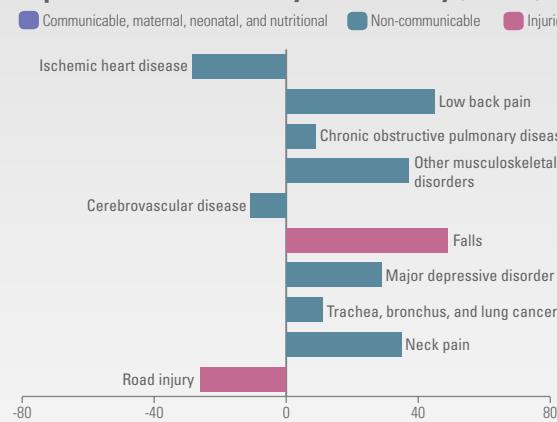
AUSTRALIA

Medicare Australia, a universal tax-funded health insurance system introduced in 1984, provides medical, pharmaceutical and hospital treatment to all permanent residents. Public hospital care is free of user charges, and access to doctors of choice for out-of-hospital care and prescription drugs is subsidized. For services not referred by a general practitioner and for all other out-of-hospital services, Medicare coverage is 85%. Private insurance covers some services such as long-term care, dental treatment and home nursing. Private expenditure represents 31.5% of total expenditure on health, and 63% of this is out of pocket. In 2011, about 45% of the population had private insurance coverage. Australia has a 2.3 ratio of nurses to physicians and 38% of the total physicians are women. The density of physicians varies from 38.3 per 10,000 population in major cities to 16.3 in very remote areas; to tackle this problem, the government has introduced incentives and education and training support. Relicensing, conditional on producing evidence of relevant continuous professional development, is compulsory for physicians, nurses, midwives, dentists and pharmacists.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	22.4; 19; 19 (2010)
Average annual rate of population change (%)	1.3 (2010-2015)
Population living in urban areas (%)	89 (2011)
Gross national income per capita (PPP int. \$)	38110 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	9.0 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	69 (2011)
External resources for health as a percentage of total expenditure on health (%)	—
Life expectancy at birth (years) [all; female; male]	82; 84; 80 (2011)
Total fertility rate (per woman)	1.9 (2010)
Neonatal mortality rate (per 1,000 live births)	3 (2011)
Infant mortality rate (per 1,000 live births)	4 (2011)
Under-five mortality rate (per 1,000 live births)	5 [4-6] (2011)
Maternal mortality ratio (per 100,000 live births)	7 [4-12] (2010)
Births attended by skilled health personnel (%)	99.1 (2009)
Antenatal care coverage - at least one visit (%)	97.1 (2009)
Antenatal care coverage - at least four visits (%)	91.2 (2009)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	92 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Australia. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

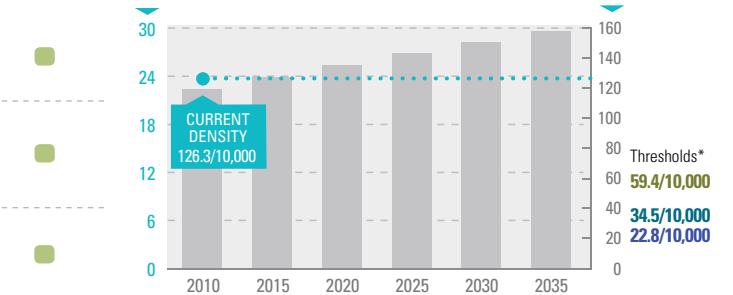
0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

16.3
Physicians

NATIONAL AVERAGE

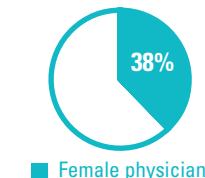
38.5
Physicians

SUB-NATIONAL HIGH

38.3
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

REGULATE:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

LICENSE/RE-LICENSE:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓/✗

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2011-2015

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✗

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

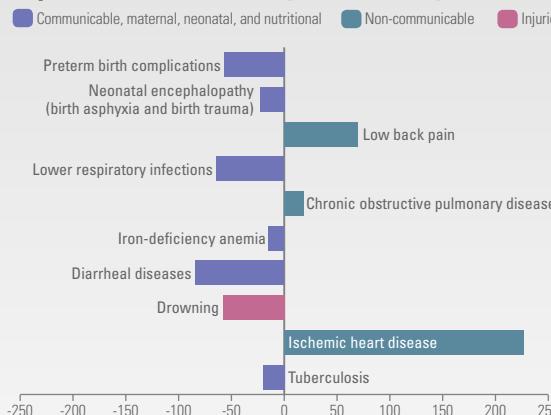
BANGLADESH

The health system is a mix of public, private and nongovernmental organization providers, with private expenditure on health comprising 63% of total health expenditure. The burden of communicable diseases is high yet declining, and the country has made good progress towards meeting Millennium Development Goals 4 and 5. Despite this, there are challenges across the domains of the availability, accessibility, acceptability and quality of the health workforce. The density of skilled health professionals is below indicative thresholds, which may present difficulty for successfully scaling up to meet these by 2035. However, concerted efforts are being made in this regard, especially as regards midwives, with the introduction of innovative training models. There are wide disparities in the distribution of the health workforce, with great variation in the density of physicians between regions. The physician workforce is 21% women, and the ratios of nurses to physicians are below the 2.5 OECD average. Further, evidence indicates that mechanisms for regulating and licensing the health workforce require strengthening. This may indicate that, while the existing human resources for health strategy from 2008 and accompanying policies appear to adopt good practice, they are not yet being fully implemented. However, positive efforts are being made to review and revitalize health professional education as part of a five-country network involving China, India, Thailand and Viet Nam.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	151.1; 31; 7 (2010)
Average annual rate of population change (%)	1.2 (2010-2015)
Population living in urban areas (%)	28 (2011)
Gross national income per capita (PPP int. \$)	1940 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	43.25 (2010)
Total expenditure on health as a percentage of gross domestic product (%)	3.7 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	37 (2011)
External resources for health as a percentage of total expenditure on health (%)	6.6 (2011)
Life expectancy at birth (years) [all; female; male]	70; 70; 69 (2011)
Total fertility rate (per woman)	2.2 (2010)
Neonatal mortality rate (per 1,000 live births)	26 (2011)
Infant mortality rate (per 1,000 live births)	37 (2011)
Under-five mortality rate (per 1,000 live births)	46 [41-51] (2011)
Maternal mortality ratio (per 100,000 live births)	240 [140-410] (2010)
Births attended by skilled health personnel (%)	31.1 (2011)
Antenatal care coverage - at least one visit (%)	49.8 (2011)
Antenatal care coverage - at least four visits (%)	25.5 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	96 (2011)
Postnatal care visit within two days of birth (%)	27.1 (2011)

Top 10 causes of morbidity and mortality (DALYs)



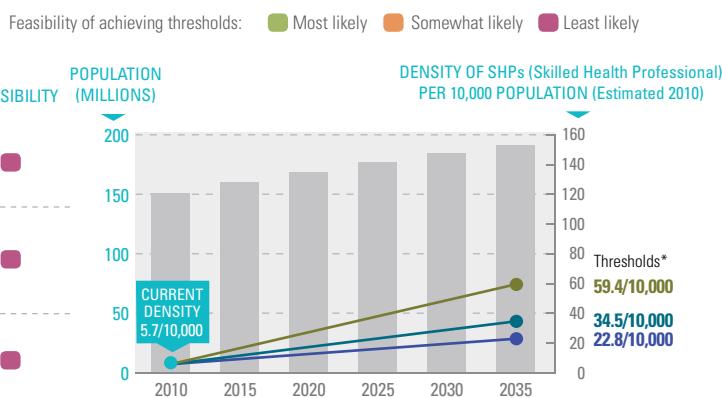
Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Bangladesh. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

- 404% increase to meet 22.8/10,000 threshold
- 662% increase to meet 34.5/10,000 threshold
- 1213% increase to meet 59.4/10,000 threshold



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW NATIONAL AVERAGE SUB-NATIONAL HIGH

1.3
Physicians

3.6
Physicians

10.8
Physicians

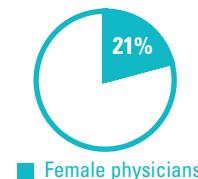
ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

.5
Nurses

TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2008

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Yes Partial No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

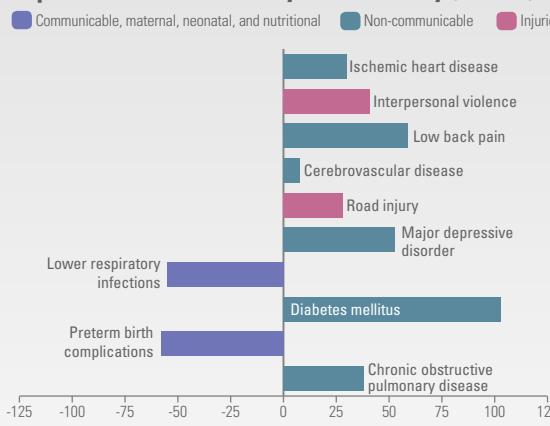
BRAZIL

Brazil recognized universal access to health care as a fundamental right in its Constitution of 1988 and created the Unified Health System (SUS) to provide free comprehensive care and essential medicines to all citizens. In parallel to the SUS, a private subsystem covers predominantly those with capacity to buy private insurance or whose employer provides health coverage – resulting in a two-tiered system. Private expenditure, of which 58% is out of pocket, represents 55% of total health expenditure. The nurse-to-physician ratio is 3.6, above the OECD average, and 36% of physicians are women. There is no national long-term plan for human resources for health, but various strategies and investments address human resources for health needs, such as geographical disparities (the density of physicians varies from 40.9 per 10,000 population in the state of Rio de Janeiro to 7.1 per 10,000 in the state of Maranhão). In June 2013, the Ministry of Health launched Mais Medicos (More Doctors), a national and international recruitment programme to fill in available positions in underserved regions at primary care level. Mechanisms for accreditation and regulation of the health workforce are in place.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	195.2; 25; 10 (2010)
Average annual rate of population change (%)	0.8 (2010-2015)
Population living in urban areas (%)	85 (2011)
Gross national income per capita (PPP int. \$)	11420 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	7.13 (2007)
Total expenditure on health as a percentage of gross domestic product (%)	8.9 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	46 (2011)
External resources for health as a percentage of total expenditure on health (%)	0.3 (2011)
Life expectancy at birth (years) [all; female; male]	74; 78; 71 (2011)
Total fertility rate (per woman)	1.8 (2010)
Neonatal mortality rate (per 1,000 live births)	10 (2011)
Infant mortality rate (per 1,000 live births)	14 (2011)
Under-five mortality rate (per 1,000 live births)	16 [14-18] (2011)
Maternal mortality ratio (per 100,000 live births)	56 [36-85] (2010)
Births attended by skilled health personnel (%)	98.9 (2010)
Antenatal care coverage - at least one visit (%)	97.3 (2010)
Antenatal care coverage - at least four visits (%)	90.2 (2010)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	96 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Brazil. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

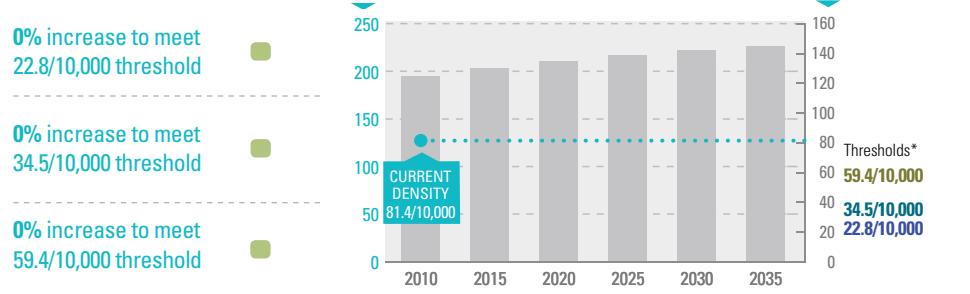
0% increase to meet **22.8/10,000** threshold

0% increase to meet **34.5/10,000** threshold

0% increase to meet **59.4/10,000** threshold

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

7.1
Physicians

NATIONAL AVERAGE

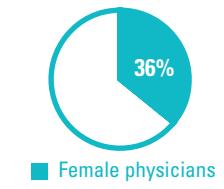
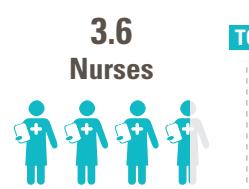
17.6
Physicians

SUB-NATIONAL HIGH

40.9
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average (2.8:1).



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

- Dentists ✓
- Midwives ✓
- Nurses ✓
- Pharmacists ✓
- Physicians ✓

REGULATE:

- Dentists ✓
- Midwives ✓
- Nurses ✓
- Pharmacists ✓
- Physicians ✓

LICENSE/RE-LICENSE:

- Dentists ✓*
- Midwives ✓*
- Nurses ✓*
- Pharmacists ✓*
- Physicians ✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓*

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓/✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓*

For which period? ?

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

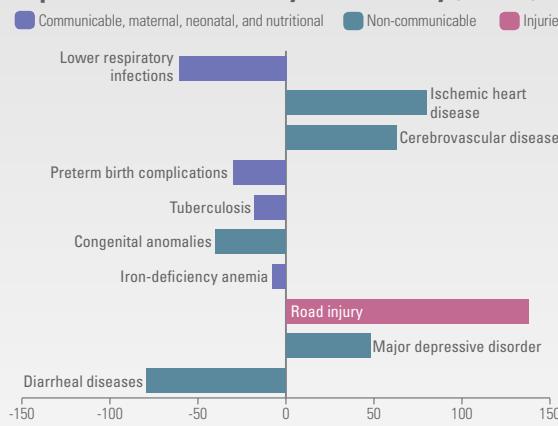
CAMBODIA

There is good progress in providing health access to people with low income through funding schemes such as the Health Equity Fund, and the country is on track to meeting the health-related Millennium Development Goals. The burden of disease appears to be shifting from communicable to noncommunicable diseases: diarrhoeal disease in particular, has decreased by 80% from 1990 to 2010. Despite these positive signs, the availability of skilled health professionals is below indicative thresholds and would need to almost double to meet the lowest of these by 2035. Inequities in accessibility are a challenge, with access to skilled birth attendants ranging between 50% and 100% from poorest to richest areas. On the other hand, the ratio of nurses to physicians is above the OECD average. There is evidence of good policies, including a costed plan for human resources for health (2008–2015), although some key areas such as preservice and in-service education may require even greater focus.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	14.4; 32; 6 (2010)
Average annual rate of population change (%)	1.7 (2010–2015)
Population living in urban areas (%)	20 (2011)
Gross national income per capita (PPP int. \$)	2230 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	32.23 (2007)
Total expenditure on health as a percentage of gross domestic product (%)	5.7 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	22 (2011)
External resources for health as a percentage of total expenditure on health (%)	15.8 (2011)
Life expectancy at birth (years) [all; female; male]	65; 66; 64 (2011)
Total fertility rate (per woman)	2.6 (2010)
Neonatal mortality rate (per 1,000 live births)	19 (2011)
Infant mortality rate (per 1,000 live births)	36 (2011)
Under-five mortality rate (per 1,000 live births)	43 [36-61] (2011)
Maternal mortality ratio (per 100,000 live births)	250 [160-390] (2010)
Births attended by skilled health personnel (%)	71.0 (2010)
Antenatal care coverage - at least one visit (%)	89.1 (2010)
Antenatal care coverage - at least four visits (%)	59.4 (2010)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	94 (2011)
Postnatal care visit within two days of birth (%)	70.4; 2010 (2010)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Cambodia. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

203% increase to meet 22.8/10,000 threshold

358% increase to meet 34.5/10,000 threshold

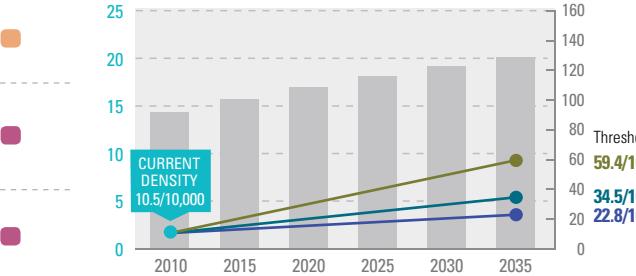
689% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

Physicians

NATIONAL AVERAGE

2.3 Physicians

SUB-NATIONAL HIGH

Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

2.5 Nurses



TO

1 Physician



16% Female physicians

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	✓
Nurses	?
Pharmacists	?
Physicians	✓

REGULATE:

Dentists	?
Midwives	✓*
Nurses	?
Pharmacists	?
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	?
Midwives	?
Nurses	✗
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓*

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓*

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓*

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ?/?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2006–2015

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

Legend: ✓ = Yes ✓* = Partial ✗ = No ?/? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

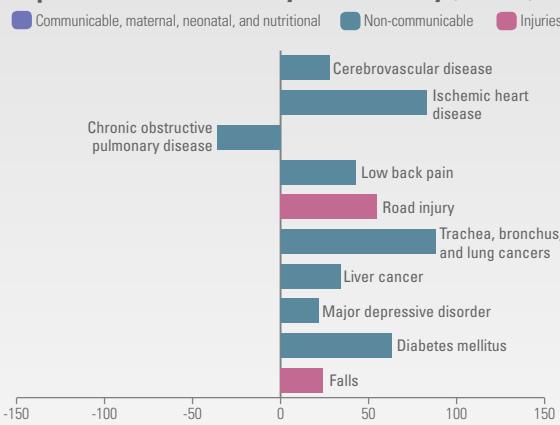
CHINA

China is making good strides towards meeting Millennium Development Goals 4 and 5. There is no single universal health coverage scheme, but a variety of schemes exist for different population groups, including a mandatory scheme for all formal sector workers. The New Rural Cooperative Medical Scheme now covers more than 90% of the rural population in China, a significant part of China's efforts to reach universal health coverage. In practice, financial coverage depends on the availability of funds, although this is being substantially improved. Lifestyle shifts are leading to a rising burden of chronic diseases, which are recognized as a policy priority. There is good availability of skilled health professionals, already above the 22.8 per 10,000 population threshold and on track to meet the 34.5 per 10,000 indicative threshold by 2035. China benefits from a low-cost medical education system, graduating about 175,000 doctors annually. In addition, about 1 million village doctors, who mostly have vocational training, are serving in rural areas. However, a bias towards urban areas in the distribution of human resources remains, and there is scope for further improving the quality of care. The plan for human resources for health for 2011–2020 is attempting to address some of these issues with measures to improve the retention, distribution and performance of the health workforce.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	1359.8; 19; 12	(2010)
Average annual rate of population change (%)	0.6	(2010–2015)
Population living in urban areas (%)	51	(2011)
Gross national income per capita (PPP int. \$)	8390	(2011)
Population living on <\$1 (PPP int. \$) a day (%)	13.06	(2008)
Total expenditure on health as a percentage of gross domestic product (%)	5.2	(2011)
General government expenditure on health as a percentage of total expenditure on health (%)	56	(2011)
External resources for health as a percentage of total expenditure on health (%)	0.1	(2011)
Life expectancy at birth (years) [all; female; male]	76; 77; 74	(2011)
Total fertility rate (per woman)	1.6	(2010)
Neonatal mortality rate (per 1,000 live births)	9	(2011)
Infant mortality rate (per 1,000 live births)	13	(2011)
Under-five mortality rate (per 1,000 live births)	15 [13–17]	(2011)
Maternal mortality ratio (per 100,000 live births)	37 [23–58]	(2010)
Births attended by skilled health personnel (%)	96.3	(2009)
Antenatal care coverage - at least one visit (%)	94.1	(2010)
Antenatal care coverage - at least four visits (%)	–	
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99	(2011)
Postnatal care visit within two days of birth (%)	–	

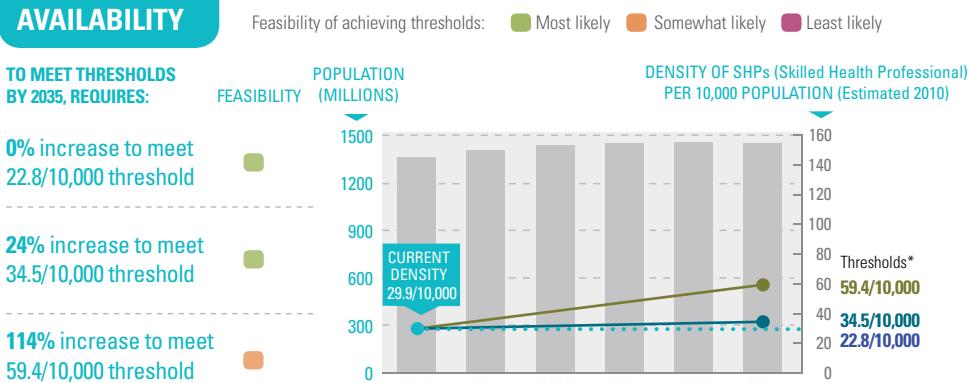
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in China. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

9.2
Physicians

NATIONAL AVERAGE

14.6
Physicians

SUB-NATIONAL HIGH

37.8
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	?
Nurses	?
Pharmacists	?
Physicians	X

REGULATE:

Dentists	?
Midwives	?
Nurses	?
Pharmacists	?
Physicians	?

LICENSE/RE-LICENSE:

Dentists	?
Midwives	?
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓ *
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	?

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓ *
informed by data and strategic intelligence?	✓ *
addressing pre-service education?	✓
addressing geographical distribution and retention?	✓ *
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓ *
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	✓ / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?

For which period?	2011–2020
Does the strategy/plan account for the financial costs and resource requirements to implement it?	?

✓ = Yes ✓ * = Partial X = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

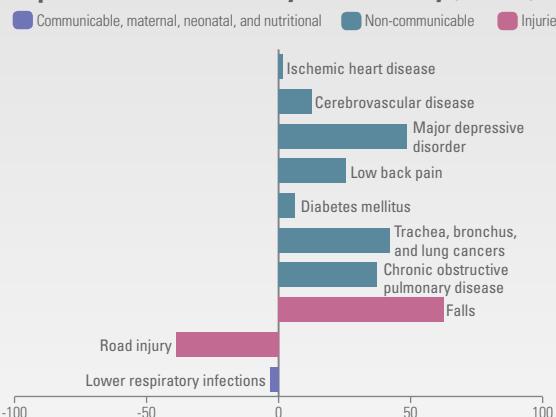
CUBA

In Cuba, government expenditure on health represents about 95% of total expenditure, the rest being out-of-pocket expenditure. There is universal access to a comprehensive package of health services free of user charges. Primary health care is given priority, aiming at dealing with 80% of health problems. The whole population has access to a family physician. Cuba has a 1.3 ratio of nurses to physicians, and 61% of physicians are women. The density of physicians in the capital is more than twice that of the region with the lowest density. Health workforce issues are given priority through programmes such as Programa del Médico y Enfermera de la Familia and Programa de Mejora Continua de la Calidad de la Atención Estomatológica y la Satisfacción de la Probación y los Prestadores. Mechanisms for physician accreditation and regulation are in place, although no information was found regarding midwifery accreditation, regulation or licensing systems.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	11.3; 17; 17 (2010)
Average annual rate of population change (%)	-0.1 (2010-2015)
Population living in urban areas (%)	75 (2011)
Gross national income per capita (PPP int. \$)	—
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	10.0 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	95 (2011)
External resources for health as a percentage of total expenditure on health (%)	0.2 (2011)
Life expectancy at birth (years) [all; female; male]	78; 80; 76 (2011)
Total fertility rate (per woman)	1.5 (2010)
Neonatal mortality rate (per 1,000 live births)	3 (2011)
Infant mortality rate (per 1,000 live births)	5 (2011)
Under-five mortality rate (per 1,000 live births)	6 [5-7] (2011)
Maternal mortality ratio (per 100,000 live births)	73 [60-87] (2010)
Births attended by skilled health personnel (%)	99.9 (2011)
Antenatal care coverage - at least one visit (%)	100 (2009)
Antenatal care coverage - at least four visits (%)	100 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	96 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Cuba. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

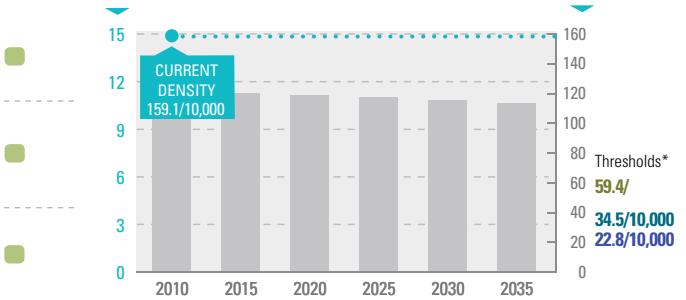
0% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: Most likely (green), Somewhat likely (orange), Least likely (purple)

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

45.2
Physicians

NATIONAL AVERAGE

67.2
Physicians

SUB-NATIONAL HIGH

100.7
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is

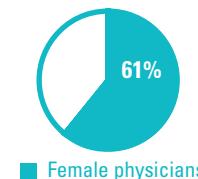
BELOW

the OECD average (2.8:1).

1.3
Nurses

TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	?
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓*
Midwives	?
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	?
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ?

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ? / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓*

For which period? ?

Does the strategy/plan account for the financial costs and resource requirements to implement it? ?

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

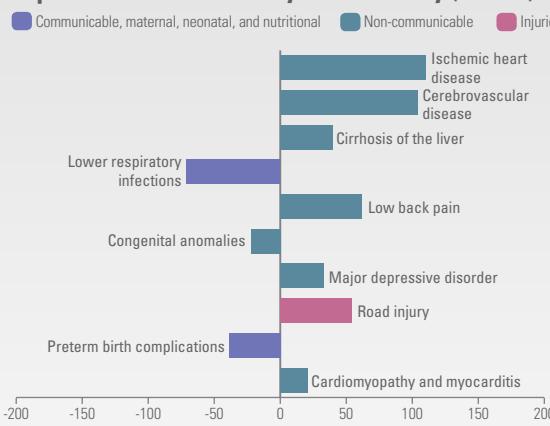
EGYPT

Egypt has been engaged in improving the performance of its health services for the past 15 years. The Health Insurance Organization (HIO) covers about half the population, and public services are also available for poor people free of charge. However, half the population reports out-of-pocket costs at the point of service. Egypt is on track to attain the health Millennium Development Goals. The country has traditionally produced numbers of health workers above regional averages, but further improving access to and the quality of services, particularly for poor people and for rural populations, will require sustained efforts to address imbalances in skills mix, improve geographical distribution through better working conditions and even greater focus on investing in required equipment and ensuring uniform quality of education. A sector reform programme initiated in 1997 and due to continue through 2018 aims at progressing towards universal health coverage, including by "investing in human resources development". Areas for improvement targeting educational institutions include reducing overcrowding, increasing financial resources, upgrading training infrastructure and equipment, improving faculty members' skills, updating curricula and strengthening formal evaluation and accreditation mechanisms. Efforts to address these challenges are conducted under the Higher Education Enhancement Project Fund.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	78.1; 32; 8 (2010)
Average annual rate of population change (%)	1.6 (2010-2015)
Population living in urban areas (%)	43 (2011)
Gross national income per capita (PPP int. \$)	6120 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	<2 (2008)
Total expenditure on health as a percentage of gross domestic product (%)	4.9 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	41 (2011)
External resources for health as a percentage of total expenditure on health (%)	0.5 (2011)
Life expectancy at birth (years) [all; female; male]	73; 75; 71 (2011)
Total fertility rate (per woman)	2.7 (2010)
Neonatal mortality rate (per 1,000 live births)	7 (2011)
Infant mortality rate (per 1,000 live births)	18 (2011)
Under-five mortality rate (per 1,000 live births)	21 [19-23] (2011)
Maternal mortality ratio (per 100,000 live births)	66 [40-100] (2010)
Births attended by skilled health personnel (%)	78.9 (2008)
Antenatal care coverage - at least one visit (%)	73.6 (2008)
Antenatal care coverage - at least four visits (%)	66 (2008)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	96 (2011)
Postnatal care visit within two days of birth (%)	64.6 (2008)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Egypt. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: █ Most likely █ Somewhat likely █ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

27% increase to meet 59.4/10,000 threshold

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

Physicians

NATIONAL AVERAGE

28.3 Physicians

SUB-NATIONAL HIGH

Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.2 Nurses



TO

1 Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	?
Nurses	?
Pharmacists	?
Physicians	✓*

REGULATE:

Dentists	✓*
Midwives	?
Nurses	?
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	?
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✗

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✗

addressing pre-service education? ?

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ?

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ? / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓*

For which period? ?

Does the strategy/plan account for the financial costs and resource requirements to implement it? ?

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

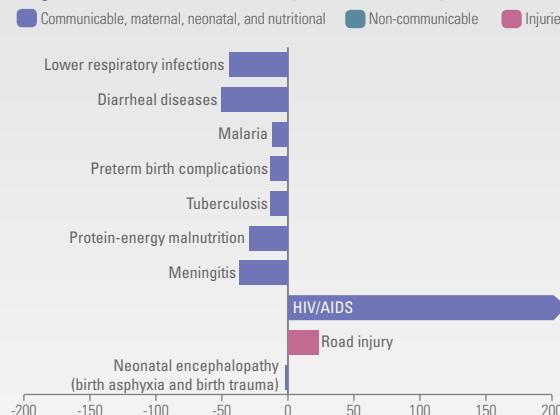
ETHIOPIA

Health care is provided on a fee-for-service basis. A key element of the health care funding reforms is to systematize waiver and exemption systems, with government allocation to facilitate access to health services showing improvement in recent years (reaching 2 million beneficiaries). However, challenges remain in identifying beneficiaries and allocating resources from local government. Communicable diseases are the greatest cause of disability-adjusted life-years (DALYs) lost. Ethiopia is making significant progress towards achieving Millennium Development Goal 4. The density of skilled health professionals is lower than indicative thresholds, and there may be challenges in geographical access with a highly unequal distribution of physicians. A low percentage of women doctors (18%) may also indicate problems with acceptability, although the ratio of nurses to doctors is above the OECD average. The Health Sector Development Plan includes a major focus on developing human resources for health, including support for salaries and training. The institutionalization and scaling up of health extension workers through the Health Extension Programme is yielding positive results. Increasing the capacity of training institutions is also seen as a priority. There is a recognized need to improve systems for collecting health workforce data.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	87.1; 41; 5 (2010)
Average annual rate of population change (%)	2.6 (2010-2015)
Population living in urban areas (%)	17 (2011)
Gross national income per capita (PPP int. \$)	1110 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	4.7 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	58 (2011)
External resources for health as a percentage of total expenditure on health (%)	44.3 (2011)
Life expectancy at birth (years) [all; female; male]	60; 62; 59 (2011)
Total fertility rate (per woman)	4.2 (2010)
Neonatal mortality rate (per 1,000 live births)	31 (2011)
Infant mortality rate (per 1,000 live births)	52 (2011)
Under-five mortality rate (per 1,000 live births)	77 [65-93] (2011)
Maternal mortality ratio (per 100,000 live births)	350 [210-630] (2010)
Births attended by skilled health personnel (%)	10.0 (2011)
Antenatal care coverage - at least one visit (%)	33.9 (2011)
Antenatal care coverage - at least four visits (%)	19.1 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	51 (2011)
Postnatal care visit within two days of birth (%)	6.7 (2011)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Ethiopia. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

1354% increase to meet 22.8/10,000 threshold

2100% increase to meet 34.5/10,000 threshold

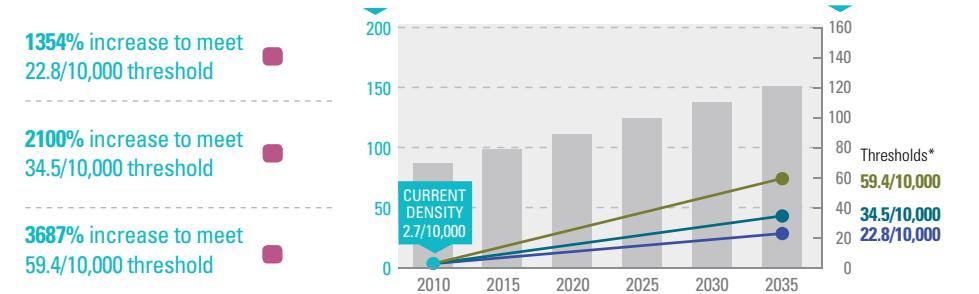
3687% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: Most likely (green), Somewhat likely (orange), Least likely (purple)

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional PER 10,000 POPULATION (Estimated 2010))



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

0.1
Physicians

NATIONAL AVERAGE

0.3
Physicians

SUB-NATIONAL HIGH

3.3
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average (2.8:1).

9.3 Nurses



TO

1 Physician



18% Female physicians

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓*
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	?
Midwives	✓*
Nurses	?
Pharmacists	?
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	✓*
Nurses	✓
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓ *

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓ *

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓ *

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ? / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓ *

For which period? 2010/11-2014/15

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

Legend: ✓ = Yes, ✓ * = Partial, ✗ = No, ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

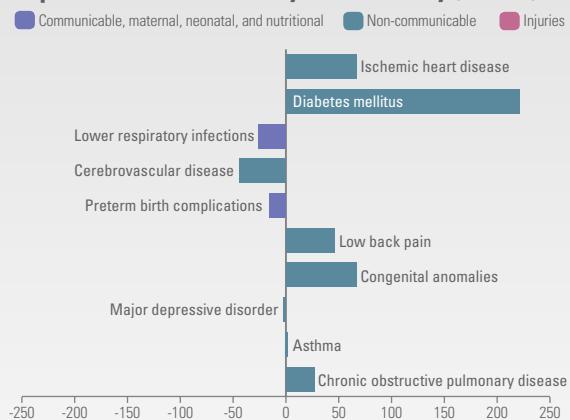
FIJI

The public health system offers most services free of charge to all residents; 40% of the population is estimated to have access to high-quality services, partly due to resource limitations and geographical barriers. Noncommunicable diseases are an important and rising burden, with heart disease and diabetes as the two major causes of DALYs lost. The data show a good availability of skilled health professionals, with likelihood of meeting the highest indicative threshold by 2035. However, these aggregate numbers may conceal a shortage of physicians, particularly in rural areas. Policy on human resources for health is attempting to address this problem with the recruitment of expatriate doctors while aiming to reduce these numbers as more nationally trained staff become available, to preserve local capacity. Another positive factor is the existence of strong mechanisms for quality control of the workforce (accreditation, regulation and licensing), including requirements of evidence of continuous professional development for relicensing health workers.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	0.9; 29; 8 (2010)
Average annual rate of population change (%)	0.7 (2010-2015)
Population living in urban areas (%)	52 (2011)
Gross national income per capita (PPP int. \$)	4610 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	5.88; 2009 (2010)
Total expenditure on health as a percentage of gross domestic product (%)	3.8 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	68 (2011)
External resources for health as a percentage of total expenditure on health (%)	7.7 (2011)
Life expectancy at birth (years) [all; female; male]	70; 72; 67 (2011)
Total fertility rate (per woman)	2.7 (2010)
Neonatal mortality rate (per 1,000 live births)	8 (2011)
Infant mortality rate (per 1,000 live births)	14 (2011)
Under-five mortality rate (per 1,000 live births)	16 [14-19] (2011)
Maternal mortality ratio (per 100,000 live births)	26 [15-48] (2010)
Births attended by skilled health personnel (%)	99.7 (2010)
Antenatal care coverage - at least one visit (%)	100 (2005)
Antenatal care coverage - at least four visits (%)	–
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute to Fiji. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: █ Most likely █ Somewhat likely █ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

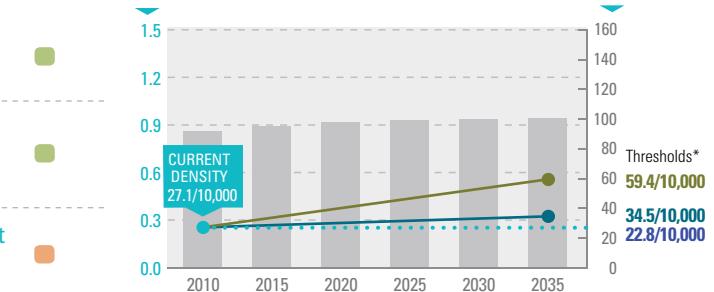
0% increase to meet 22.8/10,000 threshold

40% increase to meet 34.5/10,000 threshold

140% increase to meet 59.4/10,000 threshold

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

SUB-NATIONAL LOW

3.2
Physicians

NATIONAL AVERAGE

4.3
Physicians

SUB-NATIONAL HIGH

4.7
Physicians

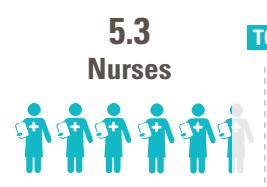
GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average (2.8:1).

5.3 TO 1



1 TO 1



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	█
Midwives	█
Nurses	█
Pharmacists	█
Physicians	█

REGULATE:

Dentists	█
Midwives	█
Nurses	█
Pharmacists	█
Physicians	█

LICENSE/RE-LICENSE:

Dentists	█
Midwives	█
Nurses	█
Pharmacists	█
Physicians	█

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓ *

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓ *

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓ *

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓ */ ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 1997-2012

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

█ = Yes █ * = Partial █ = No █ ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

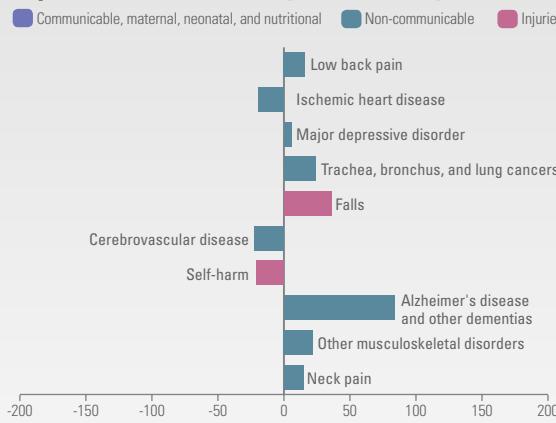
FRANCE

An employment-based statutory health insurance (SHI) covers almost 100% of the population and nearly 77% of health expenditure. In most cases, the SHI reimburses 60% of costs of services, and the remainder is typically covered by complementary private health insurance (Mutuelle); 96% of the population is covered by voluntary health insurance. Out-of-pocket expenditure is about 7%. France has a nurses-to-physician ratio close to the OECD average. About 43% of all physicians are women. There are no substantial challenges regarding availability, accessibility, acceptability and quality, but there are important geographical disparities in health personnel distribution across regions. A projected decline in the physician-to-population ratio over the next 20 years, due to retirement, has led governments to introduce measures to curb a decreasing workforce stock and to reduce existing geographical variation. Key reform instruments include: increased quotas (*numerus clausus*) for entrance to medical schools, enhanced multidisciplinary cooperation between physicians and paramedics at a local level through skills mix and task shifting (such as for dialysis to nurses and eyeglass prescriptions to optometrists), financial incentives for setting up practices in medically deprived areas and Public Service Involvement Contracts offered to medical students with financial provisions to set up practices in underserved areas.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	63.2; 18; 23 (2010)
Average annual rate of population change (%)	0.5 (2010-2015)
Population living in urban areas (%)	86 (2011)
Gross national income per capita (PPP int. \$)	35910 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	–
Total expenditure on health as a percentage of gross domestic product (%)	11.6 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	77 (2011)
External resources for health as a percentage of total expenditure on health (%)	–
Life expectancy at birth (years) [all; female; male]	82; 85; 78 (2011)
Total fertility rate (per woman)	2 (2010)
Neonatal mortality rate (per 1,000 live births)	2 (2011)
Infant mortality rate (per 1,000 live births)	3 (2011)
Under-five mortality rate (per 1,000 live births)	4 [4-5] (2011)
Maternal mortality ratio (per 100,000 live births)	8 [7-10] (2010)
Births attended by skilled health personnel (%)	97.5 (2010)
Antenatal care coverage - at least one visit (%)	100 (2010)
Antenatal care coverage - at least four visits (%)	98.9 (2010)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in France. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

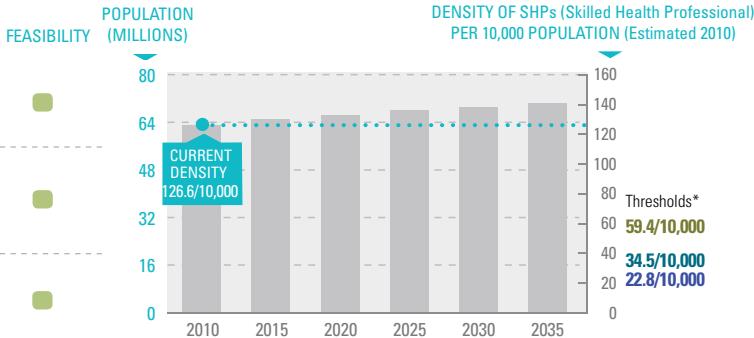
TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: Most likely Somewhat likely Least likely



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

23.9
Physicians

NATIONAL AVERAGE

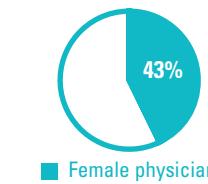
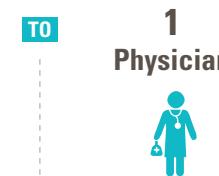
33.8
Physicians

SUB-NATIONAL HIGH

36.6
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓*
Nurses	✓
Pharmacists	✓
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?



Does the strategy/plan account for the financial costs and resource requirements to implement it?



Yes = Yes Partial = Partial No = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

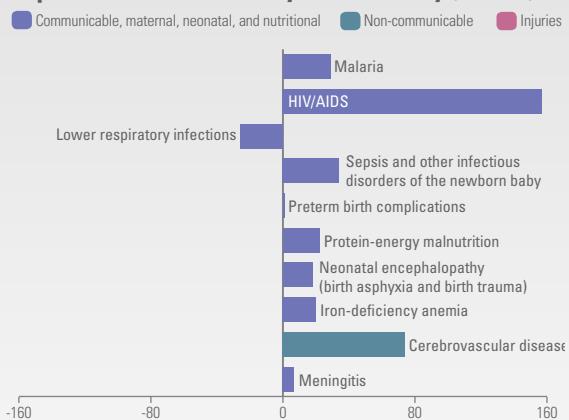
GHANA

The National Health Insurance Scheme covers about 61% of the population: a package of care that provides services for most health problems, with a particular focus on maternal and child health. Premiums are determined by income level, with exemptions for vulnerable groups. Maternal outcomes are improving, but much remains to be done to improve children's health. Although the health service has a dedicated human resources division and steps have been taken to involve other key stakeholders in policy development, evidence indicates that sustained efforts will be required to fully address workforce challenges. The availability of skilled health professionals is below indicative thresholds, and with rapid population growth, it may be unlikely to scale up effectively before 2035. The density of physicians is particularly low and features significant disparities in geographical distribution. There is need for a greater emphasis on strengthening regulatory mechanisms to improve quality. Further, data collection systems require improvement to inform effective policy. However, positive measures have been taken to improve remuneration, and there has been a decline in migration outflows of health workers, especially

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	24.3; 39; 6 (2010)
Annual population growth rate (%)	2.1 (2011)
Population living in urban areas (%)	52 (2011)
Gross national income per capita (PPP int. \$)	1810 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	4.8 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	56 (2011)
External resources for health as a percentage of total expenditure on health (%)	14.2 (2011)
Life expectancy at birth (years) [all; female; male]	64; 65; 62 (2011)
Total fertility rate (per woman)	4.2 (2010)
Neonatal mortality rate (per 1,000 live births)	29 (2011)
Infant mortality rate (per 1,000 live births)	52 (2011)
Under-five mortality rate (per 1,000 live births)	78 [66-95] (2011)
Maternal mortality ratio (per 100,000 live births)	350 [210-630] (2010)
Births attended by skilled health personnel (%)	54.7 (2008)
Antenatal care coverage - at least one visit (%)	86.7 (2008)
Antenatal care coverage - at least four visits (%)	78.2 (2008)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	91 (2011)
Postnatal care visit within two days of birth (%)	68.3 (2008)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Ghana. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

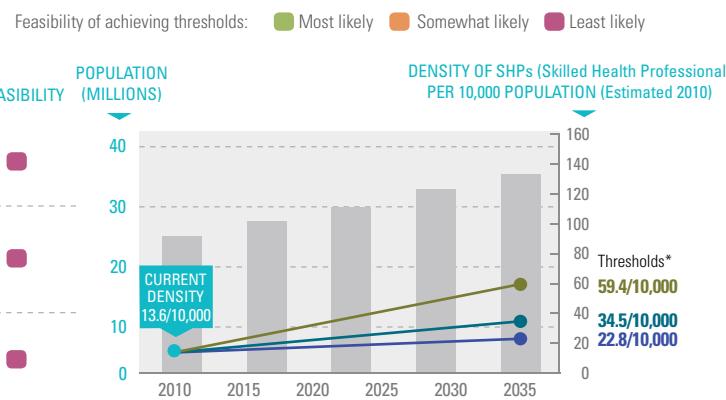
AVAILABILITY

TO MEET THRESHOLDS BY 2030, REQUIRES:

221% increase to meet 22.8/10,000 threshold

386% increase to meet 34.5/10,000 threshold

736% increase to meet 59.4/10,000 threshold



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

.1
Physicians

NATIONAL AVERAGE

.9
Physicians

SUB-NATIONAL HIGH

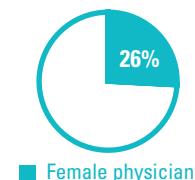
1.3
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is ABOVE the OECD average (2.8:1).



1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2007-2011

Does the strategy/plan account for the financial costs and resource requirements to implement it?



*See Annex 1 for full explanation on country profile methods and sources.

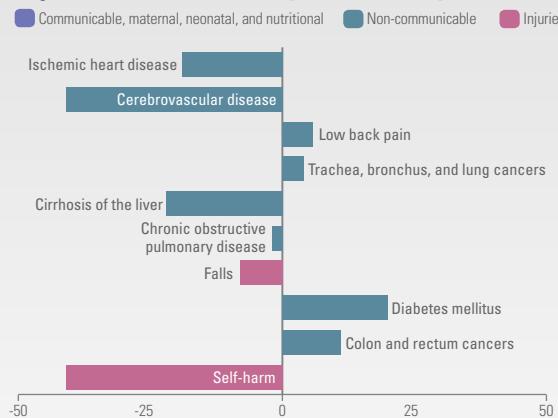
HUNGARY

Hungary has achieved almost universal coverage of its population with mandatory social health insurance, which is the main source of public funding for health services. Participation in the social health insurance is compulsory for all residents. In 2009, Hungary spent 7.4% of its GDP on health, with public expenditure accounting for 70% of total spending. There are co-payments for certain services, including pharmaceuticals, dental care and rehabilitation. Hungary's health system is under reform. The Semmelweis Plan for the Rescue of Health Care provides the framework for a strategy for human resources for health, although it does not include any staffing plan. There are disparities in the distribution of the health workforce, with the capital area of Budapest having the highest density of physicians and the rural south the lowest. The nurse-to-physician ratio is below the OECD average. Low salaries appear to be a key factor in determining emigration and retention challenges. Mechanisms for regulation and licensing of the health workforce are in place. Relicensing is mandatory for all health professionals.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	10; 15; 23 (2010)
Average annual rate of population change (%)	-0.2 (2010-2015)
Population living in urban areas (%)	69 (2011)
Gross national income per capita (PPP int. \$)	20310 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	<2 (2007)
Total expenditure on health as a percentage of gross domestic product (%)	7.7 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	65 (2011)
External resources for health as a percentage of total expenditure on health (%)	–
Life expectancy at birth (years) [all; female; male]	75; 79; 71 (2011)
Total fertility rate (per woman)	1.4 (2010)
Neonatal mortality rate (per 1,000 live births)	4 (2011)
Infant mortality rate (per 1,000 live births)	5 (2011)
Under-five mortality rate (per 1,000 live births)	6 [6-7] (2011)
Maternal mortality ratio (per 100,000 live births)	21 [15-31] (2010)
Births attended by skilled health personnel (%)	99.1 (2010)
Antenatal care coverage - at least one visit (%)	–
Antenatal care coverage - at least four visits (%)	–
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Hungary. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

23.5
Physicians

NATIONAL AVERAGE

34.1
Physicians

SUB-NATIONAL HIGH

60.8
Physicians

ACCEPTABILITY

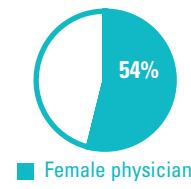
The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.8
Nurses



TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2011-2018

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Legend: ✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

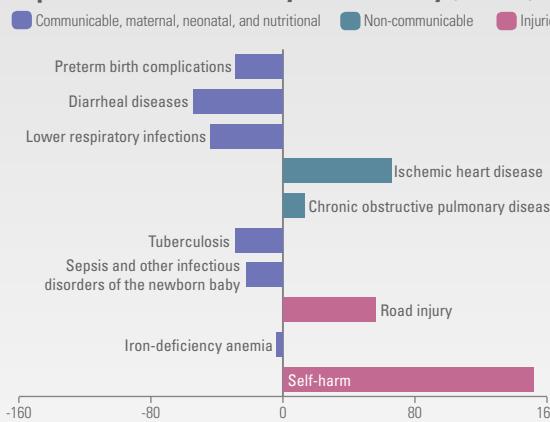
INDIA

Existing social health insurance schemes offer coverage to formal-sector workers and central government employees, and recent schemes offering care free of user charges for populations below the poverty line are being implemented and scaled up across 23 states. With one third of the population still living on less than US\$ 1 per day, there is a high burden of communicable diseases, particularly affecting newborns and infants, with limited progress towards achieving Millennium Development Goal 4. The availability of skilled health professionals is currently below the 22.8 per 10,000 population threshold, but scaling up to meet indicative thresholds by 2035 appears feasible. However, inequalities in access (both geographical and income-based) persist. Women physicians are 17% of the total of physicians, and the ratio of nurses to physicians is below the OECD average. Policy mechanisms for human resources for health development, including government leadership and collaboration with key stakeholders, and mechanisms to provide reliable data on the health workforce require strengthening. However, there are efforts to review and revitalize health professional education as part of a five-country network, also involving China, Bangladesh, Thailand and Viet Nam.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	1205.6; 31; 8 (2010)
Average annual rate of population change (%)	1.2 (2010-2015)
Population living in urban areas (%)	31 (2011)
Gross national income per capita (PPP int. \$)	3590 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	32.67 (2010)
Total expenditure on health as a percentage of gross domestic product (%)	3.9 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	31 (2011)
External resources for health as a percentage of total expenditure on health (%)	1.0 (2011)
Life expectancy at birth (years) [all; female; male]	65; 67; 64 (2011)
Total fertility rate (per woman)	2.6 (2010)
Neonatal mortality rate (per 1,000 live births)	32 (2011)
Infant mortality rate (per 1,000 live births)	47 (2011)
Under-five mortality rate (per 1,000 live births)	61 [56-68] (2011)
Maternal mortality ratio (per 100,000 live births)	200 [140-310] (2010)
Births attended by skilled health personnel (%)	57.7 (2009)
Antenatal care coverage - at least one visit (%)	75.1 (2008)
Antenatal care coverage - at least four visits (%)	49.7 (2008)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	72 (2011)
Postnatal care visit within two days of birth (%)	47.5 (2008)

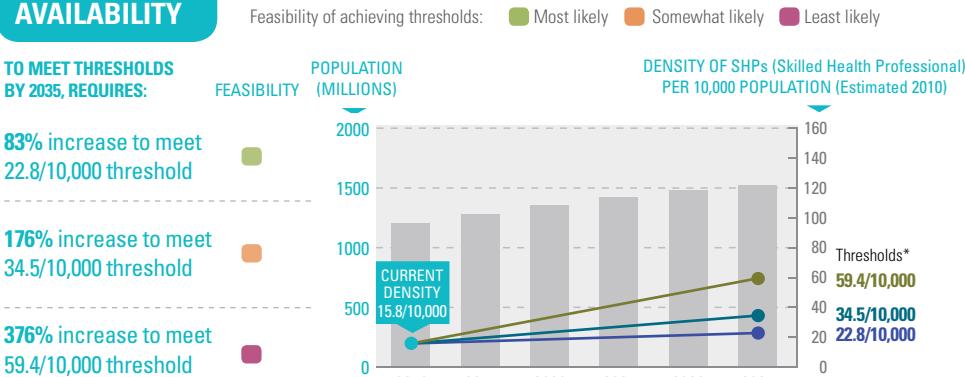
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in India. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

	SUB-NATIONAL LOW	NATIONAL AVERAGE	SUB-NATIONAL HIGH
Physicians	3.3	6.5	13.3

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓ *
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓ *

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓ *
informed by data and strategic intelligence?	X
addressing pre-service education?	X
addressing geographical distribution and retention?	✓
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓ *
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	✓ * / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?

For which period?	?
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Does the strategy/plan account for the financial costs and resource requirements to implement it?

✓ = Yes	✓ * = Partial	X = No	? = Insufficient data
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*See Annex 1 for full explanation on country profile methods and sources.

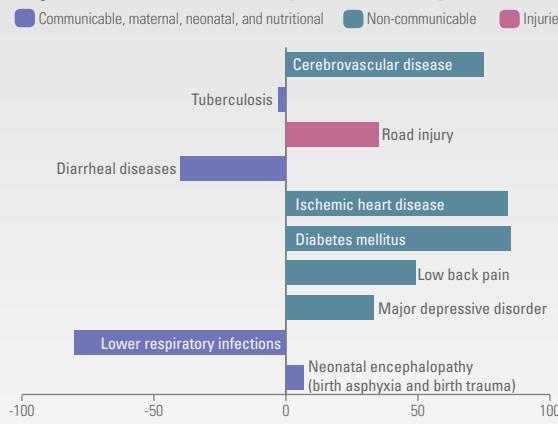
INDONESIA

Various insurance systems offer coverage to approximately 65% of the population. The country has made progress in reducing maternal mortality, and is on track to meet Millennium Development Goal 4. The rise of noncommunicable diseases is the next great health challenge to be addressed. The broad picture across the domains of availability, accessibility, acceptability and quality shows many strengths: the availability of skilled health professionals is currently below thresholds but could realistically be scaled up to meet these by 2035. This need is recognized in current policy mechanisms, with the plan for human resources for health focusing on improving quality and distribution of education institutions to address the production of human resources for health, and including costed strategies. Acceptability indicators are favourable, with women physicians comprising more than half the workforce and the ratio of nurses to physicians above the OECD average. However, challenges remain in guaranteeing equitable access. In terms of quality, accreditation procedures are currently being improved, and regulatory mechanisms also need strengthening, particularly for nurses and midwives.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	240.7; 27; 8 (2010)
Average annual rate of population change (%)	1.2 (2010-2015)
Population living in urban areas (%)	51 (2011)
Gross national income per capita (PPP int. \$)	4500 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	22.64 (2008)
Total expenditure on health as a percentage of gross domestic product (%)	2.7 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	34 (2011)
External resources for health as a percentage of total expenditure on health (%)	1.2 (2011)
Life expectancy at birth (years) [all; female; male]	69; 71; 68 (2011)
Total fertility rate (per woman)	2.1 (2010)
Neonatal mortality rate (per 1,000 live births)	15 (2011)
Infant mortality rate (per 1,000 live births)	25 (2011)
Under-five mortality rate (per 1,000 live births)	32 [28-40] (2011)
Maternal mortality ratio (per 100,000 live births)	220 [130-350] (2010)
Births attended by skilled health personnel (%)	79.8 (2010)
Antenatal care coverage - at least one visit (%)	93.3 (2007)
Antenatal care coverage - at least four visits (%)	81.5 (2007)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	63 (2011)
Postnatal care visit within two days of birth (%)	70.3 (2007)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Indonesia. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

78% increase to meet 22.8/10,000 threshold

170% increase to meet 34.5/10,000 threshold

364% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: Most likely (green), Somewhat likely (orange), Least likely (purple)

ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

1.0
Physicians

NATIONAL AVERAGE

2.0
Physicians

SUB-NATIONAL HIGH

5.4
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average (2.8:1).

4.4 Nurses



TO

1 Physician



56% Female physicians

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

REGULATE:

Dentists	✓*
Midwives	✗
Nurses	✗
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2011-2025

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

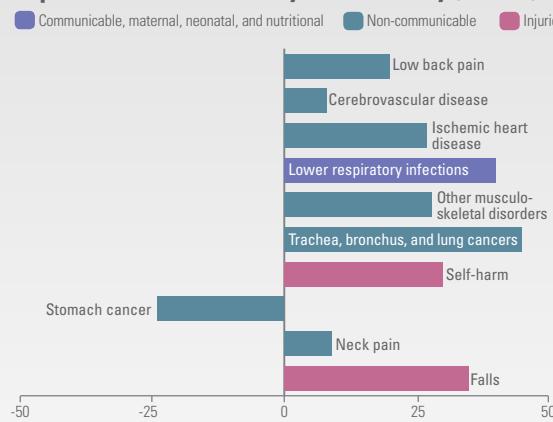
JAPAN

Japan's health system offers coverage to 98.7% of the population through a social insurance model, with maximum copayments of 30% of health care costs and lower copayments for children and older people. The availability of skilled health professionals is above the thresholds, and there is generally good accessibility to health services, but evidence indicates some geographical disparities: for example, the relative ratios of health worker densities between the highest and lowest prefectures are 2.0 for physicians and 2.3 for nurses. Further, the percentage of women physicians is unusually low (20%), while the ratio of nurses to physicians is 1.8, although other sources indicate that it is higher and significantly above the OECD average. Evidence indicates that regulatory mechanisms need strengthening to reach the standards of other high-income countries: for example, licenses for practitioners are granted for life, with no relicensing requirement. A positive element is the existence of strong mechanisms to collect accurate survey data on the health workforce. However, some evidence indicates that these data are not being adequately used to determine policy priorities. For example, there has been a focus on increasing the quota of medical students, but it is not clear whether this policy takes adequate account of health service needs, especially given changing technology and service delivery models.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	127.4; 13; 30 (2010)
Average annual rate of population change (%)	-0.1 (2010-2015)
Population living in urban areas (%)	91 (2011)
Gross national income per capita (PPP int. \$)	35330 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	9.3 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	80 (2011)
External resources for health as a percentage of total expenditure on health (%)	—
Life expectancy at birth (years) [all; female; male]	83; 86; 79 (2011)
Total fertility rate (per woman)	1.4 (2010)
Neonatal mortality rate (per 1,000 live births)	1 (2011)
Infant mortality rate (per 1,000 live births)	2 (2011)
Under-five mortality rate (per 1,000 live births)	3 [3-4] (2011)
Maternal mortality ratio (per 100,000 live births)	5 [5-6] (2010)
Births attended by skilled health personnel (%)	99.8 (2011)
Antenatal care coverage - at least one visit (%)	—
Antenatal care coverage - at least four visits (%)	—
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	98 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

14.3
Physicians

NATIONAL AVERAGE

21.4
Physicians

SUB-NATIONAL HIGH

28.6
Physicians

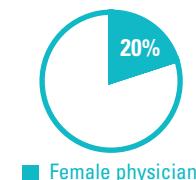
ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.8
Nurses

TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓*

informed by data and strategic intelligence? ✓

addressing pre-service education? ✓*

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓*

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓/✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓*

For which period? ?

Does the strategy/plan account for the financial costs and resource requirements to implement it? ?

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

KENYA

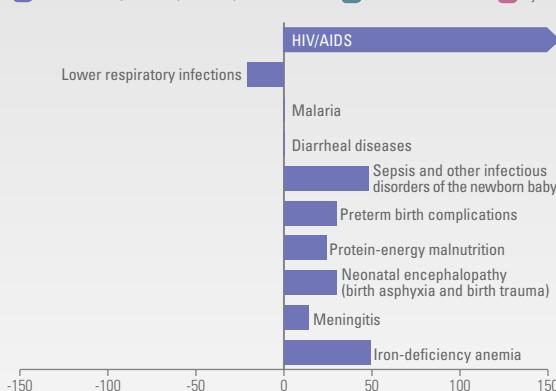
The National Health Insurance Fund in Kenya covers mostly formal-sector workers: about 25% of poor people are estimated to have medical coverage. The burden of disease is overwhelmingly due to communicable diseases, with HIV infection as the number one cause of mortality and morbidity; progress towards achieving the health Millennium Development Goals has been limited. The availability of skilled health professionals is low and there is inequality in access, ranging from 20% to 80% from the poorest to the richest people. Urban-rural inequities are also significant, particularly for access to physicians. The devolution process underway will give authority over human resources for health to the counties, which may lead to differences in availability according to how counties set priorities for resources. On a positive note, the percentage of women physicians is quite high (about one third). Evidence also indicates good mechanisms for accreditation, regulation and licensing of the health workforce through the various professional councils, including requirements for continuous professional development for relicensing physicians, nurses and dentists. However policy mechanisms, intersectoral collaboration and human resource information systems need to be strengthened to enable successful planning and management of the workforce.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	40.9; 42; 4 (2010)
Average annual rate of population change (%)	2.7 (2010-2015)
Population living in urban areas (%)	24 (2011)
Gross national income per capita (PPP int. \$)	1710 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	4.5 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	40 (2011)
External resources for health as a percentage of total expenditure on health (%)	38.8 (2011)
Life expectancy at birth (years) [all; female; male]	60; 61; 58 (2011)
Total fertility rate (per woman)	4.7 (2010)
Neonatal mortality rate (per 1,000 live births)	27 (2011)
Infant mortality rate (per 1,000 live births)	48 (2011)
Under-five mortality rate (per 1,000 live births)	73 [64-98] (2011)
Maternal mortality ratio (per 100,000 live births)	360 [230-590] (2010)
Births attended by skilled health personnel (%)	43.8 (2009)
Antenatal care coverage - at least one visit (%)	91.5 (2009)
Antenatal care coverage - at least four visits (%)	47.1 (2009)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	88 (2011)
Postnatal care visit within two days of birth (%)	42.1 (2009)

Top 10 causes of morbidity and mortality (DALYs)

■ Communicable, maternal, neonatal, and nutritional ■ Non-communicable ■ Injuries



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Kenya. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

315% increase to meet 22.8/10,000 threshold

528% increase to meet 34.5/10,000 threshold

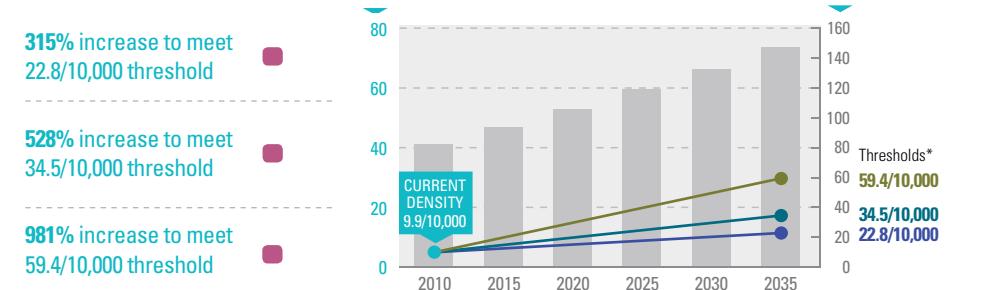
981% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional PER 10,000 POPULATION (Estimated 2010))



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

0.1
Physicians

NATIONAL AVERAGE

1.8
Physicians

SUB-NATIONAL HIGH

1.2
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is

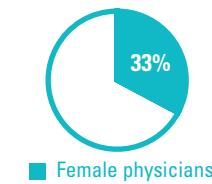
ABOVE

the OECD average (2.8:1).

4.4 Nurses TO 1 Physician



1 Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓*
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓ *

addressing pre-service education? ✓ *

addressing geographical distribution and retention? ✓ *

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓ *

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓/✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2009-2012

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

Legend: ✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

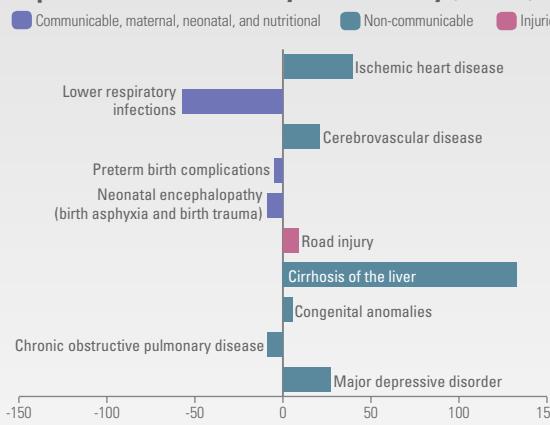
KYRGYZSTAN

After independence, Kyrgyzstan started reforming its health system, to make it more decentralized and performance oriented. Universal health coverage is achieved through a Mandatory Health Insurance Fund. Continuing commitment by government and stakeholders contributed to producing good health outcomes. Progress slowed down but was not interrupted by difficult economic circumstances and by social unrest in 2010. Issues related to human resources for health have received much attention since 1996, but the success of interventions remains limited. Family group practices and centres, staffed by one paramedic worker (feldsher), provide primary health care in remote areas; in larger villages, they also employ a midwife and a nurse. Barriers to access to primary care remain because of lack of providers, low salaries and motivation and retention problems. Despite improvements, further efforts are required to improve quality, provide functioning equipment and upgrade the qualifications of staff. The Concept for Reforming Medical Education was developed to modernize medical education and to develop accreditation mechanisms.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	5.3; 30; 6 (2010)
Average annual rate of population change (%)	1.4 (2010-2015)
Population living in urban areas (%)	35 (2011)
Gross national income per capita (PPP int. \$)	2180 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	6.23 (2009)
Total expenditure on health as a percentage of gross domestic product (%)	6.5 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	60 (2011)
External resources for health as a percentage of total expenditure on health (%)	10.7 (2011)
Life expectancy at birth (years) [all; female; male]	69; 72; 65 (2011)
Total fertility rate (per woman)	2.7 (2010)
Neonatal mortality rate (per 1,000 live births)	16 (2011)
Infant mortality rate (per 1,000 live births)	27 (2011)
Under-five mortality rate (per 1,000 live births)	31 [25-44] (2011)
Maternal mortality ratio (per 100,000 live births)	71 [44-110] (2010)
Births attended by skilled health personnel (%)	98.3 (2010)
Antenatal care coverage - at least one visit (%)	96.6 (2006)
Antenatal care coverage - at least four visits (%)	–
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	96 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Kyrgyzstan. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: █ Most likely █ Somewhat likely █ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

SUB-NATIONAL LOW

13.4
Physicians

NATIONAL AVERAGE

24.7
Physicians

SUB-NATIONAL HIGH

27.7
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	█
Midwives	█
Nurses	█
Pharmacists	█
Physicians	█

REGULATE:

Dentists	█*
Midwives	█
Nurses	█*
Pharmacists	█*
Physicians	█*

LICENSE/RE-LICENSE:

Dentists	█*
Midwives	█
Nurses	█*
Pharmacists	█*
Physicians	█*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? █

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? █

informed by data and strategic intelligence? █

addressing pre-service education? ✓*

addressing geographical distribution and retention? ✓*

addressing health workforce performance (e.g. competence, responsiveness and productivity)? █

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓*/✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? █

For which period? █

Does the strategy/plan account for the financial costs and resource requirements to implement it? █

✓ = Yes █* = Partial ✗ = No █ = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

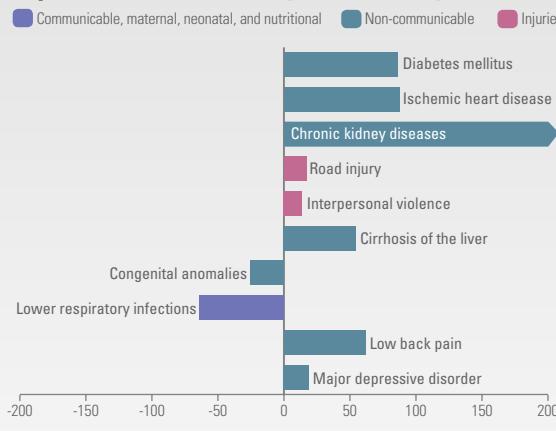
MEXICO

The health system comprises different subsystems with access linked to employment status. The contributory subsystem, funded by the employer and employees, is mandatory for salaried workers and covers 47% of the population. The non-contributory subsystem (Seguro Popular-SP) covered 64% of the uninsured population in 2011 and has enabled some progress in access to services in poorer and rural regions and among the indigenous population, even though further improvements are possible. Out-of-pocket payments represent up to 49% of total health expenditure. The burden of some communicable diseases is high, and despite good progress towards meeting the health Millennium Development Goals, there are still challenges regarding maternal mortality and gender equality. There are various strategies for health workforce planning but no formal plan for human resources for health. There is important variation in the density of physicians among regions. The ratio of nurses to physicians is below the OECD average at 1.9. There are mechanisms for regulation and licensing health workforce that differ between types of health workers.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	117.9; 29; 9 (2010)
Average annual rate of population change (%)	1.2 (2010-2015)
Population living in urban areas (%)	78 (2011)
Gross national income per capita (PPP int. \$)	15390 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	<2 (2008)
Total expenditure on health as a percentage of gross domestic product (%)	6.2 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	49 (2011)
External resources for health as a percentage of total expenditure on health (%)	0.0 (2011)
Life expectancy at birth (years) [all; female; male]	75; 78; 72 (2011)
Total fertility rate (per woman)	2.3 (2010)
Neonatal mortality rate (per 1,000 live births)	7 (2011)
Infant mortality rate (per 1,000 live births)	13 (2011)
Under-five mortality rate (per 1,000 live births)	16 [14-18] (2011)
Maternal mortality ratio (per 100,000 live births)	50 [44-56] (2010)
Births attended by skilled health personnel (%)	95.3 (2009)
Antenatal care coverage - at least one visit (%)	95.8 (2009)
Antenatal care coverage - at least four visits (%)	-
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	97 (2011)
Postnatal care visit within two days of birth (%)	54.9 (2009)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Mexico. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

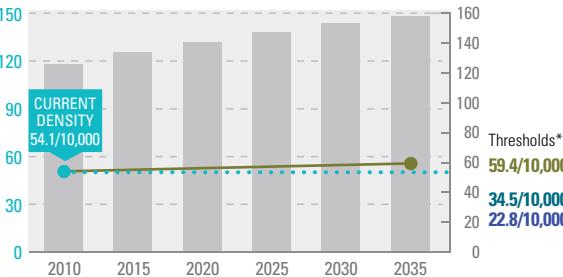
38% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: Most likely (green), Somewhat likely (orange), Least likely (red)

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

Physicians

NATIONAL AVERAGE

19.6 Physicians

SUB-NATIONAL HIGH

Physicians

ACCEPTABILITY

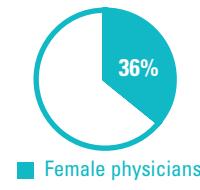
The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.9 Nurses



TO

1 Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓*
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2013-2018

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Legend: ✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

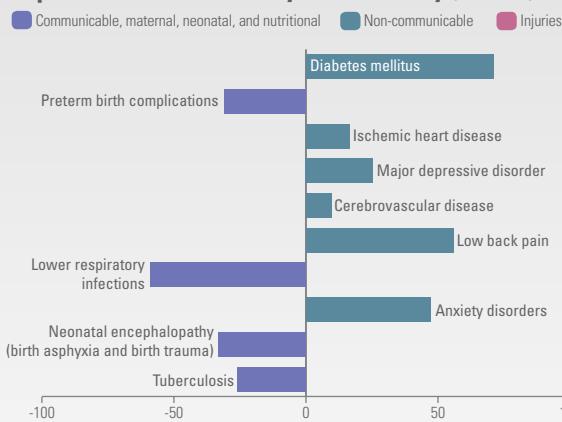
MOROCCO

In 2011, a new Constitution defined access to health services as a right. A Strategy for the Health Sector was prepared in 2012, and in July 2013 a policy document was presented to stakeholders in a national conference. It proposes scaling up human resources for health to progress rapidly towards universal health coverage. A new health insurance scheme (RAMED) has been developed to cover populations with no access to social insurance. Morocco is on track to achieving the health Millennium Development Goals, but universal health coverage is a major challenge, since population growth is high and the country is experiencing a rapid demographic and epidemiological transition. The Ministry of Health considers that health workers do not acquire all the competencies corresponding to the needs and expectations of the population. The density of health personnel is below the indicative thresholds needed to meet basic needs, and there is potential to improve the efficiency of the skills mix. The nurse-to-population ratio is about half the average in the Eastern Mediterranean Region. Geographical imbalances in the distribution of physicians remain important.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	31.6; 28; 8 (2010)
Average annual rate of population change (%)	1.4 (2010-2015)
Population living in urban areas (%)	57 (2011)
Gross national income per capita (PPP int. \$)	4880 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	2.52 (2007)
Total expenditure on health as a percentage of gross domestic product (%)	6.0 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	34 (2011)
External resources for health as a percentage of total expenditure on health (%)	0.4 (2011)
Life expectancy at birth (years) [all; female; male]	72; 74; 70 (2011)
Total fertility rate (per woman)	2.3 (2010)
Neonatal mortality rate (per 1,000 live births)	19 (2011)
Infant mortality rate (per 1,000 live births)	28 (2011)
Under-five mortality rate (per 1,000 live births)	33 [27-39] (2011)
Maternal mortality ratio (per 100,000 live births)	100 [62-170] (2010)
Births attended by skilled health personnel (%)	73.6 (2011)
Antenatal care coverage - at least one visit (%)	77.1 (2011)
Antenatal care coverage - at least four visits (%)	63.9 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	-

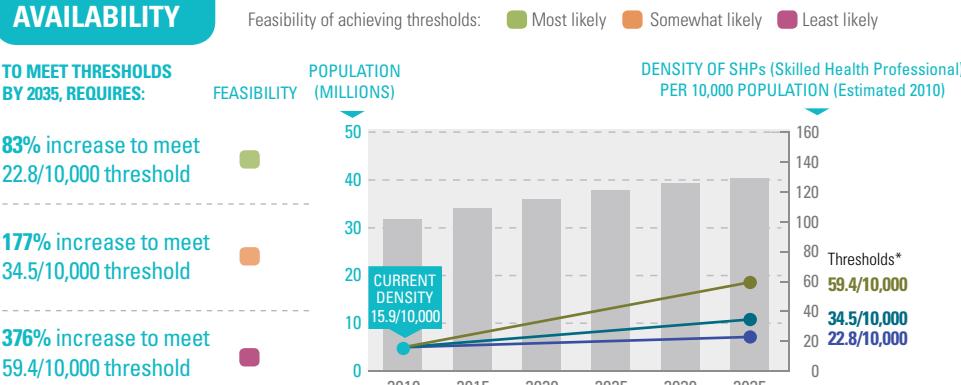
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Morocco. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW NATIONAL AVERAGE SUB-NATIONAL HIGH

6.2 Physicians

Physicians

Physicians

1.4 Nurses



TO 1 Physician



40% Female physicians



ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	■
Midwives	✗
Nurses	✗
Pharmacists	✗
Physicians	■

REGULATE:

Dentists	■ *
Midwives	✗
Nurses	✗
Pharmacists	✗
Physicians	■ *

LICENSE/RE-LICENSE:

Dentists	■ *
Midwives	■ *
Nurses	✗
Pharmacists	✗
Physicians	■ *

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓
informed by data and strategic intelligence?	✓
addressing pre-service education?	?
addressing geographical distribution and retention?	✓
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	? / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?

For which period?	2012-2016
Does the strategy/plan account for the financial costs and resource requirements to implement it?	?

✓ = Yes ■* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

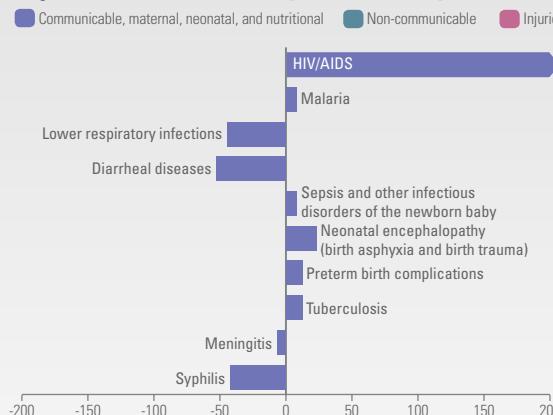
MOZAMBIQUE

Almost a third of the population (30%) is deemed to lack access to health services, and 50% have access to high-quality care. Despite progress, maternal and child mortality remain high, and there is a high burden of communicable diseases. There are a number of important health workforce challenges: the availability of skilled health professionals is low and there are both geographical and financial inequities in access. Although the percentage of women doctors is quite high and the ratio of nurses to physicians is above the OECD average, this may be a consequence of insufficient numbers of physicians, rather than an indicator of adequate skill of the workforce. Accreditation, regulation and licensing mechanisms need to be strengthened in order to improve the quality of the workforce. At the policy level, there is willingness to make human resources for health a priority and a Human Resource Development Plan (2008–2015) has been created, which will, however, need to be adequately costed.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	24; 44; 5 (2010)
Average annual rate of population change (%)	2.5 (2010–2015)
Population living in urban areas (%)	31 (2011)
Gross national income per capita (PPP int. \$)	970 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	59.58 (2008)
Total expenditure on health as a percentage of gross domestic product (%)	6.6 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	42 (2011)
External resources for health as a percentage of total expenditure on health (%)	69.8 (2011)
Life expectancy at birth (years) [all; female; male]	53; 53; 52 (2011)
Total fertility rate (per woman)	4.9 (2010)
Neonatal mortality rate (per 1,000 live births)	34 (2011)
Infant mortality rate (per 1,000 live births)	72 (2011)
Under-five mortality rate (per 1,000 live births)	103 [88-121] (2011)
Maternal mortality ratio (per 100,000 live births)	490 [300-850] (2010)
Births attended by skilled health personnel (%)	54.3 (2011)
Antenatal care coverage - at least one visit (%)	90.6 (2011)
Antenatal care coverage - at least four visits (%)	—
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	76 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Mozambique. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

1198% increase to meet 22.8/10,000 threshold

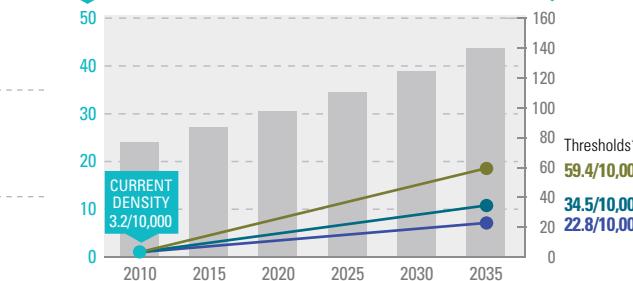
1864% increase to meet 34.5/10,000 threshold

3282% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: Most likely Somewhat likely Least likely

FEASIBILITY POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

0.2
Physicians

NATIONAL AVERAGE

0.3
Physicians

SUB-NATIONAL HIGH

3.8
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is

ABOVE

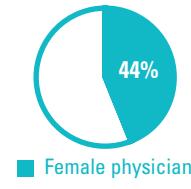
the OECD average (2.8:1).

11.3 Nurses



TO

1 Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	✓
Nurses	?
Pharmacists	?
Physicians	✓*

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	?
Pharmacists	?
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	?
Midwives	✓*
Nurses	?
Pharmacists	?
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓*

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓*

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓*

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓*

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ?/?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2008-2015

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✗

Legend: Yes ✓; Partial ✓*; No ✗; Insufficient data ?

*See Annex 1 for full explanation on country profile methods and sources.

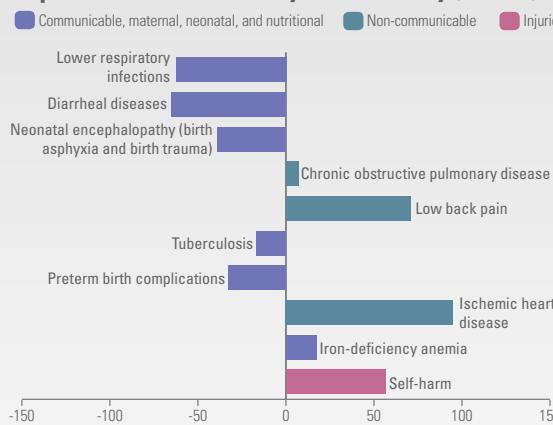
NEPAL

Although many essential services are nominally free of charge, particularly to poor and marginalized groups, there is evidence of inadequate resources to meet demand, and out-of-pocket payments constitute 62% of total health expenditure. As a low-income country with predominantly rural population, communicable diseases remain the greatest source of DALYs lost, although their burden is declining. Further, Nepal has made good progress towards reducing maternal and infant mortality, and is on track to meet both Millennium Development Goals 4 and 5. However, the availability of physicians, nurses and midwives is still low, and there is limited likelihood of scaling up to meet indicative thresholds by 2035. There may also be challenges in acceptability, with only one quarter of physicians being women and a ratio of nurses to physicians below the OECD average. Regulation and accreditation mechanisms are in place through the various health professional councils. However, the evidence indicates challenges in the motivation, retention and performance of the health workforce, which the current strategic plan for human resources for health (2011–2015) is attempting to address.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	26.8; 36; 6 (2010)
Average annual rate of population change (%)	1.2 (2010–2015)
Population living in urban areas (%)	17 (2011)
Gross national income per capita (PPP int. \$)	1260 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	24.82 (2010)
Total expenditure on health as a percentage of gross domestic product (%)	5.4 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	39 (2011)
External resources for health as a percentage of total expenditure on health (%)	14.6 (2011)
Life expectancy at birth (years) [all; female; male]	68; 69; 67 (2011)
Total fertility rate (per woman)	2.7 (2010)
Neonatal mortality rate (per 1,000 live births)	27 (2011)
Infant mortality rate (per 1,000 live births)	39 (2011)
Under-five mortality rate (per 1,000 live births)	48 [45-57] (2011)
Maternal mortality ratio (per 100,000 live births)	170 [100-290] (2010)
Births attended by skilled health personnel (%)	36.0 (2011)
Antenatal care coverage - at least one visit (%)	58.3 (2011)
Antenatal care coverage - at least four visits (%)	50.1 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	92 (2011)
Postnatal care visit within two days of birth (%)	44.5 (2011)

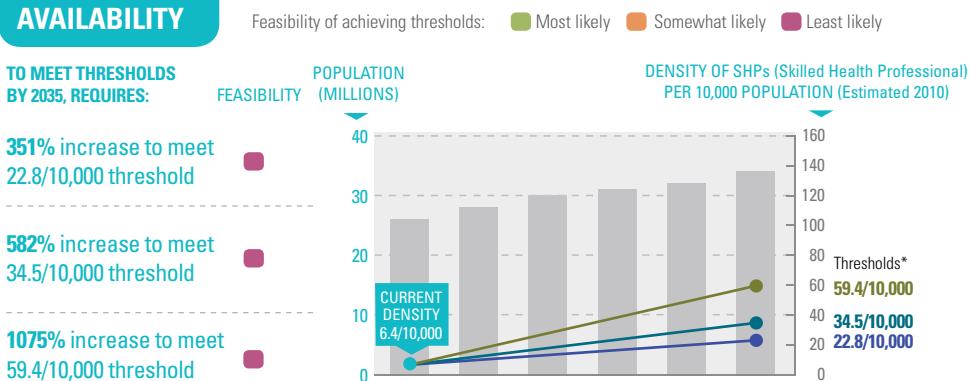
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Nepal. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

1.5
Physicians

NATIONAL AVERAGE

2.1
Physicians

SUB-NATIONAL HIGH

5.0
Physicians

ACCEPTABILITY

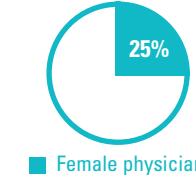
The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.1
Nurses



TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✗
Nurses	✓
Pharmacists	✓*
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✗
Nurses	✓
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓ *

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓ *
informed by data and strategic intelligence?	✓ *
addressing pre-service education?	✓ *
addressing geographical distribution and retention?	✓ *
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓ *
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	✓ * / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?	✓
For which period?	2011–2015
Does the strategy/plan account for the financial costs and resource requirements to implement it?	✓

✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

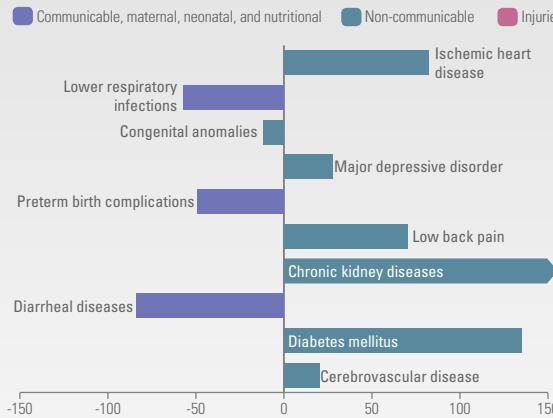
NICARAGUA

A social health insurance mechanism covers about 18% of the population. There is limited financial protection, and out-of-pocket costs are high. Certain communicable diseases remain important causes of mortality and morbidity, but noncommunicable diseases are the rising burden. The density of skilled health professionals is currently very low, but with relatively slow population growth, it may be feasible to meet the 22.8 per 10,000 population indicative threshold by 2035. The distribution of physicians also shows persistent regional disparities, posing challenges to accessibility; the financial incentives should be improved to address this challenge. Although the ratio of nurses to doctors presented here is above the OECD average, other evidence points to an excessive reliance on physicians and a scarcity of nurses. Quality control mechanisms of the workforce also appear to require improvement, in particular in relation to setting up accreditation mechanisms for health education institutions and strengthening the regulation and licensing of health workers.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	5.8; 34; 6 (2010)
Annual population growth rate (%)	1.4 (2010)
Population living in urban areas (%)	58 (2011)
Gross national income per capita (PPP int. \$)	3730 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	10.1 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	54 (2011)
External resources for health as a percentage of total expenditure on health (%)	10.8 (2011)
Life expectancy at birth (years) [all; female; male]	73; 76; 70 (2011)
Total fertility rate (per woman)	2.6 (2010)
Neonatal mortality rate (per 1,000 live births)	12 (2011)
Infant mortality rate (per 1,000 live births)	22 (2011)
Under-five mortality rate (per 1,000 live births)	26 [22-32] (2011)
Maternal mortality ratio (per 100,000 live births)	95 [54-170] (2010)
Births attended by skilled health personnel (%)	73.7 (2007)
Antenatal care coverage - at least one visit (%)	90.2 (2007)
Antenatal care coverage - at least four visits (%)	77.7 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	98 (2011)
Postnatal care visit within two days of birth (%)	7.0 (2007)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Nicaragua. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2030, REQUIRES:

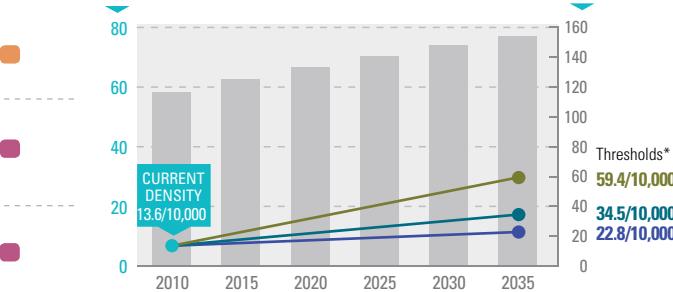
122% increase to meet 22.8/10,000 threshold

236% increase to meet 34.5/10,000 threshold

479% increase to meet 59.4/10,000 threshold

FEASIBILITY
POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional)
PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS (density per 10,000 population)

SUB-NATIONAL LOW

1.0
Physicians

NATIONAL AVERAGE

3.7
Physicians

SUB-NATIONAL HIGH

7.0
Physicians

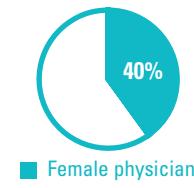
ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.

2.9
Nurses

TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✗
Midwives	✗
Nurses	✗
Pharmacists	✗
Physicians	✗

REGULATE:

Dentists	?
Midwives	✗
Nurses	?
Pharmacists	?
Physicians	✗

LICENSE/RE-LICENSE:

Dentists	?
Midwives	✗
Nurses	?
Pharmacists	?
Physicians	✗

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓

addressing pre-service education? ✓ *

addressing geographical distribution and retention? ✓ *

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓ *

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓ */ ✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2010

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✗

Legend: ✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

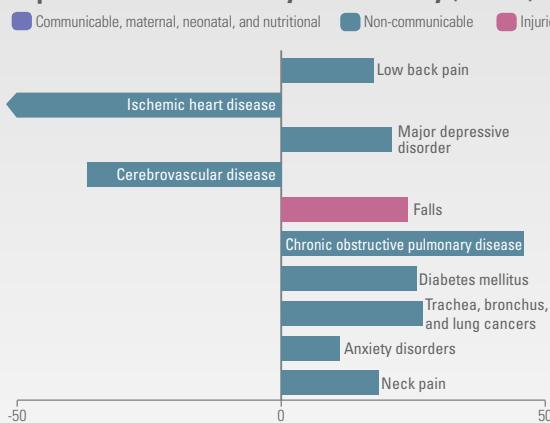
NORWAY

Norway's health system ensures universal health coverage through the tax-based National Insurance Scheme. Norway has one of the highest health expenditure in the world, at more than US\$ 4000 per person in 2010. Government expenditure on health amounts to nearly 86% of total health expenditure; private out-of-pocket expenditure is mainly for outpatient dental care and pharmaceuticals. The overall availability of health personnel is good, with a high density of physicians and nurses and a ratio of nurses to physicians above the OECD average. However, the country's demographic and geographical conditions create workforce distribution and recruitment challenges in rural areas, particularly in relation to dentists, contributing to health inequalities. Nevertheless, evidence indicates good performance across the domains of availability, acceptability and quality. Norway is one of the largest international development aid donors, exceeding the United Nation's official development assistance target of 0.7% of GDP in 2012.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	4.9; 19; 21 (2010)
Average annual rate of population change (%)	1.0 (2010-2015)
Population living in urban areas (%)	79 (2011)
Gross national income per capita (PPP int. \$)	61460 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	9.1 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	86 (2011)
External resources for health as a percentage of total expenditure on health (%)	—
Life expectancy at birth (years) [all; female; male]	81; 83; 79 (2011)
Total fertility rate (per woman)	1.9 (2010)
Neonatal mortality rate (per 1,000 live births)	2 (2011)
Infant mortality rate (per 1,000 live births)	3 (2011)
Under-five mortality rate (per 1,000 live births)	3 [3-4] (2011)
Maternal mortality ratio (per 100,000 live births)	7 [4-12] (2010)
Births attended by skilled health personnel (%)	99.1 (2010)
Antenatal care coverage - at least one visit (%)	—
Antenatal care coverage - at least four visits (%)	—
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	94 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Norway. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

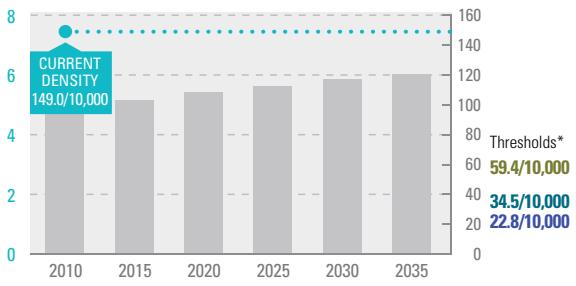
0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

FEASIBILITY (MILLIONS)

POPULATION

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

Physicians

NATIONAL AVERAGE

40.7
Physicians

SUB-NATIONAL HIGH

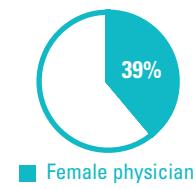
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.



1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

REGULATE:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

LICENSE/RE-LICENSE:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓ *

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓ / ✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓ *

For which period? 2011-2015

Does the strategy/plan account for the financial costs and resource requirements to implement it? ?

✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

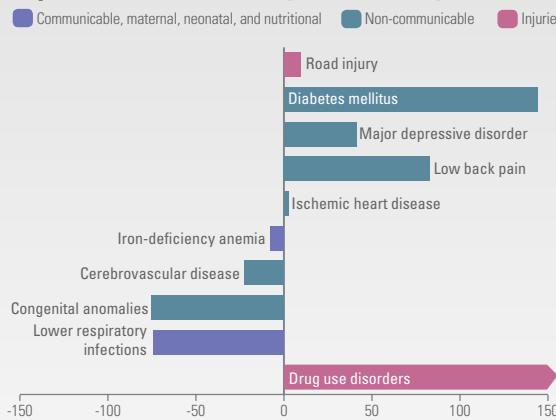
OMAN

The government funds the health care system in Oman. The government provides more than 80% of the country's health care services. Health care services are free of charge for Omani nationals, while foreign workers and expatriates have to be enrolled in an insurance system. The main health workforce policy is the Omanization policy, which aims to produce enough health workers to reduce dependence on foreign health professionals. There is an important deficit both of specialized doctors and of nurses. The staffing situation is periodically reviewed and readjusted. Health workers are distributed across Oman following Ministry of Health guidelines and indications, and rotation of workers from one region to other is common (in cycles of two years) under civil service law. There is a greater concentration of physicians in the capital city of Muscat. Women physicians are 39% of the total physician workforce. The nurse-to-physician ratio is below the OECD average. Mechanisms for regulating and licensing the health workforce are functioning adequately. Relicensing is mandatory for all health professionals. Most education institutions are in the process of obtaining accreditation.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	2.8; 27; 4 (2010)
Average annual rate of population change (%)	7.9 (2010-2015)
Population living in urban areas (%)	73 (2011)
Gross national income per capita (PPP int. \$)	—
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	2.3 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	81 (2011)
External resources for health as a percentage of total expenditure on health (%)	—
Life expectancy at birth (years) [all; female; male]	72; 76; 70 (2011)
Total fertility rate (per woman)	2.3 (2010)
Neonatal mortality rate (per 1,000 live births)	5 (2011)
Infant mortality rate (per 1,000 live births)	7 (2011)
Under-five mortality rate (per 1,000 live births)	9 [7-12] (2011)
Maternal mortality ratio (per 100,000 live births)	32 [19-51] (2010)
Births attended by skilled health personnel (%)	98.6 (2008)
Antenatal care coverage - at least one visit (%)	99.4 (2010)
Antenatal care coverage - at least four visits (%)	85.3 (2010)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Oman. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

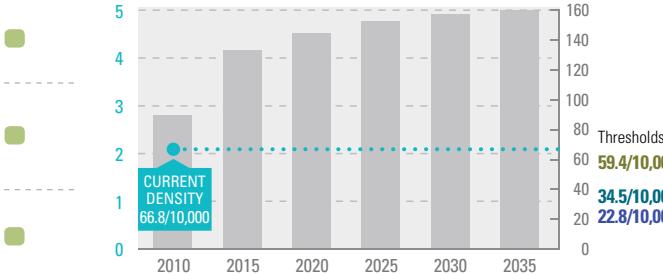
0% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

12.2
Physicians

NATIONAL AVERAGE

20.5
Physicians

SUB-NATIONAL HIGH

26
Physicians

ACCEPTABILITY

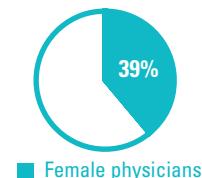
The ratio of nurses to physicians is

BELOW
the OECD average (2.8:1).

2.2
Nurses

TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2011-2015

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Yes = Yes Partial = Partial No = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

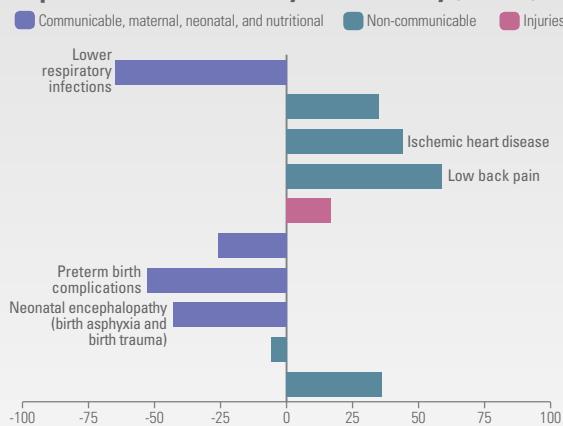
PERU

The Ministry of Health (60%) and the Seguro Social de Salud de Perú (EsSalud) (30%) cover 90% of the population. The remaining 10% receive services from the private sector, the Armed Forces and the National Police. The Integral Health Insurance (Seguro Integral de Salud – SIS) covers the informal economy workers, self-employed in rural areas and the unemployed and their families. Since Peru's system is decentralized, basic health services are defined locally according to the financial resources available and organization of services. Peru has a low health workforce density and faces geographical distribution imbalances: there are 7.7 physicians per 10,000 habitants in Lima versus less than 4.0 in rural regions such as Andean and Amazon jungle. Other types of health workers such as nurses (1 per physician) and midwives have a similar situation. The country requires strengthening of the information system for human resources for health and of the regulation of the quality of health professional education and practice. A plan for human resources for health (2010–2014) has been designed to address these challenges.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	29.3; 30; 9 (2010)
Average annual rate of population change (%)	1.3 (2010–2015)
Population living in urban areas (%)	77 (2011)
Gross national income per capita (PPP int. \$)	9440 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	4.91 (2010)
Total expenditure on health as a percentage of gross domestic product (%)	4.8 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	56 (2011)
External resources for health as a percentage of total expenditure on health (%)	1.1 (2011)
Life expectancy at birth (years) [all; female; male]	77; 78; 75 (2011)
Total fertility rate (per woman)	2.5 (2010)
Neonatal mortality rate (per 1,000 live births)	9 (2011)
Infant mortality rate (per 1,000 live births)	14 (2011)
Under-five mortality rate (per 1,000 live births)	18 [16-19] (2011)
Maternal mortality ratio (per 100,000 live births)	67 [42-110] (2010)
Births attended by skilled health personnel (%)	85.0 (2011)
Antenatal care coverage - at least one visit (%)	95.4 (2011)
Antenatal care coverage - at least four visits (%)	94.2 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	91 (2011)
Postnatal care visit within two days of birth (%)	91.5 (2011)

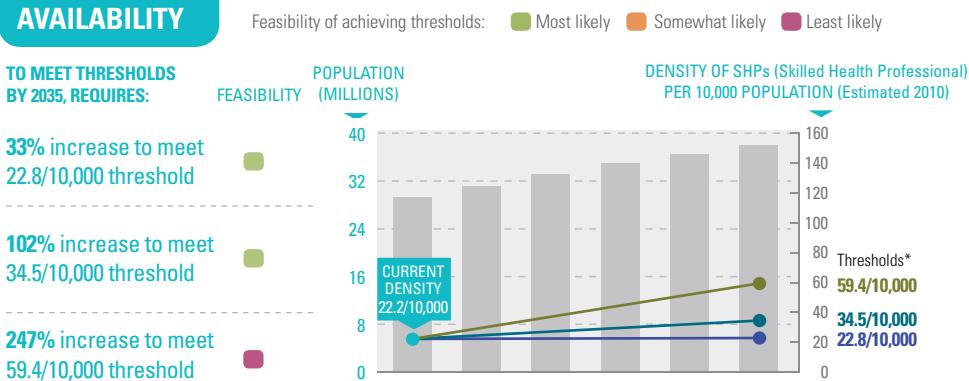
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute to Peru. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

4.0
Physicians

NATIONAL AVERAGE

9.2
Physicians

SUB-NATIONAL HIGH

7.7
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓ *
Midwives	✓ *
Nurses	✓ *
Pharmacists	✓ *
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓
informed by data and strategic intelligence?	
addressing pre-service education?	✓
addressing geographical distribution and retention?	✓
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	? / ?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?	✓
For which period?	2010–2014
Does the strategy/plan account for the financial costs and resource requirements to implement it?	✓

✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

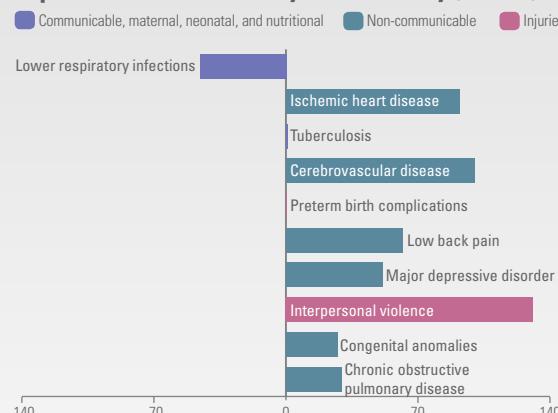
PHILIPPINES

PhilHealth coverage is theoretically available to the entire population. Funding for the scheme varies based on the population covered, although most funds come from general taxation. The service delivery system is 61% private and 39% public. PhilHealth beneficiaries have access to a comprehensive package of services. The Philippines is the largest exporter of nurses worldwide. As a result of this nurse brain drain, the Philippine health care system has experienced challenges, including numerous hospital closures and high nurse turnover. Most physicians (56%) are women. There are disparities in distribution of the health workforce. Some specific policies have been implemented to address the accessibility issue such as the Nurses Assigned to Rural Service programme or the Doctors to the Barrios programme. Mechanisms for regulating and licensing the health workforce are in place, but the evidence of accreditation for private nursing schools is scarce. A new National Database of Human Resources for Health Information System that requires facilities to register their professionals to build a database of human resources for health will attempt to address challenges in the accessibility, acceptability, availability and quality of the health workforce.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	93.4; 35; 6 (2010)
Average annual rate of population change (%)	1.7 (2010-2015)
Population living in urban areas (%)	49 (2011)
Gross national income per capita (PPP int. \$)	4140 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	18.42 (2009)
Total expenditure on health as a percentage of gross domestic product (%)	4.1 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	33 (2011)
External resources for health as a percentage of total expenditure on health (%)	2.2 (2011)
Life expectancy at birth (years) [all; female; male]	69; 73; 66 (2011)
Total fertility rate (per woman)	3.1 (2010)
Neonatal mortality rate (per 1,000 live births)	12 (2011)
Infant mortality rate (per 1,000 live births)	20 (2011)
Under-five mortality rate (per 1,000 live births)	25 [22-30] (2011)
Maternal mortality ratio (per 100,000 live births)	99 [66-140] (2010)
Births attended by skilled health personnel (%)	62.2 (2008)
Antenatal care coverage - at least one visit (%)	91.1 (2008)
Antenatal care coverage - at least four visits (%)	77.8 (2008)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	80 (2011)
Postnatal care visit within two days of birth (%)	76.9; (2008)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in the Philippines. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

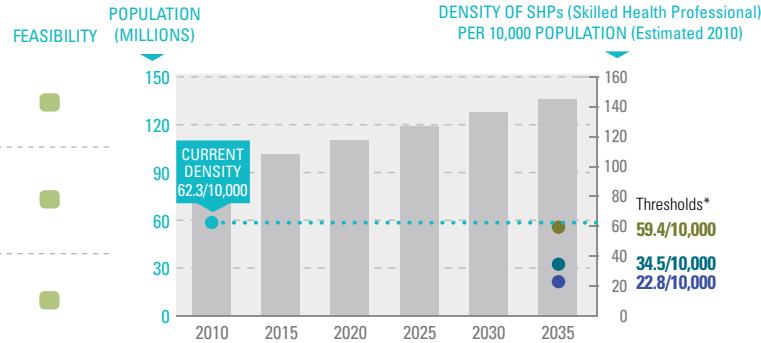
TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

39% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW NATIONAL AVERAGE SUB-NATIONAL HIGH

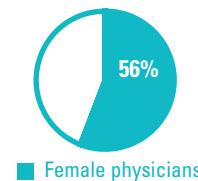
2.8
Physicians

11.5
Physicians

27.8
Physicians

3.8
Nurses

1
Physician



ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	?
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	✓*
Nurses	✓*
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓ *

informed by data and strategic intelligence? ✓ *

addressing pre-service education? ✓ *

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓ */ ✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2005-2030

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

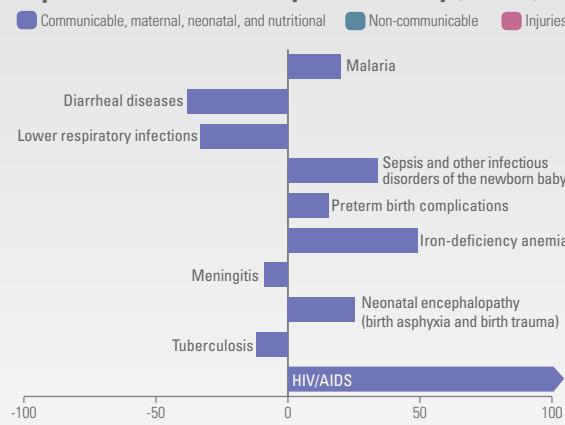
SENEGAL

About 20% of the population is covered through the compulsory health insurance scheme for formal-sector workers or through private health insurance, mainly in the form of *mutuelles*. Health services are available free of charge in public facilities. Out-of-pocket expenditure, mainly for medicines and for private services, accounts for 34% of the national health expenditure. A compulsory universal insurance scheme, a priority for the President of the Republic, is in the process of being created, as a strategy for improving equity in access to health services. Senegal has made progress towards achieving Millennium Development Goal 4 and maternal mortality rates have been reduced, but Millennium Development Goal 5 is unlikely to be achieved. Skilled health personnel attended 65% of births between 2005 and 2012, but this varies considerably according to place of residence, economic status and educational level. The National Health Plan 2009–2018 recognizes that measures are needed to tackle the scarcity of health personnel and disparities in distribution across regions, by increasing training capacity at the national level and adopting measures to promote workforce retention.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	13; 44; 4 (2010)
Average annual rate of population change (%)	2.9 (2010–2015)
Population living in urban areas (%)	43 (2011)
Gross national income per capita (PPP int. \$)	1940 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	6.0 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	58 (2011)
External resources for health as a percentage of total expenditure on health (%)	14.0 (2011)
Life expectancy at birth (years) [all; female; male]	61; 62; 60 (2011)
Total fertility rate (per woman)	4.8 (2010)
Neonatal mortality rate (per 1,000 live births)	26 (2011)
Infant mortality rate (per 1,000 live births)	47 (2011)
Under-five mortality rate (per 1,000 live births)	65 [59-91] (2011)
Maternal mortality ratio (per 100,000 live births)	370 [230-640] (2010)
Births attended by skilled health personnel (%)	65.1 (2011)
Antenatal care coverage - at least one visit (%)	93.3 (2011)
Antenatal care coverage - at least four visits (%)	50 (2011)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	83 (2011)
Postnatal care visit within two days of birth (%)	68 (2011)

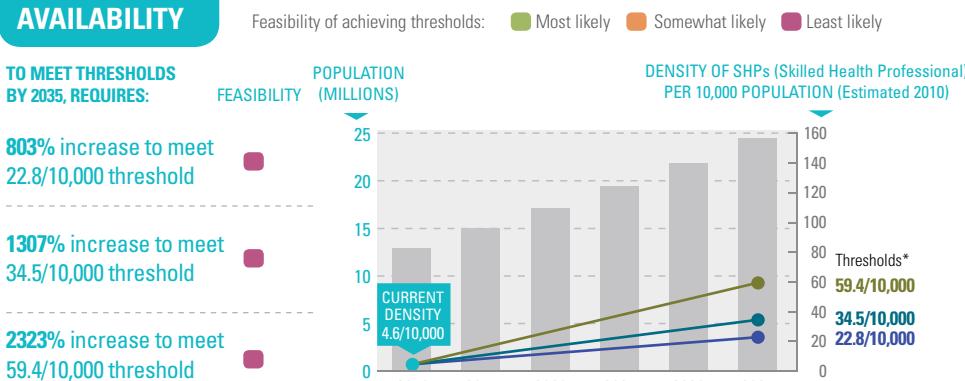
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Senegal. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

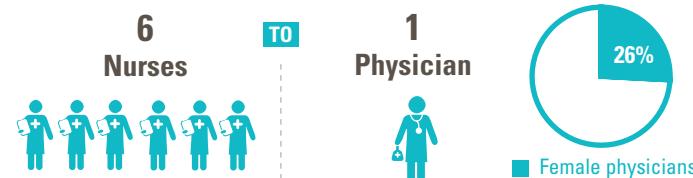


ACCESSIBILITY

	SUB-NATIONAL LOW	NATIONAL AVERAGE	SUB-NATIONAL HIGH
GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS (density per 10,000 population)	0.2 Physicians	0.6 Physicians	4.3 Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	✓*
Nurses	✓*
Pharmacists	?
Physicians	?

REGULATE:

Dentists	✓*
Midwives	✗
Nurses	✗
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	?
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓ *

Policy and Management

Is existing health workforce policy and human resource management:	
related to population health needs?	✓
informed by data and strategic intelligence?	✓
addressing pre-service education?	✓ *
addressing geographical distribution and retention?	
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓ *

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?	✓ *
For which period?	2009–2018
Does the strategy/plan account for the financial costs and resource requirements to implement it?	?

✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

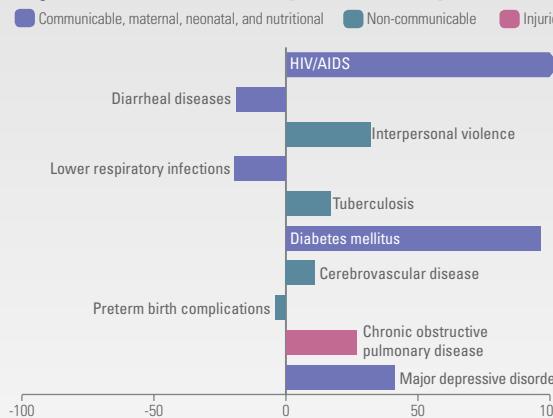
SOUTH AFRICA

South Africa's health system comprises a public-private mix, characterized by entrenched maldistribution of resources dating back to the apartheid era, and with inefficiency and inequity that contribute to falling short of the health Millennium Development Goals. Steps have been taken to put the country on a trajectory of achieving universal health coverage through a national health insurance system. The focus on human resources for health has increased as part of a 2011 strategic plan, driven by the very high burden of HIV, tuberculosis and maternal and child diseases. The ratio of nurses to physicians is above the OECD average, and the percentage of women physicians is 30%. Mechanisms for accreditation, regulation and licensing of the health workforce are in place, and some evidence indicates their efficiency. Despite some good progress, availability and accessibility still present challenges. The density of physicians is well below OECD standards, with a great variation in density of physicians between regions. Migration flows to high-income countries are important, partially compensated by inflows from poorer neighboring countries. Recently these flows have been reduced significantly, especially for nurses.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	51.5; 30; 7 (2010)
Average annual rate of population change (%)	0.8 (2010-2015)
Population living in urban areas (%)	62 (2011)
Gross national income per capita (PPP int. \$)	10710 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	13.77; 2009 (2010)
Total expenditure on health as a percentage of gross domestic product (%)	8.5 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	48 (2011)
External resources for health as a percentage of total expenditure on health (%)	2.1 (2011)
Life expectancy at birth (years) [all; female; male]	58; 60; 57 (2011)
Total fertility rate (per woman)	2.5 (2010)
Neonatal mortality rate (per 1,000 live births)	19 (2011)
Infant mortality rate (per 1,000 live births)	35 (2011)
Under-five mortality rate (per 1,000 live births)	47 [32-60] (2011)
Maternal mortality ratio (per 100,000 live births)	300 [150-500] (2010)
Births attended by skilled health personnel (%)	—
Antenatal care coverage - at least one visit (%)	—
Antenatal care coverage - at least four visits (%)	—
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	72 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in South Africa. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

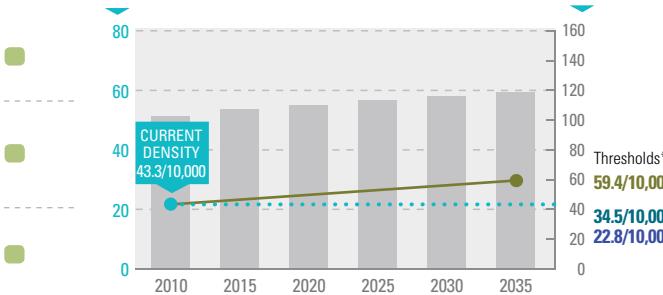
59% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional PER 10,000 POPULATION (Estimated 2010))



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS (density per 10,000 population)

SUB-NATIONAL LOW

1.8
Physicians

NATIONAL AVERAGE

7.6
Physicians

SUB-NATIONAL HIGH

14.7
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.

4.8 Nurses



1 Physician

33% Female physicians

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓*
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2012-2017

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

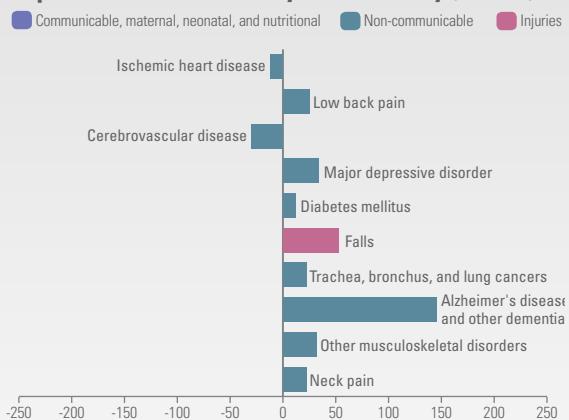
SPAIN

The structure of the health system in Spain matches its decentralized nature, and the management competencies of health care services have progressively been transferred from the central government to the Autonomous Communities. Due to the economic crisis, the sustainability of the health system in Spain has been severely affected. Recent measures (a royal decree in 2012) have shifted health coverage from universal to employment based, implicating limited access for those without a legal residence permit. Accessibility, acceptability and quality still show room for improvement. The ratio of nurses to physicians is below the OECD average, and the density of physicians varies greatly between Autonomous Communities. Planning and regulation of human resources for health vary from one Autonomous Community to another. There is no national plan for human resources for health; there is a proposal to create an integrated national registry of health professionals scheduled for 2013.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	46.2; 15; 22	(2010)
Average annual rate of population change (%)	0.4	(2010-2015)
Population living in urban areas (%)	77	(2011)
Gross national income per capita (PPP int. \$)	31400	(2011)
Population living on <\$1 (PPP int. \$) a day (%)	—	
Total expenditure on health as a percentage of gross domestic product (%)	9.4	(2011)
General government expenditure on health as a percentage of total expenditure on health (%)	74	(2011)
External resources for health as a percentage of total expenditure on health (%)	—	
Life expectancy at birth (years) [all; female; male]	82; 85; 79	(2011)
Total fertility rate (per woman)	1.5	(2010)
Neonatal mortality rate (per 1,000 live births)	3	(2011)
Infant mortality rate (per 1,000 live births)	4	(2011)
Under-five mortality rate (per 1,000 live births)	4 [4-5]	(2011)
Maternal mortality ratio (per 100,000 live births)	6 [4-7]	(2010)
Births attended by skilled health personnel (%)	—	
Antenatal care coverage - at least one visit (%)	—	
Antenatal care coverage - at least four visits (%)	—	
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	97	(2011)
Postnatal care visit within two days of birth (%)	—	

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Spain. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

TO MEET THRESHOLDS BY 2035, REQUIRES:

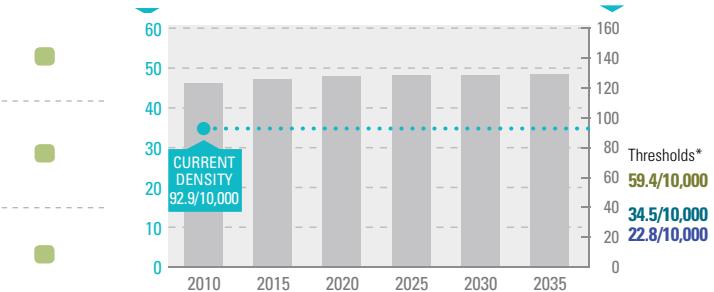
0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

0% increase to meet 59.4/10,000 threshold

FEASIBILITY
POPULATION
(MILLIONS)

DENSITY OF SHPs (Skilled Health Professional)
PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

31.9
Physicians

NATIONAL AVERAGE

39.6
Physicians

SUB-NATIONAL HIGH

57.4
Physicians

ACCEPTABILITY

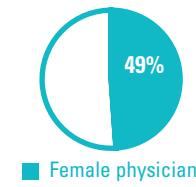
The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.3
Nurses



TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	*
Midwives	X
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	*
Midwives	X
Nurses	*
Pharmacists	*
Physicians	*

LICENSE/RE-LICENSE:

Dentists	*
Midwives	X
Nurses	*
Pharmacists	*
Physicians	*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? *

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? *

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? *

addressing pre-service education? ?

addressing geographical distribution and retention? *

addressing health workforce performance (e.g. competence, responsiveness and productivity)? *

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? */green

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? *

For which period? ?

Does the strategy/plan account for the financial costs and resource requirements to implement it? ?

✓ = Yes * = Partial X = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

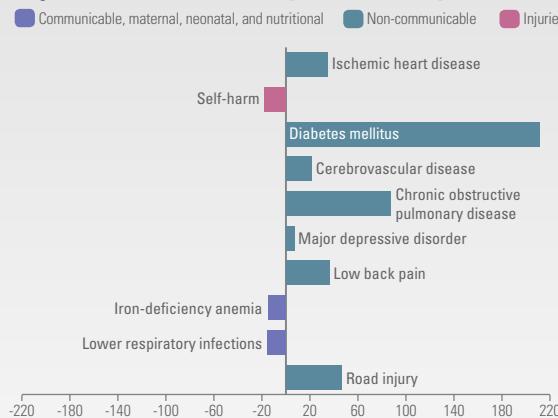
SRI LANKA

Most public health services are available free of charge to all citizens. The main health challenge is the rising burden of noncommunicable diseases, including heart disease, stroke and diabetes. The performance of the workforce across the different dimensions is generally good, with some remaining challenges. The availability of skilled health professionals is currently above the 22.8 per 10,000 population threshold and requires only a slight increase to keep pace with population growth up to 2035; it might even be feasible to meet the higher 34.5 per 10,000 population threshold. There is, however, a skewed distribution of staff towards urban areas, which affects accessibility. The ratio of nurses to physicians is above the OECD average. In terms of indicators of quality, there may be scope for improvement in accreditation of educational institutions. Improving in-service training is another area in need of attention. There is a strong policy backing for developing human resources for health, including a costed strategic plan (2009–2018), but better information systems on human resources for health are required.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	20.8; 25; 12 (2010)
Average annual rate of population change (%)	0.8 (2010–2015)
Population living in urban areas (%)	15 (2011)
Gross national income per capita (PPP int. \$)	5520 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	7.04 (2007)
Total expenditure on health as a percentage of gross domestic product (%)	3.4 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	45 (2011)
External resources for health as a percentage of total expenditure on health (%)	2.7 (2011)
Life expectancy at birth (years) [all; female; male]	75; 78; 71 (2011)
Total fertility rate (per woman)	2.3 (2010)
Neonatal mortality rate (per 1,000 live births)	8 (2011)
Infant mortality rate (per 1,000 live births)	11 (2011)
Under-five mortality rate (per 1,000 live births)	12 [10–13] (2011)
Maternal mortality ratio (per 100,000 live births)	35 [25–49] (2010)
Births attended by skilled health personnel (%)	98.6 (2007)
Antenatal care coverage - at least one visit (%)	99.4 (2007)
Antenatal care coverage - at least four visits (%)	92.5 (2007)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	70.8 (2007)

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Sri Lanka. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

5% increase to meet 22.8/10,000 threshold

60% increase to meet 34.5/10,000 threshold

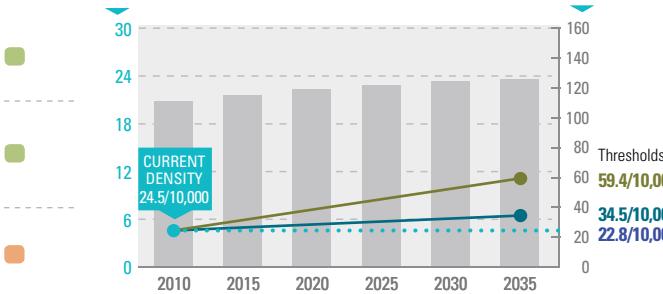
175% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

Physicians

NATIONAL AVERAGE

4.9 Physicians

SUB-NATIONAL HIGH

Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.

3.1 Nurses



TO

1 Physician



34% Female physicians

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	?
Midwives	?
Nurses	?
Pharmacists	?
Physicians	?

REGULATE:

Dentists	?
Midwives	✓
Nurses	✓
Pharmacists	✓*
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	?
Midwives	✓*
Nurses	✓*
Pharmacists	?
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓*

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✗

addressing pre-service education? ✓*

addressing geographical distribution and retention? ✓*

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓*

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ?/?

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ✓

For which period? 2009–2018

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

Legend: ✓ = Yes ✓* = Partial ✗ = No ?/? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

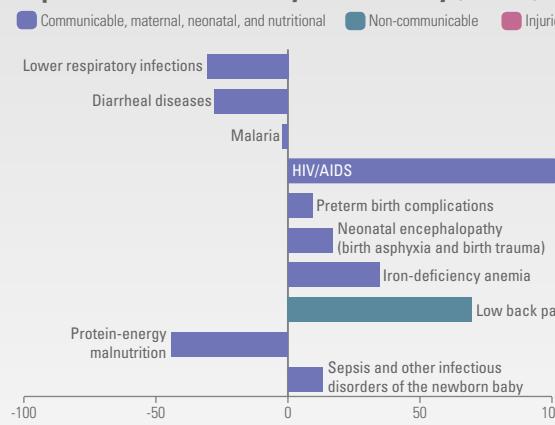
SUDAN

Although there is a National Insurance Scheme for public and formal sector employees, user fees are charged for services, and out-of-pocket payments account for up to 70–80% of total health expenditure. Noncommunicable diseases are the greatest health challenge at present, and there has been limited progress towards achieving the health Millennium Development Goals. The availability of skilled health professionals is below the minimum international thresholds – but few data are available on the accessibility and acceptability dimensions of the workforce. In terms of quality, evidence indicates that, on the whole, mechanisms for accreditation of educational institutions and regulation and licensing of the workforce are in place and functioning. The recently developed plan for human resources for health (2012–2016) aims to address important aspects such as the distribution, retention, quality and performance of the health workforce.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	35.7; 40; 6 (2010)
Average annual rate of population change (%)	2.1 (2010–2015)
Population living in urban areas (%)	33 (2011)
Gross national income per capita (PPP int. \$)	2120 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	19.80 (2009)
Total expenditure on health as a percentage of gross domestic product (%)	8.4 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	28 (2011)
External resources for health as a percentage of total expenditure on health (%)	4.5 (2011)
Life expectancy at birth (years) [all; female; male]	62; 64; 60 (2011)
Total fertility rate (per woman)	4.4 (2010)
Neonatal mortality rate (per 1,000 live births)	31 (2011)
Infant mortality rate (per 1,000 live births)	57 (2011)
Under-five mortality rate (per 1,000 live births)	86 [66–117] (2011)
Maternal mortality ratio (per 100,000 live births)	730 [380–1400] (2010)
Births attended by skilled health personnel (%)	–
Antenatal care coverage - at least one visit (%)	–
Antenatal care coverage - at least four visits (%)	–
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	93 (2011)
Postnatal care visit within two days of birth (%)	–

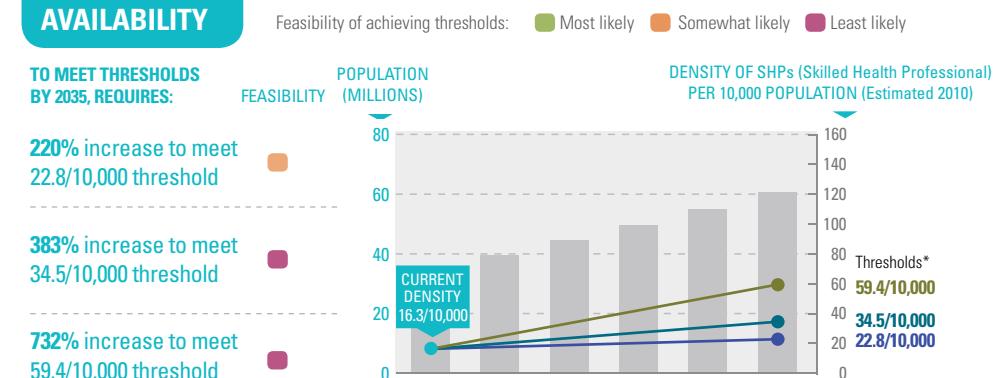
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute to Spain. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW NATIONAL AVERAGE SUB-NATIONAL HIGH

— Physicians 2.8 Physicians — Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓*
Nurses	✓*
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2012–2016

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Legend: ✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

THAILAND

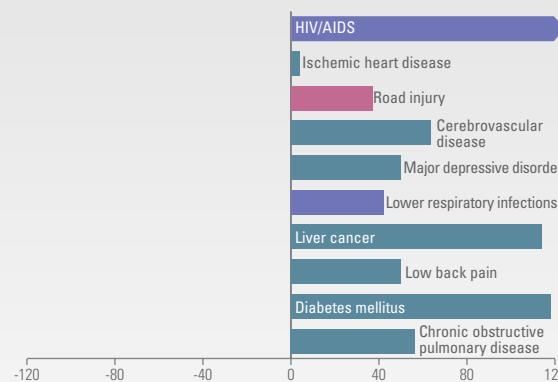
Social health insurance mechanisms, the largest of which is the Universal Coverage Scheme, cover about 98% of the population. The benefits package includes inpatient, outpatient, curative and preventive care. Noncommunicable diseases are the greatest causes of DALYs and years of life lost, with the exception of HIV infection, which is the number one cause of mortality and morbidity. Of the dimensions of availability, accessibility, acceptability and quality of the workforce, accessibility is perhaps in greatest need of attention, as disparities are observed in the geographical distribution of health workers. Availability of skilled health professionals is below the thresholds but with a good chance of scaling up before 2035. Evidence indicates that good mechanisms are in place for accrediting, regulating and licensing the health workforce. The strategic plan for human resources for health (2007–2016) includes a focus on addressing the inequitable distribution as well as other measures for scaling up and improving quality and performance.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	66.4; 21; 13 (2010)
Average annual rate of population change (%)	0.3 (2010–2015)
Population living in urban areas (%)	34 (2011)
Gross national income per capita (PPP int. \$)	8360 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	<2 (2008)
Total expenditure on health as a percentage of gross domestic product (%)	4.1 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	76 (2011)
External resources for health as a percentage of total expenditure on health (%)	0.4 (2011)
Life expectancy at birth (years) [all; female; male]	74; 77; 71 (2011)
Total fertility rate (per woman)	1.6 (2010)
Neonatal mortality rate (per 1,000 live births)	8 (2011)
Infant mortality rate (per 1,000 live births)	11 (2011)
Under-five mortality rate (per 1,000 live births)	12 [8-17] (2011)
Maternal mortality ratio (per 100,000 live births)	48 [33-70] (2010)
Births attended by skilled health personnel (%)	99.4 (2009)
Antenatal care coverage - at least one visit (%)	99.1 (2009)
Antenatal care coverage - at least four visits (%)	79.6 (2009)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	99 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)

■ Communicable, maternal, neonatal, and nutritional ■ Non-communicable ■ Injuries



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Thailand. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

32% increase to meet 22.8/10,000 threshold

99% increase to meet 34.5/10,000 threshold

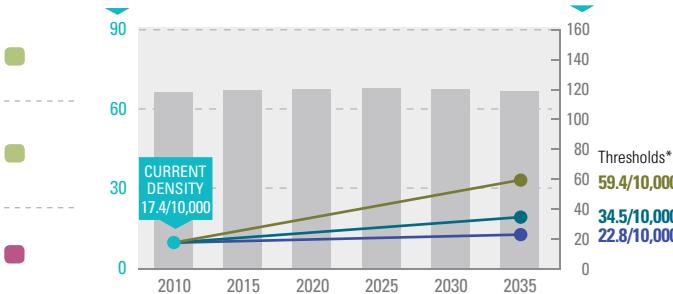
243% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional PER 10,000 POPULATION (Estimated 2010))



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

1.2
Physicians

NATIONAL AVERAGE

3
Physicians

SUB-NATIONAL HIGH

10.5
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.

5.1 Nurses



TO

1 Physician



41% Female physicians

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	✓
Nurses	✓
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓
Nurses	✓
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?



Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?



Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?



informed by data and strategic intelligence?



addressing pre-service education?



addressing geographical distribution and retention?



addressing health workforce performance (e.g. competence, responsiveness and productivity)?



addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?



Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?



For which period?

2007–2016

Does the strategy/plan account for the financial costs and resource requirements to implement it?



Legend: ✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

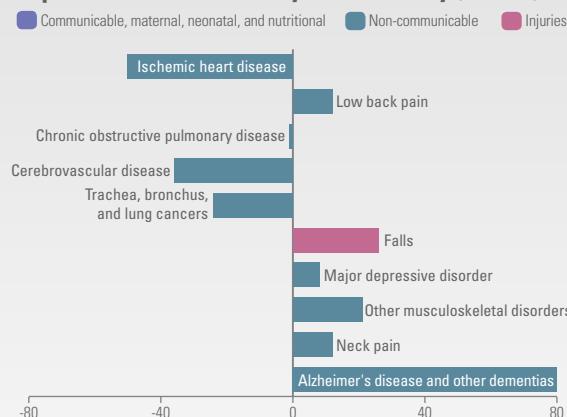
UNITED KINGDOM

England guarantees the right to health care access to all residents through its National Health Service. Public funding is supplemented by growing private medical insurance expenditure, particularly in recent years. Overall, focus on the performance of the health workforce is increasing. Various agencies and bodies such as Health Education England and the Centre for Workforce Intelligence have been set up to improve education, training and planning. Despite these concrete measures to improve the quality of the health workforce, there are still some challenges. The ratio of nurses to physicians is below the OECD average, and the density of physicians also varies across regions. Current financial constraints are creating further workforce challenges, and the passage of the new Health and Social Care Act may have implications for coherent workforce planning. In addition, England has heavily relied on professionals trained overseas to meet service demands for many years. However, in recent years measures have been taken to scale up the domestic production of health workers and move towards self-sustainability.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	62.1; 17; 23 (2010)
Average annual rate of population change (%)	0.6 (2010-2015)
Population living in urban areas (%)	80 (2011)
Gross national income per capita (PPP int. \$)	36010 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	9.3 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	83 (2011)
External resources for health as a percentage of total expenditure on health (%)	—
Life expectancy at birth (years) [all; female; male]	80; 82; 79 (2011)
Total fertility rate (per woman)	1.9 (2010)
Neonatal mortality rate (per 1,000 live births)	3 (2011)
Infant mortality rate (per 1,000 live births)	4 (2011)
Under-five mortality rate (per 1,000 live births)	5 [5-6] (2011)
Maternal mortality ratio (per 100,000 live births)	12 [10-14] (2010)
Births attended by skilled health personnel (%)	—
Antenatal care coverage - at least one visit (%)	—
Antenatal care coverage - at least four visits (%)	—
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	95 (2011)
Postnatal care visit within two days of birth (%)	—

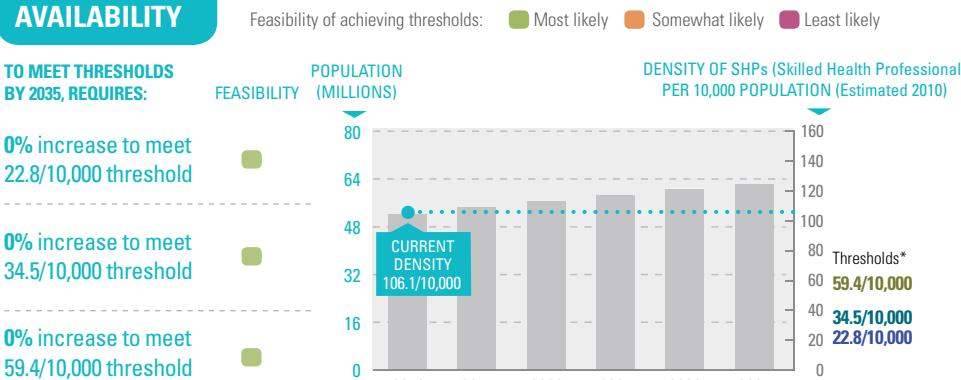
Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in the United Kingdom. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

28.8
Physicians

NATIONAL AVERAGE

36.5
Physicians

SUB-NATIONAL HIGH

53.2
Physicians

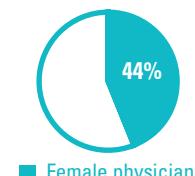
ACCEPTABILITY

The ratio of nurses to physicians is **BELOW** the OECD average (2.8:1).

1.9
Nurses

TO

1
Physician



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

REGULATE:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

LICENSE/RE-LICENSE:

Dentists	■
Midwives	■
Nurses	■
Pharmacists	■
Physicians	■

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management?	✓
Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management?	✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs?	✓
informed by data and strategic intelligence?	✓
addressing pre-service education?	✓
addressing geographical distribution and retention?	✓
addressing health workforce performance (e.g. competence, responsiveness and productivity)?	✓
addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel?	✓ / ✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms?

For which period?

Does the strategy/plan account for the financial costs and resource requirements to implement it?

✓ = Yes ✓ * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

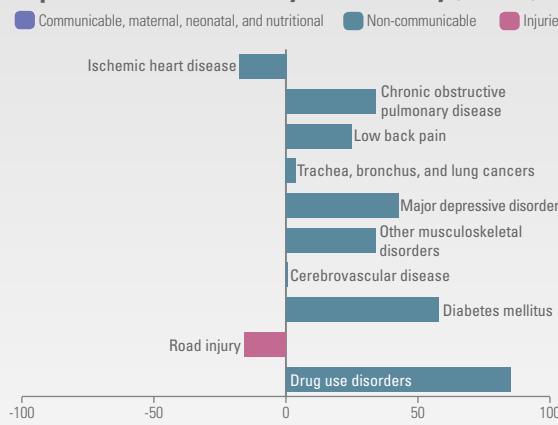
UNITED STATES OF AMERICA

In 2011, private expenditure comprised 54% of total health expenditure, of which about 21% was out of pocket. About 84% of the population has some insurance coverage, of whom 66% through their employer or personally, and the other 22% under various federal programmes. These are administered by states that are required to offer mandatory benefits; they can add other benefits such as dental services and prescription drugs. They can charge premiums and copayments. Medicare, the programme for people older than 65 years, covers about 50% of the costs of visits and surgeries, and supplies, but not long-term care or dental care. There is a 3.9 nurses-to-physicians ratio and a 24.2 per 10,000 population density of physicians with major variation between and within the 50 states and federal district. There are programmes to attract health workers to underserved areas. Shortages are expected to be high for general practitioners and for nurses, which may continue to stimulate recruitment abroad. Regulation of professional practice is state-based and therefore varies.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	312.2; 20; 18 (2010)
Average annual rate of population change (%)	0.8 (2010-2015)
Population living in urban areas (%)	82 (2011)
Gross national income per capita (PPP int. \$)	48820 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	–
Total expenditure on health as a percentage of gross domestic product (%)	17.9 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	46 (2011)
External resources for health as a percentage of total expenditure on health (%)	–
Life expectancy at birth (years) [all; female; male]	79; 81; 76 (2011)
Total fertility rate (per woman)	2.1 (2010)
Neonatal mortality rate (per 1,000 live births)	4 (2011)
Infant mortality rate (per 1,000 live births)	6 (2011)
Under-five mortality rate (per 1,000 live births)	8 [7-8] (2011)
Maternal mortality ratio (per 100,000 live births)	21 [18-23] (2010)
Births attended by skilled health personnel (%)	99.4 (2010)
Antenatal care coverage - at least one visit (%)	–
Antenatal care coverage - at least four visits (%)	97.4 (2009)
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	94 (2011)
Postnatal care visit within two days of birth (%)	–

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in the United States of America. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

0% increase to meet 22.8/10,000 threshold

0% increase to meet 34.5/10,000 threshold

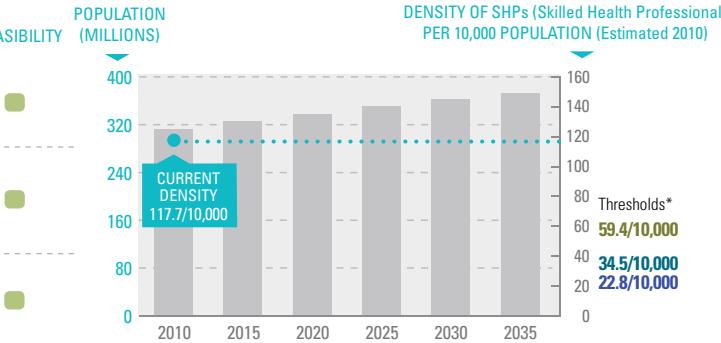
0% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: ■ Most likely ■ Somewhat likely ■ Least likely

FEASIBILITY

POPULATION (MILLIONS)

DENSITY OF SHPs (Skilled Health Professional) PER 10,000 POPULATION (Estimated 2010)



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

Physicians

NATIONAL AVERAGE

24.2 Physicians

SUB-NATIONAL HIGH

Physicians

ACCEPTABILITY

The ratio of nurses to physicians is ABOVE the OECD average.

3.9 Nurses



TO

1 Physician



Female physicians

33%

QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓
Midwives	?
Nurses	✓
Pharmacists	✓
Physicians	✓

REGULATE:

Dentists	✓
Midwives	?
Nurses	✓
Pharmacists	✓
Physicians	✓

LICENSE/RE-LICENSE:

Dentists	✓
Midwives	?
Nurses	✓
Pharmacists	✓
Physicians	✓

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ?

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✓ *

addressing pre-service education? ✓

addressing geographical distribution and retention? ✓

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ✓ / ✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? *

For which period? 2010-2015

Does the strategy/plan account for the financial costs and resource requirements to implement it? ✓

Legend: ✓ = Yes * = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.

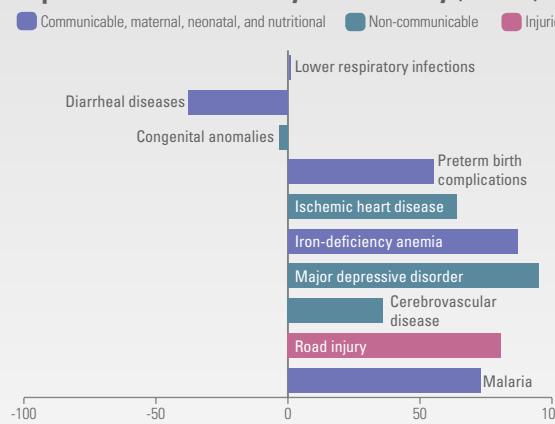
YEMEN

About half of the population is estimated to have access to basic health services, and user fees are common. Although there are exemption policies for poor people, evidence indicates that these may not be properly functioning in practice. The burden of disease relates to a mix of communicable and noncommunicable causes. Some progress has been made towards meeting Millennium Development Goal 5, but child mortality is still a concern. There are challenges across all four domains of the availability, accessibility, acceptability and quality of the health workforce. The density of skilled health professionals is low and unlikely to meet indicative thresholds by 2035; inequities in geographical distribution and accessibility persist. The percentage of women doctors is 25%. Very limited information is available on the quality control mechanisms of the workforce. Governance and coordination for human resources for health require strengthening to effectively tackle these challenges.

POPULATION AND HEALTH

Population [all (000s); proportion under 15 (%); proportion over 60 (%)]	22.8; 44; 4 (2010)
Average annual rate of population change (%)	2.3 (2010-2015)
Population living in urban areas (%)	32 (2011)
Gross national income per capita (PPP int. \$)	2170 (2011)
Population living on <\$1 (PPP int. \$) a day (%)	—
Total expenditure on health as a percentage of gross domestic product (%)	5.5 (2011)
General government expenditure on health as a percentage of total expenditure on health (%)	21 (2011)
External resources for health as a percentage of total expenditure on health (%)	4.2 (2011)
Life expectancy at birth (years) [all; female; male]	64; 66; 63 (2011)
Total fertility rate (per woman)	5.2 (2010)
Neonatal mortality rate (per 1,000 live births)	32 (2011)
Infant mortality rate (per 1,000 live births)	57 (2011)
Under-five mortality rate (per 1,000 live births)	77 [58-92] (2011)
Maternal mortality ratio (per 100,000 live births)	200 [110-370] (2010)
Births attended by skilled health personnel (%)	35.7 (2006)
Antenatal care coverage - at least one visit (%)	47 (2006)
Antenatal care coverage - at least four visits (%)	—
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	81 (2011)
Postnatal care visit within two days of birth (%)	—

Top 10 causes of morbidity and mortality (DALYs)



Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. The top 10 causes of DALYs are ranked from top to bottom in order of the number of DALYs they contribute in Yemen. Bars going right show the percent by which DALYs have increased since 1990. Bars going left show the percent by which DALYs have decreased.

HUMAN RESOURCES FOR HEALTH

AVAILABILITY

TO MEET THRESHOLDS BY 2035, REQUIRES:

288% increase to meet 22.8/10,000 threshold

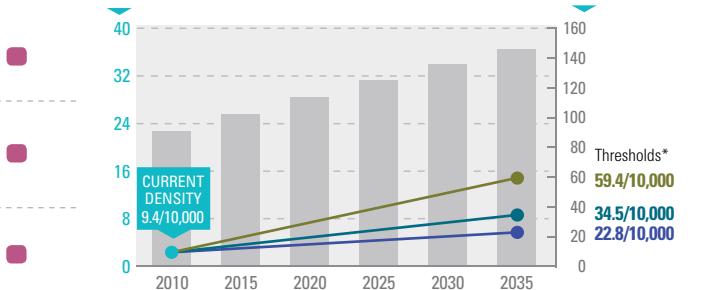
488% increase to meet 34.5/10,000 threshold

912% increase to meet 59.4/10,000 threshold

Feasibility of achieving thresholds: █ Most likely █ Somewhat likely █ Least likely

FEASIBILITY

DENSITY OF SHPs (Skilled Health Professional PER 10,000 POPULATION (Estimated 2010))



ACCESSIBILITY

GEOGRAPHICAL DISTRIBUTION OF PHYSICIANS

(density per 10,000 population)

SUB-NATIONAL LOW

0.4
Physicians

NATIONAL AVERAGE

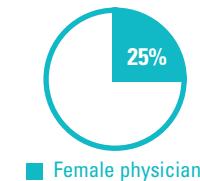
2.0
Physicians

SUB-NATIONAL HIGH

5.5
Physicians

ACCEPTABILITY

The ratio of nurses to physicians is **ABOVE** the OECD average.



QUALITY

Is there evidence that the country has mechanisms in place to:

ACCREDIT training institutions for:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

REGULATE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

LICENSE/RE-LICENSE:

Dentists	✓*
Midwives	✓*
Nurses	✓*
Pharmacists	✓*
Physicians	✓*

HRH GOVERNANCE

Is there evidence that the country is adopting recommended good practices on HRH:

Leadership and Partnership

Is there government leadership on health workforce policy and management? ✓

Is there intersectoral and multi-stakeholder partnership to inform health workforce policy and management? ✓

Policy and Management

Is existing health workforce policy and human resource management:

related to population health needs? ✓

informed by data and strategic intelligence? ✗

addressing pre-service education? ✓*

addressing geographical distribution and retention? ✓*

addressing health workforce performance (e.g. competence, responsiveness and productivity)? ✓*

addressing international mobility of health workers; and where relevant the WHO Code of Practice on the International Recruitment of Health Personnel? ?/✓

Strategy/Plan and Finance

Is there a national HRH strategy/plan resulting from the above mechanisms? ?

For which period? ?

Does the strategy/plan account for the financial costs and resource requirements to implement it? ?

✓ = Yes ✓* = Partial ✗ = No ? = Insufficient data

*See Annex 1 for full explanation on country profile methods and sources.