Wemos Briefing Paper

Human Resources for Health

Introduction

Health workers are the most valuable resource of health systems. The World Health Organization (WHO) defines health workers as health service providers (e.g. doctors, midwives) and health management and support workers (e.g. accountants, cleaners in health clinics). These workers are essential for the attainment of health-related Millennium Development Goals (MDGs). As the minimum threshold for reaching these goals the WHO has defined a population density of 2.28 health care professionals per 1000 citizens (e.g. a coverage of 80% for skilled delivery attendance). However, 57 countries worldwide do not meet this threshold and have critical shortages of health care workers. Of these countries, 36 are in sub-Saharan Africa, while the remainder include large countries such as India, Bangladesh and Indonesia. The global shortage is approaching 4.3 million health workers with an uneven distribution across the globe. Sub-Saharan Africa bears 25% of the global burden of disease but it has only 3% of the world's health workers. This is a remarkable difference with the Northern American region that has 10% of the global burden of disease, but is home to 37% of the global health workforce. There is also uneven distribution in most countries, with health professionals preferring to stay in urban areas, hereby depriving rural areas. Western countries, too, face shortages, as growth in the health workforce has not kept pace with the increasing demand for health care.
Migration of health workers from developing countries to the West – often reducing shortages in those countries – is draining health systems in developing countries. The shortage of human resources for health is resulting in a crisis for patients, for health facilities lacking sufficient staff, and for health workers themselves. It violates the Right to Health of all citizens nd the obligations of national governments and international development partners to respect, protect, and fulfil this universal right.

The human resources for health (HRH) crisis is receiving increasing attention from national governments, the WHO and the international donor community. Although the urgency to address the HRH crisis is acknowledged, its complexity may have delayed countries and donors in taking up concrete action in the health care sector.

In addressing the health workforce shortage, this briefing paper presents 'windows of opportunities' on ways to ensure people everywhere have access to a skilled and motivated health worker, supported by a robust health system.[ii] It proposes four strategic approaches that the Dutch government, members of parliament and civil society organizations can jointly take and support to address the global HRH crisis: ensuring *policy coherence* and *balanced distribution* of aid, and promoting *evidence-based interventions in developing countries* and *sound*, *coherent policies in developed countries*.

Multi-sector HRH advocacy in the Netherlands

As a follow-up to the Kampala Declaration, Dutch NGOs embarked in 2009 on a multi-year advocacy programme: the Dutch initiative on human resources for health (HRH). By joining forces, the NGO community aims to promote innovative policies and actions in the area of HRH and health systems strengthening (HSS) among policy-makers and politicians. The action programme includes conducting campaigns in support of HRH issues in developing countries. The initiative called the Dutch alliance for HRH is bringing together a wide range of actors from both the health and the cooperative development sector. Collaborating partners include Cordaid, AMREF Flying Doctors, Oxfam Novib, CBG, Abvakabo/FNV, V&VN, and the European Forum for Primary Care. This initiative will identify, promote and implement policies and practices in and by the Netherlands (government as well as other actors) to contribute to tackling the shortage in the global health workforce.

Strategy 1: Ensuring policy coherence for interventions aimed at strengthening the health system

MDGs can only be attained by overcoming the health-worker shortfall in low-income countries. As noted in the *World Health Report 2008*, sound policies on human resources have long been a neglected area and the lack of clear HR policies continues to remain a serious hindrance to health systems development.[iii] Overall, it is recognized that strengthening health systems is not possible without aligning the government's total budget for health to the 15% of national gross domestic product as committed in the Abuja Declaration.[iv]

The understanding has also grown that health must be respected in all other policies, e.g. migration policies that do not jeopardize or undermine people's health and respect, but protect and fulfil the Right to Health.

The Global Health Workforce Alliance (GHWA) has made useful recommendations for policy strengthening as part of the *Kampala Declaration and Agenda for Global Action*: [v]

- Agreement on a country-specific, comprehensive and costed HRH plan in the context of primary health care and under the authority of the Ministry of Health (MoH). This plan must reflect all components, such as training, retention, performance, remuneration, equitable distribution and migration of the workforce.
- The MoH, public sector ministries, private sector, multilateral and bilateral donors, professional associations, educational institutions, NGOs and civil society should be involved in the development of the plan.
- Harmonization and alignment on HRH policies. This could be part of a Sector Wide Approach (SWAp) that links the HRH plan to a national health plan and poverty reduction strategy.
- Development of a human resources information system, linked to the monitoring framework of the HRH plan, enhanced by operational research on workforce utilization, deployment and availability.
- Appointing HRH observers to consider information from all stakeholders in HRH.

The policies of the Dutch Ministry of Development Cooperation are strongly rooted in a human rights framework. However, in most policies related to health in developing countries, only limited reference is made to the importance of strengthening the health system and HRH. On the other hand, policy coherence is substantial between Dutch policies on health (workforce planning), migration, trade, development cooperation and education. The full potential of Dutch health-related interventions in developing countries can be achieved if implementation pays sufficient attention to the recommendations provided above. Wemos recommends that the Dutch government should also consider the following:

- Specific actions to ensure that multilateral and bilateral commitments are aligned to the country-specific HRH plan and benefit health-system strengthening, including sustained allocation of funding for training and recruitment of health workers for the public sector.
- Promotion of Dutch domestic policy coherence as a measure to guarantee health in all policies and avoid any negative impact on the health of the population both in developing countries ('over there') and at home ('here').

Strategy 2: Ensuring a balanced distribution of aid

A large part (45%) of the Netherlands' current Official Development Assistance (ODA) budget on health is dispersed through multilateral channels, including the GFATM and UNFPA. In theory, these programmes contribute to system strengthening, which is also a part of the GFATM's strategy. About 35% of its total funds are channelled to health-system strengthening (HSS). Of these HSS funds, 23% are allocated to finance existing human resources, and another 19% is used for training of staff on specific disease interventions.[vi] However, this particular training and investment does not directly strengthen the health system as a whole. Investments in HRH that improve medical education and enhance the public wage bill would have been a more straightforward link to HSS. Despite good intentions to further prioritize HSS, most investments still have opposing results for the public sector. Recent studies in Zambia and Kenya indicate a negative impact of external funds on the public health system.[vii] In many cases these multilateral funds are still hesitant to finance public health workers via national civil wage systems. However, at the same time, such funds do support various programmes that pay very generous salaries and incentives to staff. The result is an exodus of staff from the lower-salaried public sector.

The considerable Dutch contribution to multilateral funds places the Netherlands in a position to push for funding that supports national efforts in health system and human resources strengthening. This could be done through alignment with the GHWA's strategy on HRH funding: a 'checklist' for Global Health Initiatives . This checklist provides nine concrete steps for donors to consider in strengthening the health workforce through their supportive programmes. The steps include alignment with national HR plans, evidence-based policies, management capacities, access and equity, performance, sustainability and synergy.

In addition to its pro-active role in advocacy for HSS, the Netherlands could consider pursuing a more balanced distribution of its ODA health budget among bilateral and multilateral funds and civil society organizations (CSOs).[x] A change in favour of more bilateral funding would be in line with the call from the African Union, which urges donors to provide *direct support* to the health sector and the Accra Declaration which calls for *bilateral support* through national fiduciary systems. Balancing aid with more attention to strengthening the non-governmental sector (NGOs) is needed, especially considering that in some developing countries more than half of the healthcare services is provided by NGOs, often faith-based organizations.

Wemos therefore recommends that the Dutch government should also consider undertaking the following:

- Pro-active support and creation of more synergy between disease-specific programmes and health systems for the benefit of both. This will also enhance the functioning of a health system with sufficient numbers of health staff, and the outcomes of disease-specific programmes. The Netherlands can use its position on the board of the Global Fund for AIDS, TB and Malaria (GFATM) to reiterate the benefits.
- Increase bilateral funding for health (ODA), through e.g. SWAps, and contribute actively to the functioning of partnerships, such as the International Health Partnership with the aim of establishing a joint mechanism for sustained and predictable funding for health systems in developing countries.[xi]

Strategy 3: Ensuring evidence-based interventions in developing countries (taking action 'there')

"Europe is committed to support international action to address the global shortage of health workers and the crisis in human resources for health in developing countries". [xiii]
In a response to the HRH crisis the European Union (EU) presented the *EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries.*[xiv] The Programme for Action highlights the scale and complexity of the health workforce crisis and proposes actions for EU member states with interventions at the global, regional and national levels. However, actual implementation by EU member states is lagging behind.
A prominent south-south learning community is the regional network for *Equity in Health in East and Southern Africa* (EQUINET) that emphasizes several recommendations on HRH policies.[xv] These include:

- Health sector-wide retention packages that are agreed upon with all stakeholders, costed and managed by institutions that have the capacity to monitor national HRH targets.
- 'Core' non-financial incentive-retention strategies have been defined. These include career paths, stimulating training and encouraging deployment through investment in services (including 'centres of excellence'), providing housing mortgages / loans, rewarding performance and securing health worker health and access to health care.
- Both financing and monitoring 'scaling up' HRH schemes and retention strategies must be country-owned and explicitly outlined in HRH strategic plans. In-service training plans. In-service training plans, standardization and accreditation of health workers, assessments to develop different types of task-shifting and country-specific multipurpose health workers are elements of these plans.
- District and primary health-clinic management development whereby HRH strategies must focus on primary health care staff and inclusion community or health extension workers. Financial and non-financial incentives (schooling, housing) for community and health extension workers must be strengthened.

The Netherlands could fund and promote similar evidence-based interventions among its partner countries. The Global Health Workforce Alliance has defined some best practices, including the training of health extension workers in Ethiopia, which is aimed at improving primary health services in rural areas through an innovative community-based approach focused on prevention, healthy living and basic curative care.[xvi] Another example is a strategy employing task shifting,[xvii] as in Pakistan's 'Lady Health Workers Programme'. Women in the community act as a liaison between the formal health system and the community to disseminate health education messages on hygiene and sanitation. These health workers have contributed to a considerable reduction of maternal and infant mortality in several regions.[xviii] These programmes should be implemented in parallel to structural measures such as improving medical education, health workers' working terms and conditions such as health infrastructure, medical equipment, availability of drugs, etc.

Wemos sees a role for the Dutch government to act as a knowledge broker in the EU framework. We encourage the Dutch government to take a more pro-active role in European policy discussions and implementation of interventions related to HRH.[xix]

Strategy 4: Promoting sound, coherent policies in developed countries (actions here)

In its Working on Care Policy,[xx] the Dutch Ministry of Health, Welfare and Sport (MoH) outlines how the Netherlands is working towards securing enough personnel for the care sector. The plan reflects the government's policy stance that discourages the recruitment of health personnel from outside the EU. Though the current influx of health workers from outside the EU is minimal (55 permits were granted in 2008[xxi])

effective measures are needed to secure enough personnel for the years to come and to secure a future-proof staffing of the health sector. Participation of the MoH and stakeholders in the creation of a 'Global code of practice on the international recruitment of health personnel' as initiated by the WHO [xxii] is a first step to a European and Dutch code. Wemos believes this code should define *self-sufficiency* in the national workforce and *the obligation to support* other countries in (compensating) HRH development as crucial elements to reduce both push and pull factors[xxiii] that stop health systems from functioning properly and lead to health worker migration.[xxiv] It is crucial to prevent our policies and practices in health, foreign policy and/or migration having a negative impact on the health of the population in developing countries. The fact that the UK is allowing a large number of Ghanaian health workers to enter their health system means that their domestic labour market policy is not achieving self-sufficiency and therewith having a negative impact on the functioning of the health system in Ghana. The investment of the Ghanaian government in training these health workers is exceeding the amount of ODA of the UK directed to the health sector.

Based on the high level of policy coherence in the Netherlands, we therefore urge the Dutch government to take a more pro-active role in the various dimensions of the HRH agenda on the international level.

Wemos contributes to the structural improvement of people's health in developing countries through advocacy. Wemos believes that investing in strengthening health systems, including human resources for health, deserves a high priority in Dutch development cooperation.

i WHO (2006). The world health report 2006: Working together for health.
i Global Health Workforce Alliance. Country collaboration framework (draft 2009).
iii WHO (2008) World Health Report 2008: Primary Health Care: Now more than ever.
iv Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases (2001)
v Ibid: note ii
vi Homogene Groep Internationale Samenwerking 2010 (HGIS groep 2010). Bijlage 7 Uitgaven HIV/AIDS, Malaria en Tuberculose
vii Global Fund. Scaling up for impact. Results report.(March 2009) 3.3 Health systems strengthening
viii Wemos (2008) Summary Influence Externally Funded Programmes (EFPs) on Human Resources in Health. A case study in Kenya and Zambia.
ix GHWA (August 2009) HRH Funding: a 'checklist' for Global Health Initiatives.
x The Netherlands Overseas Development Assistance (ODA) allocated to health stands at 9%. To achieve the health-related Millennium Development Goals the WHO Commission on Social Determinants (WHO, 2008) recommends attaining 15% of the 0.7% ODA norm.
xi African Union (2007). Africa Health Strategy 2007-2015
xii The International Health Partnership and related initiatives (IHP+ 2009)
xiii European Commission (December 2005). A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007-2013). COM (2005) 642 Endorsed in May 2007
xiv Ibid.
xv EQUINET with University of Namibia, Namibia, University of Limpopo, Training and Research Support Centre and in co-operation with the Regional Health Secretariat East, Central and Southern Africa (ECSA- HC) (2009). Recommendations from the regional meeting on health worker retention in East and Southern Africa.
xvi WHO/GHWA. (2008). Country Case Study: Ethiopia's Human Resources for Health Programme.
xvii Task shifting is a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting can make more efficient use of the human resources currently available (WHO/HSS/2007.03)
xviii WHO/GHWA.(2008). Country Case Study: Pakistan's Lady Health Workers Programme.
xix Wemos (2009): World Health Day 2009. Attention for HRH.
xx Labour Market Letter 2007 Working on Care. Ministry of Health, Welfare and Sport. November 2007
xxi In 2008 some 200 work permits for the health sector were granted to knowledge migrants, half of them to persons from developing countries (Georgia, Indonesia, Rwanda, Surinam and South Africa). In 2008, some 55 residency permits were granted to health workers from developing countries (http://parlis.nl/kst127852)
xxii http://www.wemos.nl/nl-NL/Content.aspx?type=news&id=3213
xxiii See also the Wemos briefing paper 'Health workers on the move' obtainable via info@wemos.nl
xxiv http://www.who.int/hrh/public_hearing/draftcode/en/index.html

Colophon:
Wemos Foundation P.O. Box 1693 1000 BR Amsterdam The Netherlands
T: +31 (0)20 435 2050 E: info@wemos.nl www.wemos.nl
Text: Esther Jurgens, Remco van de Pas and Wemos Photo: Roel Burgler
Design: ingerdesign.nl

Wemos November 2009

You can support our work by a financial donation. Transfers to our bank account 42.25.727 at ING Bank Amsterdam: Beneficiary: Stichting Wemos, Amsterdam, the Netherlands IBAN: NL25 INGB 0004 2657 27 BIC/Swift: INGBNL2A

wemos Health for All