



**ACTION FOR  
GLOBAL HEALTH**

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THE HUMAN RESOURCES FOR HEALTH CRISIS

MAPPING POLICIES

# ADDRESSING THE GLOBAL HEALTH WORKFORCE CRISIS: **CHALLENGES** **FOR FRANCE, GERMANY, ITALY, SPAIN AND THE UK**



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Action for Global Health is a network of European health and development organisations advocating for the European Union and its Member States to play a stronger role to improve health in development countries. AfGH takes an integrated approach to health and advocates for the fulfilment of the right to health for all. One billion people around the world do not have access to any kind of health care and we passionately believe that Europe can do more to help change this. Europe is the world leader in terms of overall foreign aid spending, but it lags behind in the proportion that goes to health.

Our member organisations are a mix of development and health organisations, including experts on HIV, TB or sexual and reproductive health and rights, but together our work is organised around a broad approach to health. AfGH works to recognise the interlinkages of global health issues and targets with a focus on three specific needs: getting more money for health, making health care accessible to those that need it most and strengthening health systems to make them better equipped to cope with challenges and respond to peoples' needs.

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## EXECUTIVE SUMMARY

In 2006, the World Health Organisation (WHO) estimated that 57 countries, 36 of them in Africa, were facing a severe shortage of adequately trained and supported health personnel. The international, and in some cases targeted, recruitment of health care workers from countries that need them most is one of the major driving forces behind this crisis.

On 21 May 2010, the 63rd World Health Assembly took the long-awaited step of adopting a new WHO Global Code of Practice on the International Recruitment of Health Personnel. Ministers of Health agreed to stop recruiting health workers from developing countries unless agreements are in place to protect the health workforce, and to provide technical and financial assistance to these countries as they strengthen their health systems. Even a complete implementation of the WHO code, however, is unlikely to completely stem 'brain drain' in the health sector, nor provide and retain sufficient numbers of trained staff, particularly if other factors beyond the code are left unaddressed.

This report compares the foreign and domestic policies regarding health workers in the five EU countries home to the Action for Global Health (AfGH) network, which have some of the highest densities of doctors and nurses in the world. It looks at the reasons for health shortages in both source and destination countries, exploring what needs to change or to be put into practice in order to fulfil the requirements of the WHO Code of Practice and to strengthen health systems in the developing world. Two countries on the list of countries below the minimum density of health professionals recommended by WHO, El Salvador and Madagascar, are included to show how a chronic lack of investment in the health sector has resulted in both high unemployment rates among newly qualified doctors, and the poor paying for the health care of the rich.

AfGH calls for European Member States to take immediate action to simultaneously tackle the push and pull factors driving the international migration of health personnel, starting with full implementation of the WHO Global Code of Practice and the EU Programme for Action on the Critical Shortage of Health Workers. EU Member States must fully fund health systems strengthening, ensuring that 25 % of all health ODA is allocated to national health workforce strategies and to reaching the target of an additional 3.5 million new health workers by 2015. The full set of recommendations is given at the end of this report.

# 01

## 01 INTRODUCTION

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On 21 May 2010, the 63rd World Health Assembly (WHA) took the long awaited step of adopting a new WHO Global Code of Practice on the International Recruitment of Health Personnel, six years after the idea was first proposed. Ministers of Health agreed to stop recruiting health workers from developing countries unless agreements are in place to protect the health workforce, and to provide technical and financial assistance to these countries as they strengthen their health systems.

This Global Code of Practice is long overdue. Current unregulated large-scale migration is having a devastating impact on the health systems of source countries – many of which are struggling to meet the health Millennium Development Goals (MDGs). In 2006, WHO estimated that 57 countries, 36 of them in Africa, were facing a severe shortage of adequately trained and supported health personnel<sup>1</sup>. The international, and in some cases targeted, recruitment of health care workers from countries that need them most is one of the major driving forces behind this crisis.

In what has been described as a global ‘tug of war’, countries all over the world are seeking to solve their health worker shortages by recruiting from overseas, while health workers, increasingly women, are seeking to improve their situation by means of migration.

Globally, an extra 4.3 million health workers are needed to make essential health care accessible to all<sup>2</sup>. Whether wealthy or poor, most countries in the world are facing increasing demands on their health systems and yet offer unattractive working conditions to health professionals. As a result, British midwives travel to Australia, Zimbabwean doctors transfer to South Africa, Senegalese nurses relocate to France and German doctors migrate to Switzerland. Even in the face of their own shortages in rural and underserved areas, countries such as India and the Philippines continue to send trained nurses abroad.

### A tiger without teeth?

The Code of Practice is the first major international recognition of the truly global nature of the health worker shortage and the role that unregulated migration is playing in undermining the health MDGs. The Code sets out guiding principles and voluntary international standards for the ethical recruitment of health workers, to increase the consistency of national policies and prevent unethical practices. It discourages states from actively recruiting health personnel from developing countries that face critical shortages and encourages them to facilitate the “circular migration of health personnel” to maximise skills and knowledge sharing when health care professionals return to their home nations after time abroad. Bilateral agreements between source and destination countries are highlighted as critical for better international coordination of migration. The Code recognises two different but equal rights – those of communities to the right to health and the rights of individuals who seek employment. Prior to the Code of Practice, there was no existing legal and comprehensive instrument applicable to both sending and receiving countries.

The Code of Practice promises to have a significant impact on the deplorable shortage of health workers in low-income countries. However, the voluntary nature of the Code leaves it vulnerable to dilution or being ignored. To meet the health MDGs, WHO members will need to respect its provisions fully. While it is important to respect the right of health workers to migrate, both developing and developed countries need to prioritise health systems strengthening and use the Code of Practice as a tool to train and retain health workers where there is most need.

Even a complete implementation of the WHO Code, however, is unlikely to completely stem brain drain in the health sector, nor provide and retain sufficient numbers of trained staff, particularly if other factors beyond the Code are left unaddressed. These include the role of private sector actors continuing to recruit from developing countries and the substantial gender dynamics of the crisis, given that 80 % of the global health workforce is female<sup>3</sup>.

<sup>1</sup> World Health Report, Working Together for Health, WHO, 2006.

<sup>2</sup> World Health Report, Working Together for Health, WHO, 2006.

<sup>3</sup> Merchants of Labour, ILO, 2006 and Human Resources for Health: A Gender Analysis, A. George, July 2007.

# 01

## 01 INTRODUCTION

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### Key points from the WHO Code of Practice

- ▶ International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries (art3.5)
- ▶ Member States should strive to create a **sustainable health workforce** and work towards establishing effective planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel (art3.6)
- ▶ Effective gathering of national and international **data, research and sharing of information** on international recruitment are needed to achieve the objectives of the Code (art3.7)
- ▶ Member States should facilitate **circular migration** of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries (art3.8)
- ▶ Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training (art5.1)
- ▶ Member States should use this Code as a guide when entering into bilateral, regional or multilateral agreements, to promote international cooperation and coordination on international recruitment (art5.2)
- ▶ Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas (art5.7)

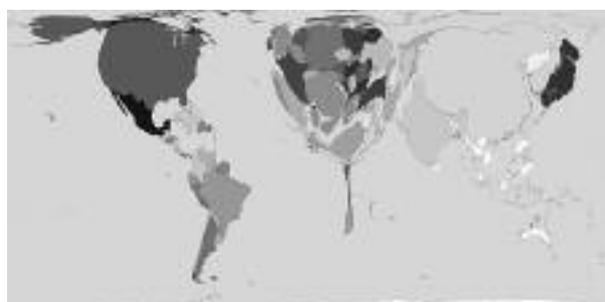
Source: European Public Health Alliance (EPHA), 2010.

### What is the minimum number of health workers required?

There is no universal norm or standard for a minimum density or coverage of human resources for health (HRH) in any given country or region recommended by the WHO. However, the 2006 World Health Report estimated that countries with a density of fewer than 2.28 doctors, nurses and midwives per 1,000 people generally fail to achieve a targeted 80 % coverage for skilled birth attendance and child immunization. There is a direct relationship between the ratio of health workers to population and survival of women during childbirth and children in early infancy. As the number of health workers declines, survival declines proportionately.

The map below illustrates the huge scale of the need in developing countries. In Africa, the density is only 0.8 health workers per 1,000 people, compared to 10 per 1,000 in Europe.

**Territory size shows the proportion of all physicians (doctors) that work in that territory.**



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In 2009, the High Level Taskforce on Innovative International Financing for Health Systems (HLTF) offered two estimates of the number of health workers required to achieve the health-related MDGs. One, developed by the WHO, found that 3.5 million more health workers (including additional managers and administrators) across 49 low-income countries were required to accelerate progress towards – and in many cases to achieve – the health-related MDGs, while also expanding coverage for other diseases and contributing to the hunger target in MDG 1. The other set of calculations, by the World Bank and other institutions, found that these 49 countries required 2.6-2.9 million additional health workers – including managers, whose critical role is too often overlooked.

At present, Europe trains 173,800 doctors a year, Africa only 5,100. This in itself is a problem that needs to be addressed. But the situation is exacerbated by the hiring of health personnel from Africa and other developing nations to address staffing shortages in EU Member States. EU Member States can and must plug their own staff shortfalls by addressing their own health policies, thereby putting an end to the 'pull factor' in health worker migration from developing countries. Equally, they must also act to address the 'push factors' in crisis countries, without which health workers will continue to seek better opportunities, whether in the EU or elsewhere.

With the entry into force of the Lisbon Treaty, the eradication of poverty is the main objective of EU development cooperation and policies. This is more than a noble ambition, as treaty provisions on development are binding and enforceable and require a commitment to policy coherence. This means that EU and Member State policies must support – or at the very least not harm – national, local and regional efforts to eradicate poverty in Southern partner countries. The EU must therefore ensure that its policies and practices on the recruitment and retention of health workers do not undermine progress on the health MDGs.

As the world's largest aid donor and one of the main recruiters of health workers from developing countries, the EU and its Member States have a major responsibility to ensure the Code is respected and not watered down.

**European Member States can support this commitment by allocating 0.1 % of GNI to development health spending, 25 % of which should focus on ways of improving working conditions, pay and training for doctors, midwives and nurses in the developing world.**

## About this report

This report compares the foreign and domestic policies regarding health workers in the five EU Member States home to the Action for Global Health network, which have some of the highest densities of doctors and nurses in the world. It looks at the reasons for health shortages in both source and destination countries, exploring what needs to change or to be put into practice in order to fulfil the requirements of the WHO Code of Practice and to strengthen HRH in the developing world. Two countries on the list of countries below the minimum density of health professionals recommended by the WHO, El Salvador and Madagascar, are included to show how a chronic lack of investment in the health sector has resulted in both high unemployment rates among newly qualified doctors and the poor paying for the health care of the rich.

# 02

## 02 EUROPEAN UNION COMMITMENTS TO HUMAN RESOURCES FOR HEALTH (HRH)

“ There is a global market for health workers, but it is a distorted market, shaped by global inequity in health care provision and the capacity to pay workers, rather than by health needs and the burden of disease ”

*EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries, 2005*

There has been a longstanding understanding in Europe that the shortages of health-workers in developing countries is a critical factor preventing the scaling up of service provision necessary to allow improved health care and improved health indicators. At an EU level this awareness came to the fore in reaction to the epidemics of HIV/AIDS, Malaria, and Tuberculosis. In 2005 the EU adopted a Programme of Action to combat these poverty diseases through external action including a separate section devoted to addressing the human resource crisis for health providers. It was by then clear that the lack of health workers in developing countries had reached a critical point and was a major obstacle to the scaling up of services required to confront not just the major infectious diseases but of achieving all three of the health-specific MDGs:

*“The lack of trained health providers undermines efforts to scale up the provision of prevention, treatment and care services. The EU will support a set of innovative responses to the human resource crisis. At regional level, the EC will use its support for the AU and the New Partnership for Africa’s Development (NEPAD) to help ensure strong African leadership in the formulation and coordination of a response to the human resource crisis. The aim should be to increase incentives for health workers to remain in or return to developing countries or regions where the need is greatest rather than to create barriers to migration.”*

- Programme for Action on AIDS, TB and Malaria, 2005

By the end of 2005, the European Commission had adopted a Communication outlining an EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries. The actions proposed in the EU Strategy for Action were comprehensive and covered actions at country, regional and global level. At country level, it called for support and financing for national human resource plans and the inclusion of HRH issues in Poverty Reduction Strategies. At regional level, it called for greater leadership from the African Union and the New Economic Partnership for African Development (NEPAD), as well as an Inter-Ministerial Conference on Human Resources for Health in Africa. Globally, the concept of a European Code of Conduct and circular migration were among the main actions recommended.

### Programme for Action to tackle the shortage of health workers in developing countries

In December 2006 the European Commission adopted a Communication outlining a ‘Programme of Action’, broadly following the previous Communication, but also adding some important elements, such as more detailed actions to specific world regions, as well as commitments towards finance, and monitoring and evaluation. The Programme of Action also went into greater detail than had previously been the case on the links between EU health, employment, and migration policies and the human resources for health crisis in developing countries. This was reflected in the priorities identified by the Council of Ministers in their Council Conclusions on 14 May 2007 where they highlighted the need for:

4 Policy Coherence for Development - Establishing the policy framework for a whole-of-the-Union approach COM (2009) 458 adopted 15 September 2009 was accompanied by a staff working paper. Quote from page 1999. ([http://ec.europa.eu/development/icenter/repository/SWP\\_PDF\\_2009\\_1137\\_EN.pdf](http://ec.europa.eu/development/icenter/repository/SWP_PDF_2009_1137_EN.pdf))

5 COM(2007) 630 European Commission White Paper 'Together for Health: A Strategic Approach for the EU 2008-2013' was adopted on 23 October 2007.

6 Ministers meeting on 5-6 December 2007 in the Employment, Social Policy, Health and Consumer Affairs Council of Ministers adopted conclusions ([http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/lsa/97445.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/97445.pdf)) drafted on 29 November 2007 by the Health Permanent Representatives Committee. (<http://register.consilium.europa.eu/pdf/en/07/st15/st15611.en07.pdf>).

7 COM(2008) 725 Green Paper on the European Workforce for Health adopted 10 December 2008.

- Developing principles for the recruitment of health workers from developing countries to work in the EU;
- An EU code of conduct for the recruitment of health workers;
- Improved information systems (especially statistics) on human resources for health;
- Expanding medical education and health staff training and supporting regulatory agencies in improving standards and achieving a balance between demand and supply for qualified staff;
- Exploring ways and means to facilitate the temporary migration of health workers from developing countries into the EU.

Evidence of any impact on the ground of these commitments has been at best sparse. Indeed, the EU Commission's own report on Policy Coherence for Development some two years after these Council Conclusions found "little evidence that the EU through its policies has contributed to reducing migration of health workers from the three African countries to the EU so far"<sup>4</sup>.

### EU Health Workforce Policies

There has been some recognition of the need for EU Member States to change their domestic policies in line with development policy.

In October 2007, the EU Commission adopted a White Paper entitled 'Together for Health: A Strategic Approach for the EU 2008-2013'<sup>5</sup>. This White Paper explicitly included the adoption of the Programme of Action when referring to the need to ensure the principle that "health in all policies" was attained. The White Paper also highlighted the need for the EU to take a leadership role in global health, particularly so as to achieve the health related MDGs and principles of Aid Effectiveness. Half the principles of the White Paper related to global health in general and included specific reference to the health workforce crisis.

The reaction to the White Paper by the Council of Ministers endorsed the approach and included recognition of:

*"the need to strengthen the health perspectives in EU external policies, including global health and for tackling issues related to the migration of health professionals, development aid in the field of health, trade in health products, and sharing EU health values with other countries."*

And underlined:

*"the need for effective implementation of the Strategy, based on close and structured dialogue with the Member States and civil society as well as on regular monitoring of the progress achieved."*<sup>6</sup>

Following the adoption of the EU Health Strategy a consultation on issues relating to the EU Health Workforce was opened with the adoption of a Green Paper. This Green Paper included the problem of health sector 'brain drain' of health workers migrating from developing countries to the EU. The Green Paper was largely descriptive of the preceding policy initiatives, but did highlight the need for both the inclusion of measures to combat brain drain issues in migration policies in general, and the need to elaborate a code of conduct on the ethical recruitment of health workers:

*"The EU has made a commitment to develop a Code of Conduct for the ethical recruitment of health workers from non-EU countries and to take other steps to minimise the negative and maximise the positive impacts on developing countries resulting from the immigration of health workers to the EU. The need to deliver on these commitments is reiterated in the Progress report on the implementation of the PfA adopted in September 2008."*<sup>7</sup>

### The Kampala Declaration and Agenda for Action

In response to growing international concern about the impact of health migration on health service delivery in developing countries, the first ever Global Forum on Human Resources for Health was convened in Kampala, Uganda in 2008.

The Kampala Declaration and related Agenda for Action called for higher commitment by governments and development partners to human resources for health, providing an overarching global framework for priority actions to close the health worker gap within a decade.

The Global Health Workforce Alliance is tasked with monitoring progress towards implementing the Agenda for Action. Hosted by the WHO, the Alliance is a partnership of national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating for solutions. A key focus is the development and implementation of **evidence- and needs-based country HRH plans** in Africa, South Asia and Latin America.

# 03

## 03 HOW DO MEMBER STATE DEVELOPMENT POLICIES ADDRESS THE HRH CRISIS IN THE DEVELOPING WORLD?

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The countries reviewed in this report have all made strong, vocal commitments to addressing the shortage of health workers in the developing world in multiple fora. As EU Member States they are all signatories to the Programme for Action to tackle the shortage of health workers in developing countries. All of them are members of the International Health Partnership and related initiatives (IHP+), designed to strengthen national health plans. All except Spain are members of the G8 and the Development Ministries of Germany, France and the UK are partners in the Global Health Workforce Alliance. In addition, each has made specific commitments to the importance of addressing HRH in their official development policies. However, as the following profiles show, some countries are doing more than others in terms of practical initiatives and solid funding commitments to address health worker shortfalls.

### G8 Commitments

In their role as G8 countries, the UK, Germany, France and Italy have all made successive commitments to addressing the critical shortage of health workers in developing countries since the Gleneagles summit in 2005.

In 2008 in Toyako, Japan, the G8 pledged to “work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers”. They also committed to supporting the development of robust health workforce plans and establishing specific, country-led milestones. USD 60 billion was pledged to fight infectious disease and strengthen health systems by 2012.

At the 2009 G8 summit in L'Aquila, Italy, the G8 renewed their commitment to an integrated approach to health, the importance of supporting national health systems with universal coverage, promoting the principles of Primary Health Care through active involvement of civil society and finally promoting a multi-sectoral approach to health that takes into account the social determinants of health: “It is essential to strengthen health systems through health workforce improvements”.

This year, the G8 Muskoka declaration highlighted task shifting as a way to make better use of scarce health workers.

## FRANCE

In 2009, France surpassed Germany as the largest European donor country. However in terms of commitment to global health, France sits in the middle of the countries reviewed in this report, with only 0.041 % of GNI going to health ODA<sup>8</sup>.

France has taken a leading role in recent years in putting health systems strengthening on the international agenda, including during the EU presidency in 2008. Strengthening health care systems, especially human resources for health, is one of three core pillars of French foreign policy on health as set out in the '2007-2012 Global Strategy for Cooperation and Development in the Health Sector'. The initial focus of French efforts in this area was to fund training programmes in developing countries. However, the evaluations of this training policy, including one conducted at the request of the Ministry of Foreign Affairs in 2000 throughout sub-Saharan Francophone Africa, highlighted the lack of consistency and overall plan of this policy. It also revealed a very sharp slowdown in scholarship policies and a decline in fellowship training due to the decrease of direct technical assistance.

In 2009, France published its 'Strategy for the strengthening of human resources for health in developing countries'. This document sets out France's future commitments regarding the strengthening of health workers at the bilateral and multilateral levels, the latter of which absorbs the majority share of French ODA to health (69 % in 2009).

In respect to strengthening HRH, France supports 20 countries, mostly from Sub-Saharan Africa, with about 30 projects either entirely dedicated to human resources for health or including a HRH component. The main focus of these projects is training staff, building and furnishing health facilities and financing the production and implementation of national plans for HRH development. Some projects focus on the 'retention' of health workers, helping health staff to remain in the areas where they work, by providing them with housing, a motorbike or with computers, desks and medical equipment. In addition, France launched a hospital twinning programme, 'ESTHER', which links hospitals in France with health facilities in Africa, in order to provide comprehensive and quality care for people living with HIV/AIDS and related diseases. Among other activities, ESTHER includes the training of health professionals in 18 developing countries.

France has signed nine bilateral agreements on migration flows with countries in Francophone Africa to date. Some of the ratified agreements (i.e. Senegal, Benin and Congo) address the issue of migration with a comprehensive approach and a particular focus on health professionals and support for HRH development<sup>9</sup>. In addition, France seconds an expert to the WHO in Geneva to work as the Coordinator of the Health Workforce Migration and Retention Programme<sup>10</sup>. The French government has also ratified the WHO Code of Practice.

<sup>8</sup> Source: 2010 Reality Check, Action for Global Health 2010. Figures refer to 2008.

<sup>9</sup> Innovations in Cooperation. A guidebook on bilateral agreements to address health workers migration, I. Dhillon, M. Clark, R. Kapp, May 2010, ed. by Realizing Rights & Aspen Institute.

<sup>10</sup> Muskoka Accountability Report, Annex 5, G8, 2010.

# 03

## 03 HOW DO MEMBER STATE DEVELOPMENT POLICIES ADDRESS THE HRH CRISIS IN THE DEVELOPING WORLD?

### GERMANY

Germany is one of the largest European donors to overseas development, allocating just over USD 1 billion to global health in 2008. However Germany has some way to go to reach the 0.1 % of GNI target, ranking only just above Italy with 0.03 %<sup>11</sup>.

On the positive side, health systems strengthening (HSS) is a strategic priority in German development cooperation on health, with emphasis on health sector reform and building workforce capacity<sup>12</sup>. In particular, the health sector strategy positions efforts to strengthen human resources for health (HRH) as an integral part of Germany's HSS strategy and these aspects are integrated into the overall macroeconomic and health sector framework along four dimensions: policy, management, the labour market and education. A discussion paper on the HRH crisis was published in 2010<sup>13</sup>.

Germany's Ministry for Economic Cooperation and Development (BMZ) does not calculate the resources provided specifically on HRH. It has been estimated that a range of 25–50 % of funds provided for health systems strengthening can be attributed to capacity building, which amounts to between USD 15.6 and USD 31.25 million in 2009<sup>14</sup>.

Meanwhile, the German technical development agency, the Deutsche Gesellschaft für technische Zusammenarbeit (GTZ) supports partner countries in their formulation of health-policy strategies and staff development plans. It advises on adapting legal frameworks and works towards

increasing the management, administrative and planning capacities of health workers and health personnel. Other priorities of German HSS activities are the decentralization of health services and the development of social security instruments, and the improvement of health infrastructure. German engagement for human resources for health is integrated in its broader health programmes; HRH support is implemented both through projects and sector budget support. Both instruments are integrated into existing coordination structures, such as sector-wide approaches (SWAPs), where Germany prioritises human resource management and planning.

Germany is directly involved in health sector reform processes in 16 countries (Bangladesh, Cambodia, Cameroon, Indonesia, Kenya, Kyrgyzstan, Malawi, Nepal, Pakistan, Rwanda, South Africa, Tajikistan, Tanzania, Ukraine, Uzbekistan and Vietnam). In addition, there are two regional programmes, one in the Caribbean (Dominican Republic, Haiti and Cuba) and one in West Africa (Ivory Coast, Guinea, Sierra Leone and Liberia). Some country programmes deal with HRH as a cross-cutting issue while others are implementing special programme components. These health worker programme components include pre- and in-service training by universities and other training institutions, the development of E-learning curricula and information systems, development of quality assurance and standards, the creation of monetary and non-monetary incentives to place and retain health workers, sector financing, private service provision and community based services improve HRH especially in rural and remote areas. In addition, reintegration support is offered to professionals who have trained in Germany when they return to their home country.

11 Source: 2010 Reality Check, Action for Global Health 2010. Figures refer to 2008.

12 Germany's global health strategy is defined in its health sector strategy: Federal Ministry for Economic Cooperation and Development 2009. Sector Strategy: German Development Policy in the Health Sector. Available at: [http://www.bmz.de/en/publications/type\\_of\\_publication/strategies/konzept187.pdf](http://www.bmz.de/en/publications/type_of_publication/strategies/konzept187.pdf)

13 BMZ (2009): Ansätze und Instrumente der deutschen Entwicklungspolitik im Bereich Fachkräftemangel im Gesundheitswesen. Diskussionspapier des Thementeam Gesundheitsystementwicklung.

14 CRS code 12110, gross disbursements in constant 2008 USD. Estimate made by key informant.

## ITALY

Health is one of six priority areas in official Italian development policy<sup>15</sup>. In 2008, Italy committed USD 558.9 million to health ODA. Of all the countries in this review, Italy has furthest to go to reach the WHO target of 0.1 % of GNI to health aid, dedicating only a quarter of this amount (0.025 %) in 2008<sup>16</sup>.

In its global health policies, Italy promotes a horizontal approach designed to ensure universal access and effective and efficient health services. Between 2005 and 2009, Italy claims to have made a bilateral contribution of USD 12.45 million to HRH<sup>17</sup>. Italy also purports to be actively supporting health systems strengthening and human resources for health by means of its contributions to multilateral organisations such as the Global Fund, the WHO, UNAIDS and UNFPA, which together receive the bulk of Italian development funds, and by means of its involvement in the International Health Partnership and related initiatives<sup>18</sup>. In practice the share of funding devoted to health system strengthening in multilateral organisations is quite variable.

Italy's 2009 Guidelines for Cooperation in Global Health call for "a level of human resources which are adequate both in qualitative and quantitative terms referring to the public health system needs"<sup>19</sup>. According to this framework, human resources for health should have:

- *Effective systems of training and on-going education based on experience and best practices, which should be taught using active learning;*
- *Salary, working conditions and adequate incentives, which can thwart the unequal geographical distribution, the mobility to the private sector, to the urban areas and to foreign countries, also through the promotion of the adoption of international codes aimed to regulate the migration of human resources for health;*
- *Adequate professional improvement, supervision and motivation.*

The Guidelines also call for support, training and incentives to increase the numbers of community health workers. Such health workers are to be integrated into the national health system and programmes must fit with the local cultural context, in particular regarding reproductive health, maternal, neonatal and child health, as well as the control of communicable and non communicable diseases.

In November 2010, Italy signed a major partnership agreement with Ethiopia to strengthen the health system with EUR 8.2 million. The aim of the support is to increase the coverage and quality of health services and also to boost the capacity to generate and use strategic information. Some 35 % of the contribution was allocated directly to the Federal Ministry of Health as health budget support for the MDG Fund. The Italian Development Agency has also promoted South-South cooperation on HRH, such as support for an agreement between Niger and Tunisia, whereby Tunisia trains health professionals from Niger.

<sup>15</sup> Source: 2010 Reality Check, Action for Global Health 2010.

<sup>16</sup> Muskoka Accountability Report Annex 5, p. 40.

<sup>17</sup> Promoting Global Health: L'Aquila G8 Health Experts' Report 2009, pp31-32. Available here: [http://www.g8italia2009.it/static/G8\\_Allegato/G8%20Health%20Experts%20Report%20and%20Accountability\\_30%2012%20%202009-%20FINAL%5B1%5D.pdf](http://www.g8italia2009.it/static/G8_Allegato/G8%20Health%20Experts%20Report%20and%20Accountability_30%2012%20%202009-%20FINAL%5B1%5D.pdf)

<sup>18</sup> MAE-DGCS: Salute globale: principi guida della cooperazione italiana, July 2009. Available at:

<sup>19</sup> [http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/LineeGuida/pdf/Principi\\_Guida\\_Sanita.pdf](http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/LineeGuida/pdf/Principi_Guida_Sanita.pdf)

# 03

## 03 HOW DO MEMBER STATE DEVELOPMENT POLICIES ADDRESS THE HRH CRISIS IN THE DEVELOPING WORLD?

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### SPAIN

Comparative to its size economically, Spain is a generous donor to global health ODA, providing a total of USD 688 million in 2008. Between 2005 and 2008, Spanish health ODA increased from EUR 102 to EUR 496 million, with a tripling of multilateral aid and an increase in bilateral aid from EUR 130 to EUR 150 million<sup>20</sup>. However, even with these aid increases, in terms of meeting the GNI commitment, Spain is not even halfway at 0.045 %<sup>21</sup>.

Spanish development policy, including on health, is defined by the 'Master Plan', a framework approved every four years by Parliament. The current policy is based on the Primary Health Care approach defined at Alma Ata and highlights the importance of public health systems as crucial to the attainment of the MDGs. The Master Plan 2009-2012 singles out the IHP+ as an initiative that can implement aid effectiveness principles in order to strengthen health systems. Of the six specific objectives on health, two are directly connected to addressing the health care worker shortage: Objective 1 focuses on the "formation, consolidation and sustainability of effective and equitable health systems", while Objective 2 commits Spain to the development of "sufficient and motivated human resources". The prominence of these two objectives at the beginning of the report reflects the importance that Spain allocates to these issues, at least on paper. However, there is no plan of action on or any concrete amount of resources allocated to fulfilling these aims.

The Spanish central administration argues that health systems must be reinforced as a package, taking into account the synergies and complex relationship between the different health system components and that if one sector is developed out of proportion with another this will lead to dysfunction (for example, too many doctors but no supplies). Spain regards general budget support to be the best tool to fight the HRH shortfall and has committed to allocate 60 % of bilateral aid to health system strengthening under the principles of IHP+ by means of direct sector budget support by 2012. However, since regional authorities contribute half of Spain's bilateral aid and they are not committed to IHP+ principles, and there are no mechanisms to coordinate different stakeholders to fulfil the Master Plan, the 60 % goal will be extremely hard to reach. Currently Spain contributes less than 11 % of all bilateral aid to general budget support.

In addition to increasing funding available for comprehensive health system strengthening, the Spanish Agency for Development Cooperation (AECID) has developed its first health sector plan that includes several indicators on HRH strengthening for bilateral aid managed by NGOs and has pledged that by 2013, 80 % of NGO projects supported will include a component on training health workers.

<sup>20</sup> Central Administration Health AID Sectorial Diagnosis, December 2009.

<sup>21</sup> Source: 2010 Reality Check, Action for Global Health 2010. Figures refer to 2008.

## UNITED KINGDOM

The UK is the leading European donor to global health<sup>22</sup>. In 2009, the British Department for International Development (DFID) allocated 15 % of total ODA, approximately EUR 1.5 billion, to improving health in developing countries. However, this amount still falls short of the 0.1 % GNI target set by the WHO, at only 0.058 % of GNI<sup>23</sup>.

The UK is one of the few countries with publically available figures on the proportion of health ODA allocated to health systems, and the only country to have completed a voluntary scorecard on its progress to meet its IHP commitments<sup>24</sup>. Between 2002/03 and 2008/09, DFID bilateral expenditure on health systems increased from GBP 106 million to GBP 268 million. The share of total bilateral expenditure in health allocated to health systems increased to 37 % in 2008/09<sup>25</sup>. Although no exact figures are available, the UK claims to be meeting the WHO target of 25 % of health aid towards human resources for health strengthening<sup>26</sup>.

UK funding to health systems is channelled through a mixed funding approach including bilateral programmes, direct support to national health sector plans of partner countries, and multilateral organisations and global funding instruments such as the World Bank, and the Global Fund for AIDS, TB and Malaria<sup>27</sup>. Some of the activities supported include health staff salaries and retention schemes, pre-service education and training of health workers, enhancement of skills among health workers and productivity as well as management and supervision of front-line workers.

In Sierra Leone, the UK is supporting the Ministry of Health with improved workforce surveillance and strategic intelligence, including a payroll review, and the training of 1,000 new health workers to meet the increased demand created by the abolition of user fees. DFID has also provided support to specific health worker initiatives, including the Royal College of Obstetrician and Gynaecologist training programmes in five target countries (three in Africa) and the training of 12,000 midwives in Pakistan. In Ethiopia, DFID has awarded GBP 25 million over four years to increase the number of community health workers tenfold<sup>28</sup>.

DFID and the Department of Health jointly support the UK International Health Links Funding Scheme, which provides grants and support to health institutions across the UK, allowing British health professionals to strengthen and improve health worker capacity of partners in 10 developing countries in Africa and Asia<sup>29</sup>. The Scheme has given out over 30 grants to support long-term institutional partnerships between UK organisations and their 'Links' in the developing world. Building on the success of this scheme, DFID is currently developing a new Health Systems Partnership Fund to enable UK based health workers to support human resources training in developing countries. The programme will be funded up to GBP 5 million per year and will enable more British health professionals to share their skills with midwives, nurses and doctors in developing countries through teaching, training and practical assistance.

<sup>22</sup> Euromapping 2010, available at [www.euroresources.org](http://www.euroresources.org)

<sup>23</sup> Source: 2010 Reality Check, Action for Global Health 2010. Figures refer to 2008.

<sup>24</sup> IHP scorecard available at: <http://network.human-scale.net/groups/united-kingd>

<sup>25</sup> Health Portfolio Review, DFID 2009, p. 12. Available at: <http://www.dfid.gov.uk/Documents/publications1/health-portfolio-review-rpt-2009.pdf>

<sup>26</sup> Muskoka Accountability Report, Annex 5, GB, 2010.

<sup>27</sup> DFID PQ response September 2010.

<sup>28</sup> Muskoka Accountability Report, 2010.

<sup>29</sup> DFID PQ response Sep 2010. See also <http://www.thet.org/thet-launches-new-international-health-links-funding-scheme>

# 03

## 03 HOW DO MEMBER STATE DEVELOPMENT POLICIES ADDRESS THE HRH CRISIS IN THE DEVELOPING WORLD?

### COMPARISON OF THE RELATIVE STRENGTHS AND WEAKNESSES OF THE FIVE COUNTRIES

COUNTRY	STRENGTHS	WEAKNESSES
<b>FRANCE</b>	<p>Renewal of commitment and leadership on health systems strengthening</p> <p>ESTHER Twinning Programme</p>	<p>Strong policy commitments are not translating into funding for health systems</p> <p>Failure of HRH training initiatives</p>
<b>GERMANY</b>	<p>Support for health sector reform in 16 developing countries</p>	<p>Strong policy commitments are not translating into funding for health systems</p> <p>Lack of clarity on who will lead implementation of the WHO Code</p>
<b>ITALY</b>	<p>Direct support to the MDG fund within the health budget of Ethiopia</p> <p>Renewal of commitment and leadership on health systems strengthening at G8 summit in 2009</p>	<p>The bulk of Italian ODA goes to vertical funds</p> <p>Lagging behind other major donors on the 0.7 ODA and 0.1 health targets</p>
<b>SPAIN</b>	<p>Strong policy commitment to strengthen public health systems (60 % of bilateral aid via IHP+ by 2012)</p> <p>The new AECID health plan includes several HRH indicators: 80 % of NGO projects funded by AECID in 2012 must include HRH training.</p>	<p>The 60 % goal on health system strengthening is unlikely to be met</p> <p>Diversity of actors without adequate space for suitable coordination, especially between central and regional administrations</p>
<b>UK</b>	<p>Strong pre- and in-service training initiatives including the new Health Systems Partnership Fund</p> <p>Relative transparency on progress towards HRH and HSS goals (e.g. IHP scorecard)</p>	<p>The UK is a major source destination for migrant health workers: action needs to be taken to address the role of private recruitment agencies.</p>



## The International Health Partnership and related initiatives (IHP+)

The International Health Partnership and related initiatives (IHP+)

The International Health Partnership and related initiatives (IHP+) was launched in September 2007 with the aim of better harmonizing donor funding commitments, and improving the way international agencies, donors and developing countries work together to develop and implement national health plans. The core concept is to mobilise donor countries and other development partners around **a single country-led national health plan**, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

The IHP+ now includes 49 partners, including 24 developing countries. All of the five countries profiled in this report are members of the IHP+.

# 04

## 04 CASE STUDIES

### MADAGASCAR: ACUTE SHORTAGES OF HEALTH WORKERS IN RURAL AREAS

Coverage of health personnel in Madagascar is well below the threshold recommended by the WHO (2.3 health workers per 1,000 inhabitants) with approximately only 2 doctors and 3 nurses/midwives per 10,000 inhabitants<sup>30</sup>. As such, the country is one of the 49 priority countries listed by the WHO as needing greater support to strengthen the health workforce.

The deficit of health workers in Madagascar occurs across the whole country. However, health coverage is higher in metropolitan and in urban areas than rural areas. Regional differences in the distribution of health human resources are significant and considerably weaken the health care system, compromising the health of the population. Over 40 % of the population live more than 5km away from a health facility.

According to the Ministry of Health, some 6,000 health care professionals are 'missing'. At the current pace it would take at least six years to fill the number of positions required, not including replacements for retirees and the proportion of new graduates who turn to specialisation. To address this, it will both be necessary to increase the number of health workers trained each year, but also to increase the number of positions available.

	TOTAL NEEDS	AVAILABILITY	MISSING
PHYSICIANS	5068	3988	1080
DENTISTS	147	80	67
PARAMEDICS	7627	6252	1375
ADMINISTRATIVE STAFF	8796	5346	3450

Source: Feasibility study for the preparation of the health human resources development plan, International Health Unit, University of Montreal 2009.

The reasons for the shortage are familiar to most developing countries. Less than 200 students graduate in general medicine each year. The quota of graduates cannot be increased due to the limited capacity of hospitals for practical training. For budgetary reasons, not all these trained staff are able to find positions in the national health system. The exact unemployment rate of health personnel is not known but it is estimated that there are high unemployment rates among doctors in urban areas. The ageing of the health workforce (nearly 50 % will retire within 10 years) and limited training capacity are aggravating factors.

Most doctors in rural areas work seven days a week and have little or no holidays. Doctors sent out to the bush do not know how long they will stay there and if they will have opportunities for advancement in their careers. There is no salary increase from one year to another and staff poorly paid. Health worker housing is situated far away from the clinic and lacks electricity and water. Local schooling is either not available or poor in quality. Some of the locations are insecure and it can be dangerous for health workers to go out at night, sometimes covering long distances. Older physicians in particular are seeking more rewarding working conditions and more comfortable living conditions for the end of their career.

Medical students are required to spend the third year of their studies abroad. Although measures have been taken to penalise doctors who do not return home (including disqualification from public service if they return) there is anecdotal evidence, if not concrete statistical data, that the brain drain, particularly to France, is significant. Many Malagasy doctors move to France to become nurses and caregivers in the private sector.

<sup>30</sup> World Health Statistics, WHO 2010.



## Efforts to change

Like 189 other countries, Madagascar has subscribed to the Millennium Development Goals, with a series of targets to be achieved by 2015. Health is a priority objective of the government, as the third of eight commitments made by the authorities as part of the Madagascar Action Plan for 2007-2011. This document replaces the Poverty Reduction Strategic Paper (PRSP) and gives directions for the government's general policies, including those related to health.

The Development Plan for the Health Sector sets out interventions and outcomes for 2011 in order to address key challenges: staff shortages, inadequate distribution of available staff, inadequate working conditions, weak management systems, and inadequate initial and ongoing training. Beyond the health sector, the Ministry of National and Higher Education, the Ministry of Decentralization, the Ministry of Finance and Budget are also concerned with actions to develop to increase the coverage of HRH in the whole country.

The Ministry of Health has pledged to produce a Plan for the Development of Human Resources for Health (PDHRH), supported by consultants from the Unit of International Health at the University of Montreal. This team has been working for several years on the development of this Plan by providing studies documenting precisely the HRH situation and proposing strategic priorities while evaluating the technical and financial feasibility for the government. The latest study was produced in February 2009. However, the political context has changed since then, which threatens the implementation of their final recommendations. The Ministry plans to have the final Plan ready for January 2011.

The various projects initiated by the Ministry of Health to promote the recruitment and retention of health workers in rural areas range from modest incentives to the development of a network of community health workers, recruitment of private physicians and the extension of coverage through the creation of health huts. The national community-based health policy seeks to overcome the shortage of HRH to ensure access to basic health services to the community. In this way, the community level becomes an extension of the health system. The policy relies on community workers who have a kit of essential items (including mosquito nets and contraceptives), to develop awareness, detect possible signs of danger and to invite patients to visit a health centre.

There are six training centres for paramedical students training on average 350 students each year: in Antananarivo, for example, about 120 paramedics graduate every year, while in Sava it is between 30 and 40. The relocation of the Training Institute for Paramedical of Antananarivo in new premises in 2011 will allow it to take on 100 additional students, provided that the new institute is also equipped with additional teaching resources. The INSPC (National Institute for Public and Community-based Health) is developing with the Ministry and the faculties of medicine a new official diploma entitled 'community-based general practitioner' that would recognise and value this specialty.

However all these efforts need to be scaled up. Donor support for HRH in Madagascar is very weak and poorly coordinated, and NGOs involved in this subject are few and far between. High turnover and poor management at the Department for Human Resources at the Ministry of Health have held back progress. Staff report being totally overwhelmed with the management of personal requests from health workers regarding their allocation. Although serious efforts are underway in Madagascar to address the critical shortage of health workers, the political crisis has led to the suspension of aid from USAID, the World Bank and the IMF.

## Conclusion

A clear relationship exists between the health systems of Madagascar and France. The implementation of the WHO Code should result in a bilateral agreement between the two countries to ensure that migration is well managed and that both countries can benefit by circular migration. Such an agreement will also need to address the resource needs of the Ministry of Health as it attempts to develop its health care workforce and reach rural areas. However in the context of political instability and donor hesitance, the prognosis for Madagascar is not good.

# 04

## 04 CASE STUDIES

### EL SALVADOR: PLENTY OF DOCTORS, YET STILL ON THE CRITICAL LIST

El Salvador is a country of contrasts. Despite being classified as a middle income country, equality is a major cause of concern: the UNDP human development reports identify El Salvador alongside Guatemala and Brazil as one of the most inequitable countries in Latin America, the world's most inequitable subcontinent. Although the average income is USD 3,460 per year, the number of Salvadoran households living in poverty has increased by 10 % during the last decade and more than 2.6 million people live on less than two dollars per day<sup>31</sup>.

But El Salvador's paradoxes are not limited just to wealth. According to the WHO, El Salvador has a crisis in human resources for health with only 12 doctors per 10,000 people. The Ministry of Health of El Salvador, calculates that the average shortfall is at least 40 %. In 2008, as much as 53 % of the population had no access to health care. However, the cause is not a lack of trained and prepared professionals, because there are hundreds of doctors qualifying every year and who are unable to find a position in the public health system.

#### Public versus private

The problems with El Salvador's health system and its workforce stem principally from the Civil War in the 1980s. For decades, the only place that Salvadorians could train to become a doctor was in the public national university, regarded as a source of opposition by the government and, therefore, inadequately funded. Although the war ended almost 20 years ago, the quality of education and medical service still suffer from serious problems.

In El Salvador, doctors are perceived as elitist and removed from the needs of real people. Some people are drawn to the profession to gain prestige and money and the topic of community medicine is derided and looked down on by medical students. This image of a medical career is far from the truth in a context in which the health budget has been at no more than 2 % of GNI for many years. It also does nothing to aid the recruitment of doctors to the rural and poor communities where they are needed. A recent report published by the WHO stated that since 70 % of nurses in El Salvador believe that there is no opportunity for advancement, or performance related pay at their workplace, efforts to improve the motivation of health workers need to be made a priority.

It is common in El Salvador for medical professionals to be hired not by the day but by the hour. A typical doctor may have two hours a day in a hospital and a few hours in a private clinic to supplement his income. Esteban<sup>32</sup>, a human resource manager of a private hospital in San Salvador, remembers when he began to practice and how difficult it was to find a work after spending 11 years studying medicine. He recalled that many colleagues, after spending the required year of voluntary work in a hospital, remained working for free, waiting for a position and taking advantage of the fact that "if a patient likes you, you can send him to your clinic". In this way, job insecurity is directly leading to practices that undermine public health systems.

The Dr. Hugo Morán Quijada Health Centre provides primary health care to 28,053 inhabitants living in the municipalities of San Salvador and Mexicanos. It is open from 7 a.m. to 7 p.m. during the week and it is visited by 700 patients per week. For this amount of hours and consultations they have 20 doctors. The ratio of care should be in the order of 35 patients per doctor. Unfortunately the calculation is not so simple: 11 of the 20 doctors work just two hours per day, six work only four hours a day and only one is a full time member of staff. At tertiary hospitals, 60 % of specialists work just two hours per day and predominantly only in the mornings so that they can run private practice in the afternoons. Of the 30 hospitals in El Salvador, 42.5 % of doctors work only two hours per day, 25.8 % work for four hours and less than 20 % are full time staff.

Although the country is small, much of the country is mountainous and inaccessible and therefore has no health service to speak of. Some 70 % of the consultations at hospitals are primary care visits because there are no resources at community level. Investment in primary care has been low and patchy until very recently.

#### Four national health systems: a prescription for disaster

El Salvador has traditionally had not one, but four national public health systems. Each system has its own expenditure per capita, distinct services and different pay-scales. The first is operated by the Ministry of Health and intended to cover all primary health, especially for the unemployed, the poor and all those not covered by the other three health systems. Per capita expenditure is only USD 87 per year. Soldiers and teachers have their own health systems as part of the benefits package and formal employees yet another. Doctors can earn four times more working for the teacher health system than the Ministry of Health. The Ministry of

<sup>31</sup> El Salvador Annual Report, UNDP, 2009.

<sup>32</sup> Names have been changed to protect identity.



Health can spend USD 87 per person per year, the social security system USD 221 per person per year and the teacher system can spend USD 340 per year. This results in an extremely fragmented and dysfunctional system, in theory overseen by the Ministry, but in practice left to its own devices.

Although each system is financed separately, the Ministry of Health remains responsible for covering the financial gap for each of the other systems. The Ministry pays for all primary care consultations for formal employees, soldiers and teachers, without any compensation mechanism to recover this funding. The result is that the Ministry, responsible for providing care to almost 80 % of the population, has been all but brought to its knees. El Salvador is therefore a good example of 'inverse care', when people with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least.

### Reasons for hope: a brave new Ministry of Health

After 20 years with one party in power, a change of government has now put health at the forefront of the political agenda. Dr. Maria Isabel Rodriguez, the new Minister of Health of El Salvador, is a strong woman. The former Dean of the School of Medicine at the National University, Dr. Rodriguez is one of several ministers who have made a courageous commitment to reform the national health system to cover the 80 % of the population.

The President of El Salvador has charged the new Ministry of Health to reach a budget of 5 % of GDP by 2014. According to the Secretary of State for Public Health, Eduardo Espinoza, "No country can achieve universal coverage with less than 6 % of GDP; Costa Rica and Panama are doing it, more less, with 5 %". In 2008, the year before the present Government took power, health accounted for 1.8 % of the total budget with an expenditure of USD 399.3 million. Notwithstanding the global economic crisis, in 2009 the health budget has increased to USD 450 million, and in 2011 it is expected to exceed USD 517 million, or 2.4 % of GDP.

The budget increase will mainly be directed at a gradual reform of the Primary Health Care system, which aims, among other things, break the biggest barriers of health care access of El Salvador, which are the rural-urban inequities. To do this, a family medicine and health promotion model is being proposed, carrying doctors and nurses to all communities to reach out the half of the population that today does not have regular access to health care.

In July 2010, health care reform started in the 63 poorest municipalities of the country with the least access to health facilities. Up to 10 of these municipalities had health services fully managed by NGOs because of the weakness of the state there. With the new model, health care will be structured to cater for a group of up to 600 families, each of whom will have access to a community health team made up by a doctor, a nurse, a nursing assistant, three community health workers and an 'all-rounder'. There will be a family doctor for every 3,000 people and a community health worker for every 200 families. Every two groups of families will have access to a psychologist and a nutritionist, and other specialities will be accessible for each four groups of families. By 2014 it is expected that this new system must be operational in all municipalities.

### Conclusion

The implementation of the WHO Code is unlikely to have a major impact on El Salvador as the crisis is the result of a chronic underinvestment in the health system. El Salvador is pioneering a new way to deliver primary health care to its people, with a potentially powerful model for achieving the MDGs. So far, the World Bank and Latin American Development Bank have made it possible for El Salvador to increase the health budget. However, it remains to be seen if the country can sustain the financing of salaries on the basis of loans that must ultimately be repaid. International donors have yet to step forward to support El Salvador in these health reforms or to address specific problems with HRH and health system strengthening. Since El Salvador is not a low income country, it is unlikely to be high on the priority list for assistance.

# 05

## 05 GOING BEYOND THE CODE: NEXT STEPS

### What will it cost?

In 2006, the World Health Organisation estimated that a USD 10 per capita increase in health expenditure would be required to train and recruit missing health workers. This would mean an average overall cost of USD 136 million for training and USD 311 million for employment.

The Task Force on Scaling up Education and Training (2008) estimated that USD 26.4 billion would be required over 10 years to train 1.5 million health workers required in Africa.

Similarly, in their 2009 paper 'Estimates of health care professional shortages in Sub-Saharan Africa by 2015', Richard Scheffler et al. used forecast modeling to conclude that USD 20 billion is needed to scale up HRH in the region.

Source: Investing in health workforce: Efficiency and effectiveness of aid flows, presentation by Dr. Gulin Gedik, HRH Department, WHO, 16 March 2010.

The WHO has estimated that 25 % of all health spending should be allocated to human resources for health. Currently, very little information is known about the exact spending of the five countries profiled in this report in this area. It is almost impossible to gain accurate figures on the exact amount of health aid allocated to HRH because this is not captured in the spending breakdowns. As a matter of urgency, Member States should make figures available on how much ODA is being allocated to addressing the health worker shortfall.

Experience has shown that piecemeal attempts to address the HRH shortfall are likely to fail because the causes of the crisis are multiple and complex. The measures promoted by the WHO Code of Practice (no direct recruitment from developing countries, bilateral agreements and circular migration initiatives) are only a starting point. HRH spending often represents over half of health ministries' budgets and is the single largest cost element in providing health services in low income countries. However, HRH without other inputs such as drugs and supplies, functioning equipment, and adequate management, are ineffective<sup>33</sup>. The cost of meeting the unmitigated international demand for health care workers is increasingly being borne by the world's poorest nations. The growing consensus is that national health systems in developing countries need to be adequately resourced and that developing countries need to have an evidence-based and well-resourced human resource plan in place as part of their national health strategies.

The following table summarises some of the major causes of the human resources for health shortfall in developing countries and proposed solutions that could support, surround, or be incorporated within a national HRH plan.

<sup>33</sup> WHO/Global Health Workforce Alliance 2009. Financing and Economic Aspects of Health Workforce Scale-up and Improvement.



## CAUSE

Governments cannot afford to pay staff, increase wages or improve depressing working conditions, including poor facilities, equipment and lack of essential medicines but also long hours and gender based violence. In some countries, graduates cannot find employment because there is no budget to hire them. HIV positive health workers also face stigma and discrimination.

Tendency to fund health in a short term or vertical approach, especially in response to emergencies such as HIV/AIDS.

Health budget ceilings and restraints on public sector salaries imposed by IMF and World Bank in return for loans.

Insufficient numbers of health care workers are being trained in developing countries. Africa has a quarter of the number of medical schools in Europe.

Jobs in the public health sector are regarded as too demanding and poorly paid. Gender segregation of occupations is a major source of inequality worldwide with implications for the development of robust health workforces<sup>34</sup>.

About half of the global population lives in rural areas, yet more than 75 % of doctors and 60 % of nurses are found in urban areas<sup>35</sup>.

Health systems are not responsive to the needs of communities, particularly vulnerable and marginalised groups.

Recruitment of health workers by the private sector, religious organisations, and international NGOs resulting in brain drain from the public sector.

Lack of coordination between public and private health initiatives.

## SOLUTIONS

Direct support to health sector budgets, investment in salaries, management training, professional development and health systems strengthening. Financing must be predictable, long-term and sustainable.

Simultaneous expansion of health workforce as interventions are scaled up. PEPFAR has introduced specific targets for training of additional health workers.

Relaxation of macro-economic restraints to allow governments to increase salaries and spend more on health. In Uganda, the Parliament negotiated USD 30 million for maternal and child health initiatives as a condition on a World Bank loan. The government of Malawi negotiated an agreement with the IMF to increase health care worker salaries.

Direct financial support to pre-service training institutions and programmes. The Italian government has supported the medical school in Liberia.

Redefine the nursing profession to include management skills and practices usually only carried out by doctors. In Italy, male recruitment to nursing schools increased when management was included in the training programme.

Recruitment and retention schemes including financial and non-financial incentives. Zambia offers a package of benefits to health workers who commit to spending three years in rural communities.

Deployment of well trained, well paid and equipped community health workers can both extend rural coverage and convey community realities back to the health system. In Ethiopia, 33,000 'health extension workers' have been recruited in local villages. However, this must not replace measures to increase numbers of well-trained doctors, nurses and midwives.

Strictly monitored and enforced Codes of Conduct. A voluntary NGO Code of Conduct for Health Systems Strengthening was launched in 2008 to change practices that undermine Ministries of Health in low income countries<sup>36</sup>. Donors and governments need to both enforce and incentivize adherence to such Codes.

Increased communications and transparency between donors, NGOs and Ministries. Map human resource capacity before implementing health programmes.

Sources: Maximising Positive Synergies, WHO, 2009; Merchants of Labour, ILO, 2006; Taking Stock: Health Worker Shortage and the Response to AIDS, WHO, 2006; A Critical Shortage of Health Care Workers, Global Health Council, October 2007; Investing in Health Workforce: Efficiency and effectiveness of aid flows, Presentation by Dr. Gulni Gedik, HRH Department, WHO, 16 March 2010.

34 [http://hrhresourcecenter.org/sg\\_gender](http://hrhresourcecenter.org/sg_gender)

35 Taking Stock: health worker shortage and the response to AIDS, WHO, 2006.

36 Can NGOs help build the public-sector health workforce? Health Alliance International, 2010.

# 05

## 05 GOING BEYOND THE CODE: NEXT STEPS

Donors have been reluctant so far to take the step of paying health care workers salaries directly, given the long-term commitment this entails and the barrier of macro-economic restraints imposed by loan conditions. However, the growing interest in general budget support, has led to greater calls for sector budget support (SBS) or in other words, direct support to the health budget as a way to make progress on the MDGs. In this way, donors come the closest to compensating developing countries for the costs they bear in training doctors and nurses for other countries. Without strong investment in the health system of developing countries, the push factors driving health worker migration are unlikely to recede. Significantly, health sector budget support must also be sufficiently long-term to ensure sustainability and allow for the time-lag between medical school recruitment and qualified doctors and nurses being deployed.

According to the 2008 European Court of Auditors report on EC Development Assistance to Health Services in Sub-Saharan Africa, it has been European Commission policy to provide technical assistance to strengthen priority sector ministries as well as ministries of finance, approximately 10 % of General Budget Support (GBS) funding being reserved for this purpose. However, in the 12 countries with GBS examined by the Court, in only one case (Niger) were funds allocated for specific technical assistance to the Ministry of Health.

The advantages of providing both general and sector budget support within the same country are that general budget support allows for a broader political dialogue on a wider range of issues that could address some of the 'underlying principles' and sector budget support enables donors to participate in a more focused and effective policy dialogue to monitor developments in a specific sector. As health cuts across sectors, it is important that both dialogues (the political dialogue within general budget support and the sector dialogue within sector budget support) link up and reinforce each other.

The IMF continues to support expenditure ceilings on health budgets because they "help prevent overspending on showcase projects". However, the relaxation of macro-economic restraints to allow Ministries to increase public sector wages has been successful in the case of Malawi, where salaries were increased by topped up by 52 % (with the increased income tax revenue providing income). In Uganda, the Parliament negotiated USD 30 million for maternal and child health initiatives as a condition on a World Bank loan<sup>37</sup>.

Although the volume of aid to global health has increased over past decades, the percentage share allocated to HRH has been tiny. Donor responses have in part exacerbated the trends, in so far as they have naturally responded to the health emergencies of HIV/AIDS and other infectious diseases with short-term approaches without the necessary expansion on the health care workforce. For obvious reasons, the strategy was to deploy existing workers, use task shifting, and provide in-service training rather than the longer-term effort of training new health workers. In some cases incentives used to achieve project goals have had repercussions for the local labour market, such as volunteers receiving more in allowances than nurses receive in salaries<sup>38</sup>. In others, imbalances between rural and urban workforces have been exacerbated<sup>39</sup>.

Increasingly, global health initiatives and multilateral actors such as the Global Fund and PEPFAR, are recognising the importance of maximising their contributions to health workforce strengthening and introducing targets for the training of health workers. In Malawi, the government re-allocated a major grant from the Global Fund to support its Emergency Human Resource Programme, increasing the numbers of staff across all levels of the health system as a result<sup>40</sup>.

37 WHO/Global Health Workforce Alliance 2009. Financing and Economic Aspects of Health Workforce Scale-up and Improvement.

38 Centre for Global Development, Zeroing In: AIDS Donors and Africa's Health Workforce, 2010.

39 WHO, Maximising positive synergies between health systems and global health initiatives, 2009.

40 R. Brugha et al., Health Workforce responses to global health initiatives funding: a comparison of Malawi and Zambia, Human Resources for Health, 2010.



It is not only global health initiatives that need to question their actions. In recent years the number of NGOs active in supporting global health has grown exponentially, especially in Africa. Research by AfGH in Zambia has revealed that high salaries offered by NGOs have had a detrimental effect on the ability of the national health system to recruit staff to rural areas<sup>41</sup>. In increasing recognition of the role that international NGOs (often in response to donor demands for quick and tangible results) are inadvertently playing in worsening the HRH crisis, a group of six NGOs launched a voluntary NGO Code of Conduct for Health Systems Strengthening in 2008<sup>42</sup>. The 50 signatories of the Code to date have pledged to avoid hiring health or managerial professionals from the local public sector, and to work towards fair salary structures in all sectors of the health care system, including community health workers. The document also urges NGOs to invest in education and training as a way to compensate for the workers that they hire and to coordinate planning with Ministries of Health<sup>43</sup>.

In an evaluation of the implementation of the Code in May 2010, Health Alliance International highlighted some of the best practices of NGOs in this regard. Most NGOs are no longer hiring expatriates when local personnel are available and do not hire people from the public sector unless it is first approved by the Ministry of Health. Some NGOs have adjusted their pay scales to match those of the local government and university salaries. Others are working directly with universities to train doctors and nurses, thus preparing them for a primary health care role<sup>44</sup>. Donors have a role to play in supporting these initiatives and incentivising adherence to the NGO Code.

41 AfGH, Zambia: Aid Effectiveness in the Health Sector, 2009.

42 <http://ngocodeofconduct.org>

43 N.Bristol, NGO Code of Conduct hopes to stem internal brain drain, *The Lancet*, Volume 371, Issue 9631, p.2162, June 2008. Available at: <http://www.thelancet.com/journals/lancet/article/PIIS014067360860937X/fulltext>

44 Health Alliance International, Can NGOs help build the public-sector health workforce? Successes and Challenges implementing the NGO Code of Conduct for Health Systems Strengthening, 2010. Available at: [http://ngocodeofconduct.org/wp-content/uploads/implementing\\_ngo\\_code\\_of\\_conduct\\_report\\_may-2010.pdf](http://ngocodeofconduct.org/wp-content/uploads/implementing_ngo_code_of_conduct_report_may-2010.pdf)

# 06

## 06 ARE MEMBER STATE DOMESTIC HEALTH POLICIES ADDRESSING THE HRH CRISIS IN THE DEVELOPING WORLD?

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### FRANCE

France provides a national health service funded largely by health insurance. In 2000, the WHO rated French health care as the best in the world. According to the latest figures, French national expenditure on health is the highest of all the AfGH countries reviewed in this report at USD 4,627 per capita.

France has a total of 227,683 doctors and 494,895 nurses according to the WHO, placing it on a par with the European average in terms of density of health care professionals. However, France has a severe shortage of midwives, particularly in rural and disadvantaged areas. There are fewer midwives in France than in the UK but more births: 20,000 midwives per 800,000 births in France against 35,000 midwives per 650,000 births in the UK.

In an attempt to reduce health service costs in the 1980s, France dramatically reduced the number of medical students permitted to qualify as midwives and doctors. Currently only 1,000 midwives are permitted to graduate each year. Of these, dozens will never exercise their profession, either unmotivated by the unattractive wages, conditions in maternity units or the lack of opportunities for professional development. The major outcome of this quota policy has been a halving of the numbers of trained GPs and specialists as well as a halving of the number of interns in hospitals, who provide the bulk of emergency and continuity of care. The remaining vacant positions, especially in peripheral hospitals and in rural areas, have gradually been occupied by doctors with non-EU qualifications. These doctors are not permitted to practice all aspects of medicine and are paid 40 % less than EU qualified doctors on a salary only just above the minimum wage.

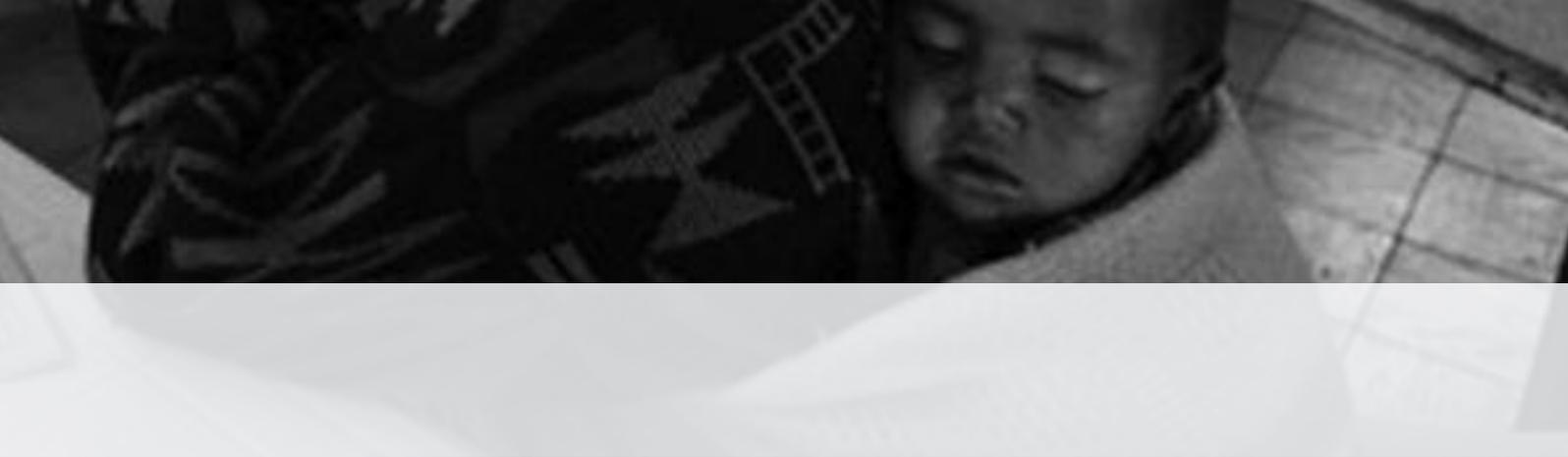
Although France is now training health care professionals in greater numbers, it may be a case of too little too late. According to estimates by the Ministry of Health the number of doctors in France will decline nearly 10 % over the next decade. Between 2006 and 2030, the French population is expected to grow by approximately 10 %, with more births, an increasingly ageing population and high medical expenses. Even with the raising of the quota on how many doctors are permitted to qualify to 8,000 each year, the current level of density will not be regained until 2030. Official projections show that the density of doctors will decrease from 37 per 10,000 to 27 per 10,000 by 2020, creating a critical situation for the provision of care, especially in rural areas. As in Spain and Germany, newly qualified doctors prefer to practice in urban centres or privately. Even today, 2.3 million French people live in areas considered as “in difficulty or fragile in terms of medical presence”.

### Overseas recruitment

In 2007 France employed 7,966 doctors who were not French citizens (3.5 % of all physicians). Of these, 53 % are Europeans (Belgians, Germans, Italians), while the rest are non-European, mainly from the Maghreb (Algeria, Morocco, Tunisia). Foreign-trained doctors and nurses are primarily employed in hospitals.

Most of France's foreign-trained health workers are from the EU. International recruitment of doctors and nurses without EU qualifications to both public and private practice was prohibited in 1999, with the exception of refugees and asylum seekers. Only nurses with EU diplomas are permitted to practice. However, there are no such restrictions on recruiting foreign trained pharmacists and certain health facilities do manage to circumvent this legislation. The strategies being employed to address the current and impending staff shortages are focused on addressing the retirement age, co-operation between hospitals and incentives to encourage health professionals to work in underserved areas<sup>45</sup>.

<sup>45</sup> OECD Health Working Papers No. 36, Projet OECD Sur La Migration Des Professionnels De Santé: le cas de la France, DELSA/ELSA/WP2/HEA(2008)3.



## Coherence

France has taken a number of steps to address the anticipated HRH crisis. Quotas have been raised since 2002 on the number of students in medicine, dentistry, pharmacy and nursing. Training and financial support to increase the retention of health staff in the hardest hit areas have been accompanied by efficiency measures using ICTs, task shifting and new outpatient services. Doctors have been allowed to continue to practice medicine after retirement. Grants have also been made available to support foreign medical students that wish to return home or who wish to participate in North-South networks in higher education and research.

In 2008, the French government set up an inter-ministerial platform for HRH, gathering representatives from the Ministries of Health, Foreign Affairs, Immigration, Education, Development (AFD) and the main relevant organisations: bar councils for physicians, midwives, universities and representatives of the civil society. This platform aims at sharing experience among French actors and assesses the different actions undertaken on the issue of HRH.

## Conclusion

With the exception of midwives, densities of health workers in France are not yet presenting major problems. However, the country needs to rapidly take action to ensure a well balanced coverage of the health workforce is maintained throughout the whole territory, especially in rural areas. A better understanding of the enter and exit flows of health workers including foreign staff would also help to plan efficiently the actions needed to address any future shortage in specific health professions such as midwives and other specialists.

## Strengths

- Inter-ministerial platform enables coordination between Ministries and bodes well for implementation of the WHO Code.
- Steps are being taken to prevent a future crisis, including the raising of quotas on medical school entrances.

## Weaknesses

- Legislation designed to reduce the possibility of health workers being recruited from developing country health systems is being circumvented by private agencies.
- Working conditions especially for midwives and general practitioners need to be dramatically improved as a matter of urgency in order to attract new recruits.

# 06

## 06 ARE MEMBER STATE DOMESTIC HEALTH POLICIES ADDRESSING THE HRH CRISIS IN THE DEVELOPING WORLD?

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### GERMANY

Germany has Europe's oldest universal health care system, dating back to 1883. Over 10 % of the national budget is allocated to health, equivalent to USD 4,200 per capita<sup>46</sup>.

On paper, Germany fares well in terms of ratios of doctors and nurses to population, with densities above the EU average. Despite this high coverage, recent estimates suggest that approximately 17,000 full-time physicians were lacking in 2010; this shortage will rise to 56,000 in 2020 and 166,000 in 2030. For health workers other than doctors there was even a slight 'oversupply' of 30,000 health staff in 2010. However, a shortage of about 14,000 full time staff is predicted by 2020, rising to 786,000 in 2030<sup>47</sup>. Germany is predominantly a source country for health worker migration. Significant numbers of German doctors and nurses are migrating to Scandinavia, Switzerland, the US, but also both Italy and France, as documented in these country's profiles.

### Overseas recruitment

Currently there is no recruitment of health workers from abroad. Nurses from non-EU countries can technically only be granted a German work permit if the Federal Employment Agency has concluded a placement agreement with their home country (currently only the case for Croatia). Highly-skilled employees (including in the health sector) can receive a work permit if they can prove an annual income of at least EUR 63,000. Under this rule, only medical doctors and other health specialists can presently qualify for a German work permit.

Nonetheless, 11 % of all physicians and 10 % of nurses working in Germany have been trained overseas. In 2006, 4.5 % of all employees working in the health sector were foreign nationals and 4.6 % naturalized citizens. The share of foreign nationals was lowest in the profession of medical doctors (3.9 %) and highest for less qualified positions such as nursing and geriatric nursing assistants (6.1 %) <sup>48</sup>.

Although Germany does not actively recruit foreign health workers, projections indicate that this will change in the near future and that proactive policy making is required to avoid a critical shortage. As a response to the anticipated skilled worker shortage in health and other sectors, the German government is currently developing a new policy for recruiting workers from non-EU countries and for accrediting foreign certificates and degrees<sup>49</sup>.

### Coherence

While the Ministry of Health led negotiations on the WHO Code of Practice, various institutions will be involved in its implementation, including the Ministry of Labour and Social Affairs, the Ministry of the Interior, the Federal Office for Migration and Refugees and the Development Ministry (BMZ). The BMZ contributes to overcoming the shortfall of health workers in developing countries through its development programmes (see above). The regulation of the recruitment of foreign health workers for domestic health care is an interagency topic which touches labour market, health and immigration policy issues.

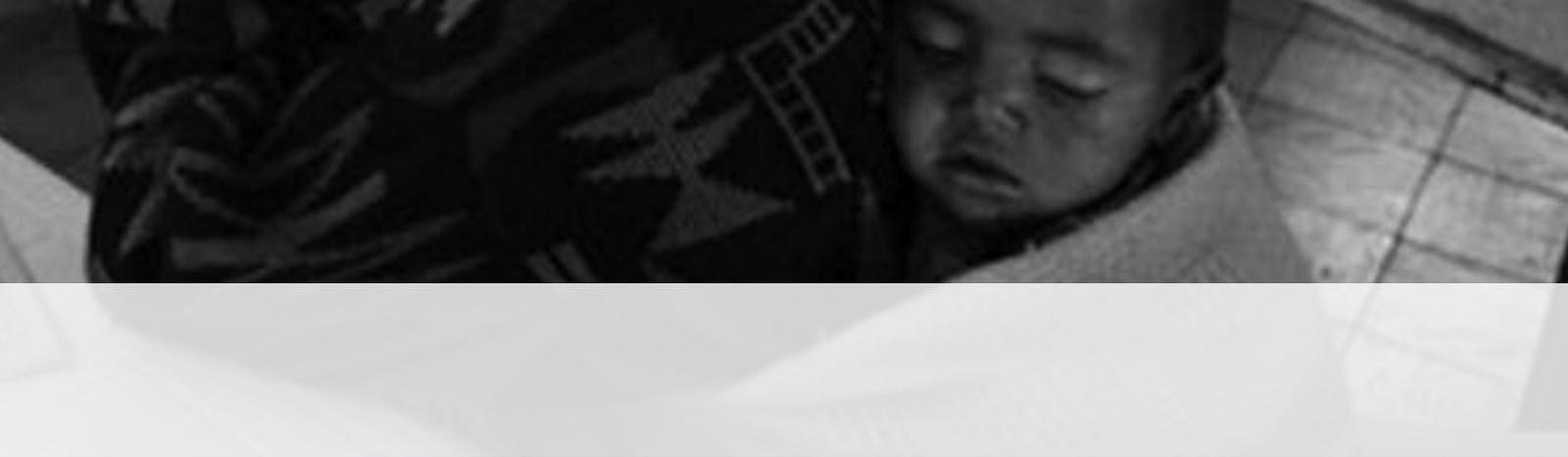
Until now, no concrete action has been taken by the relevant ministries. Coordination among the ministries is in its infancy at best; there is no interagency working group and it is unclear who exactly in the Ministry of Health will take the lead in implementing the WHO Code of Practice. This also applies to measures currently being discussed under the notion of 'circular migration', which refers to temporary employment and training of foreign health workers in Germany and temporary deployment of German health professionals in developing countries. The idea is to address urgent, short-term needs for health personnel in developing countries through this approach while, at the same time, training foreign health professionals in Germany to fill the HRH gap in these countries in the medium term. It is currently unclear which position the German government take in relation to circular migration, and how related exchange and training programs will be taken forward.

<sup>46</sup> World Health Statistics, WHO, 2010.

<sup>47</sup> Dennis A. Ostwald, Tobias Ehrhard, Friedrich Brunsch, Harald Schmidt and Corinna Friedl, 2010: Fachkräftemangel: Stationärer und ambulanter Bereich bis zum Jahr 2030, edited by PricewaterhouseCoopers AG Wirtschaftsprüfungsgesellschaft, Frankfurt am Main, p.35-38.

<sup>48</sup> Anja Afentakis and Karin Böhm 2009: Beschäftigte im Gesundheitswesen. Gesundheitsberichterstattung des Bundes, Heft 46, edited by Robert Koch-Institut, Berlin.

<sup>49</sup> Spiegel Online, 20 October 2010; <http://www.spiegel.de/politik/deutschland/0,1518,725775,00.html>



## Conclusion

While there is no imminent crisis, Germany needs to rapidly take action to establish interagency coordination structures which will allow the development of policies and tools to implement the WHO Code, and to avoid the severe shortage of German health workers looming on the horizon.

## Strengths

- Germany already has strong legislation in place to ensure international recruitment is managed jointly with the source country.
- Discussions are already underway on how to integrate migrants into the health system in an equitable way.

## Weaknesses

- Currently, coordination between government agencies is weak.
- Retention measures need to be taken to prevent German doctors migrating, and to incentivise them to take up rural posts.

# 06

## 06 ARE MEMBER STATE DOMESTIC HEALTH POLICIES ADDRESSING THE HRH CRISIS IN THE DEVELOPING WORLD?

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### ITALY

The Italian National Health Service was established in 1978 and aims at granting universal access to a uniform level of care throughout the country, financed by general taxation. The system is decentralised and managed at the regional level. In 2007, Italy's total expenditure on health amounted to 8.7 % of GDP<sup>50</sup>. Universal health coverage has been achieved, although regions widely differ in terms of health care quality and health expenditure, with a clear North-South divide.

Italy has traditionally ranked very high globally in the WHO rankings on doctor patient ratios, a few years ago second only to Cuba in terms of the number of doctors it produces. Currently, there are 215,000 doctors in Italy, giving a ratio of 37 per 10,000 people, similar to that in Germany and France. In Italy however, the number of doctors is surplus to government requirements. Competition for public service is fierce, with newly qualified doctors typically facing a long job search before finding regular employment. Nevertheless, Italy will face a shortage of highly specialised doctors in the near future. In fact there is a shortage of qualified specialists in certain sectors, such as anaesthesia and radiology. In paediatrics, the number is expected to halve from 2015 to 2030 if the current enrolment and turnover trends continue. This shortage could result in a lack of 50,000 specialists in the next five years.

While Italy trains more physicians than it needs, it does not train enough nurses to meet current demand. Every year, 17,000 nurses retire and only 8,000 enter the field<sup>51</sup>. According to the Italian Federation for professional nurses, health assistants and childcare workers (IPASVI), there were 364,663 professional nurses (6.1 nurses for every 1,000 inhabitants) at the end of 2009. There are different estimates of the size of this national shortage, but all estimates place it above 50,000 nurses<sup>52</sup>. The main sectors affected are emergency care and hospitals, especially during holiday periods.

The causes of the nursing shortage are attributed to several main factors. In the 1990s, health expenditures were put under strict control and since 2005 the budget for human resources has been reduced by 9 %. There has been a lack of investment in training sufficient numbers of health care workers to meet the needs of an ageing population. There are also strong limitations on access to medical schools increasing trend towards specialization away from primary health care and high retirement rates. As is the case in most countries, nursing is regarded as an extension of the women's traditional role in society and not a role that is highly respected and remunerated. In order to make nursing more attractive as a career some hospitals recently introduced management training into nursing courses, resulting in a large increase in applications from men.

### Overseas recruitment

About 4.4 % of all physicians in Italy were born abroad, an increase of 1 % since 2004<sup>53</sup>. A much larger proportion, 28.4 % of nurses registered with the Italian Nursing Federation are from outside Italy. Very few of the foreign born doctors in Italy are from developing countries. The majority are now from Europe and since the fall of the Berlin Wall, increasingly from the former Soviet Union<sup>54</sup>. With nurses however the picture is very different. A far greater proportion of foreign nurses come from outside the EU, with a notable proportion from developing countries such as Peru and India, both countries that are on the WHO critical list of countries with a density of health workers below a critical threshold to achieve an 80 % coverage rate for skilled birth attendance and child immunisation<sup>55</sup>.

Doctors and nurses from outside of the EU face considerable barriers to practice medicine in Italy, since citizenship is almost essential for a successful career in the public sector. Access to specialization, for example, is limited for non-EU citizens even if their medical degree is Italian. Another important obstacle for foreign doctors is the language barrier, since Italian is not widely spoken abroad. Some 80 % of the members of the main association of foreign doctors (AMSI) were trained in Italy.

50 [http://ec.europa.eu/health/ph\\_information/dissemination/echi/echi\\_25\\_en.pdf](http://ec.europa.eu/health/ph_information/dissemination/echi/echi_25_en.pdf)

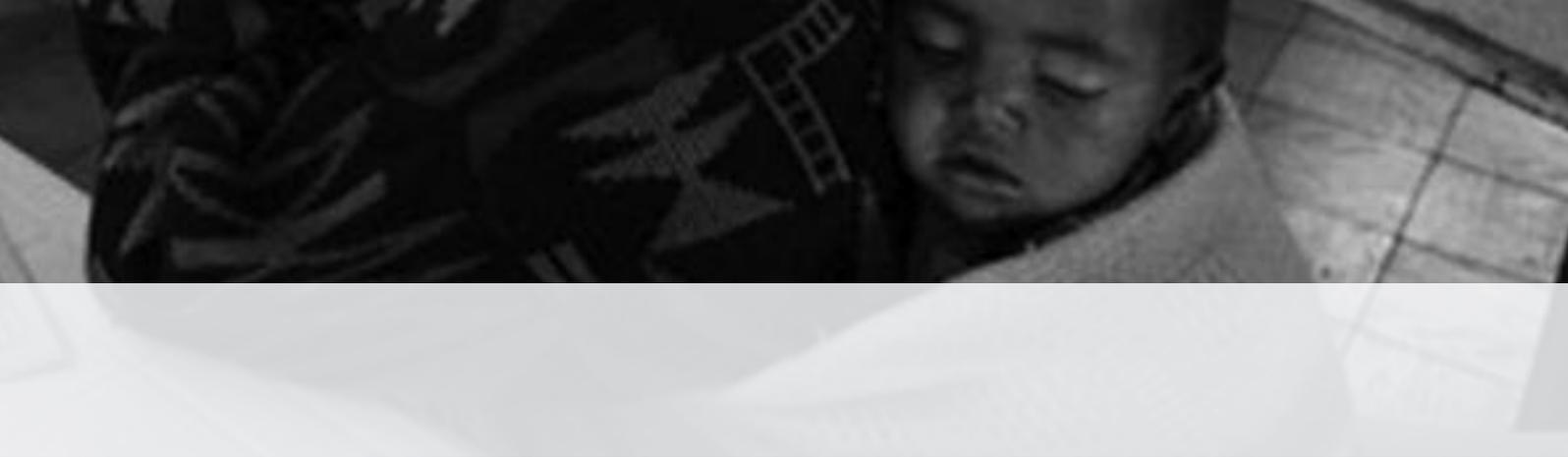
51 Chaloff, J. (2008), 'Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy', OECD Health Working Papers, No. 34.

52 Data from 'Dossier statistico immigrazione Caritas/Migrantes' quoted in <http://www.stranieriinitalia.it/briguglio/immigrazione-e-asilo/2006/aprile/scheda-ric-sim-infermieri.html>

53 Il Sole 24 Ore, 20/09/2010.

54 Il Sole 24 Ore, 20/09/2010.

55 <http://infocooperation.org/hss/documents/s15627e/s15627e.pdf>



## Coherence

The acute nursing shortage in Italy first led Italian policy makers to establish exemptions for nurses within the annual ceilings (2,000 nurses in 2001) and then to enshrine a permanent exemption from quotas in migration law in 2002. According to this regulation, only professional nurses are exempt from migration quotas and can be offered a permanent job in Italy. In 2005, of the 7,000 foreign nurses working in Italy, most were in the private sector. Some of these nurses later try to make the leap to the public sector<sup>56</sup>.

Some Italian regions recruit nurses from Eastern European countries such as Romania through bilateral programmes with nursing training institutes. Recruitment of nurses from abroad was particularly intense during the 1990s when the shortages were acute. According to a report by Bocconi University in 2005, eight employment agencies were active in the nurse recruitment sector, of which six provided only foreign health personnel, relying directly in international recruitment<sup>57</sup>. Agencies offer language and training courses, both before and after leaving the home country, and often provide housing assistance. However more recently, the need to recruit internationally has been considerably alleviated by increasing numbers of Italian students entering in nursing schools, encouraged by the raising of enrolment quotas.

## Conclusion

The Italian public health system is feeling the strain due to a legacy of past policies and inadequate forward planning. The decentralised system is already reliant on nurses from countries in desperate need of them, who form in some cases a 'second class' tier of the health service in Italy because they are often recruited by private agencies. There remains a great deal for Italy to do in order to implement the WHO Code and ensure that the requisite growth of the national health service does not have a negative impact on the attainment of the MDGs.

## Strengths

- The system for training, recruiting and retaining physicians in Italy appears to be functioning well.
- Measures are being taken, albeit slowly, to increase the numbers of nurses entering the profession.

## Weaknesses

- Italy is unlikely to resolve its impending HRH crisis unless it increases investment in the health system overall.
- Domestic and foreign policy on human resources for health are in conflict. The implementation of the WHO Code presents a timely opportunity to bring them into alignment.

<sup>56</sup> Chaloff, J. (2008), 'Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy', OECD Health Working Papers, No. 34.

<sup>57</sup> 'Politiche Migratorie, lavoratori qualificati, settore sanitario. Primo Rapporto EMN Italia' a cura di IDOS-Punto di Contatto dell'EMN, con il supporto della Direzione Centrale Immigrazione e Asilo del Ministero dell'Interno.

# 06

## 06 ARE MEMBER STATE DOMESTIC HEALTH POLICIES ADDRESSING THE HRH CRISIS IN THE DEVELOPING WORLD?

### SPAIN

The Spanish National Health System in its current form was constituted in 1986 and decentralised in 2002. In 2008, national expenditure on health was only USD 2,700 per capita, the lowest contribution of all five EU Member States reviewed in this report<sup>58</sup>. As a percentage of GDP, the budget was 8.5 % – slightly above the UK and slightly below Italy.

Spain is below the EU average for density of doctors and nurses, with 21 doctors and 74 nurses/ midwives per 10,000 people. Currently, Spain has a deficit of 9,000 doctors. The shortage is acute among family doctors in rural areas, anaesthetists, paediatricians, radiologists, psychiatrists and gynaecologists. If current trends continue, the shortfall will be 25,000 doctors by 2025.

#### Reasons for the shortfall

Since the year 2000, the Spanish population has increased by six million, without a proportional expansion of the health budget. Spain has the second highest life expectancy in Europe, at 81 years and people over the age of 65 constitute over 16 % of the population. The health care they require is labour intensive and likely to be long term.

In 1983, Spain topped the European league tables for the number of qualifying medical students. However there was a shortage of residencies available for students to complete their training.

One of the consequences of the high levels of unemployment among doctors has been a deterioration in terms and working conditions as there was more people willing to work even for worst conditions. In relation to this, working conditions within the public sector have made the profession much less attractive to potential students. Meanwhile, the establishment of quotas on the number of new students allowed to train has left the country unprepared for increasing health demands of the population.

In 1992, Spain decentralized the health system and the autonomous communities invested considerably in health facilities and services, without making parallel increases in the numbers of new doctors and nurses. For example, primary health care professionals now represent 38 % of the total health staff but cater for 90 % of the population's health problems. In 10 years the number of primary health care personnel has decreased by 10 % while consultations have increased by 45 %<sup>59</sup>.

This has led to competition for professionals across the 17 autonomous regions without any coordination to avoid the inevitable shortfalls and inequities across regions. In 2003, legislation was introduced to standardise the labour market and to introduce a register, without success.

Due to the problems with the labour market, many of Spain's trained health workers have moved to Portugal or the UK, where conditions are relatively more attractive. Approximately 8,000 Spanish health professionals work abroad<sup>60</sup> and the efforts put in place to promote volunteer return have so far been unsuccessful<sup>61</sup>.

#### Overseas recruitment

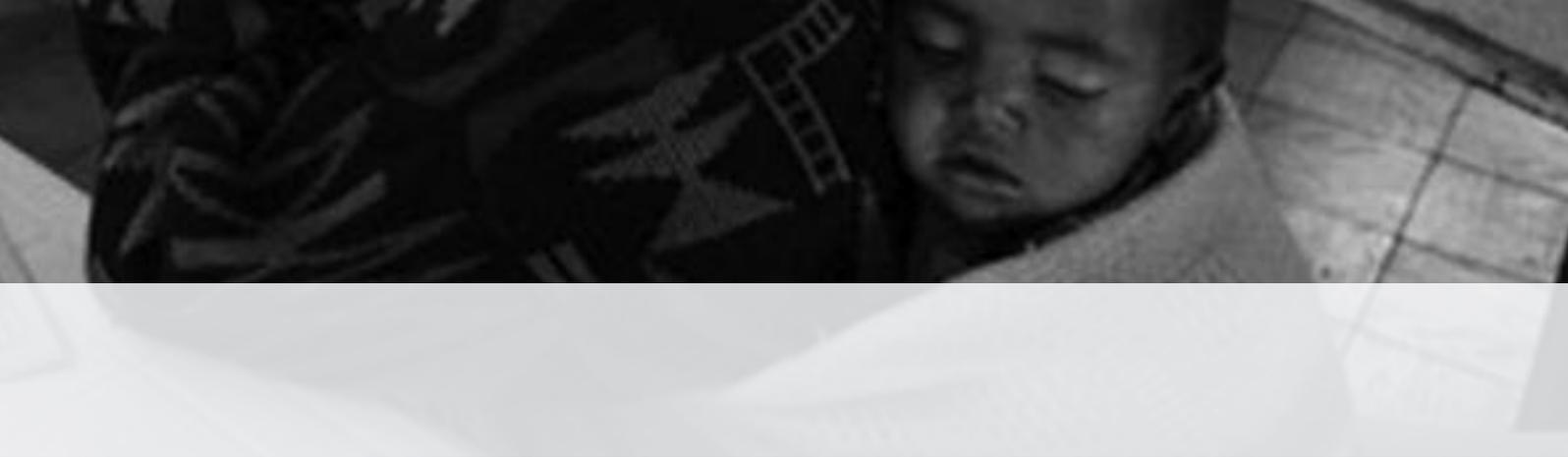
Spanish legislation allows a maximum of 10 % of non-EU doctors in new residency positions. However, there is no limit for those already studying in Spain or who have a residence permit. The system does not capture how many of them studied medicine in their own country. Since Spain has no centralised register of its health personnel, there is no way to know exactly how many health professionals are from abroad. However, according to the Madrilenian Medical Association, it is estimated that the number of foreign professional doubled between 2002 and 2006 and that in 2010, 50 % of the resident positions were occupied by students from outside the EU. Foreign doctors fill positions that Spanish health workers have left, especially as rural doctors. Due to a common language, most of them come from Central America or the Caribbean, although a growing proportion are from Eastern Europe.

58 World Health Statistics, WHO, 2010.

59 According to the Spanish Society of Communitarian and Family Medicine.

60 Madrid Medical Association

61 The Return Plan attracts just 14 professionals, Público, 26/4/2010.



## Coherence

Although there is no official public policy to recruit health workers from abroad, health managers are able to exploit a loophole in the legislation to enable this in practice. Job descriptions can be written to include specific skills that national applicants are unlikely to have and entered into a “catalogue of occupations of difficult coverage”. This makes it possible to justify the hiring of a non-EU health worker. Each of the autonomous communities has one such list updated each quarter. During the last quarter of 2010, nine communities requested foreign workers via the catalogue – eight of them requested health professionals (mainly general practitioners) and four of them exclusively requested health workers<sup>62</sup>.

## Conclusion

Spain is a good example of the effects of increasing international migration both in terms of the brain drain of its own health professionals to other countries and the temptation to take the easiest option to recruit personnel rather than address the root cause. Legislation to restrict recruitment from overseas is ineffective, regions compete with one another for staff and efforts to limit emigration have been so far unsuccessful. As one of the few EU Member States with a growing population, it is urgent that Spain places more effort into resolving these problems, starting with the collection of national statistics and implementation of the WHO Code.

## Strengths

- Spain brought in positive legislation on the management of health professionals in 2003 that would greatly improve the situation if it was implemented.
- Awareness of the scale of the HRH shortage in Spain is increasing and restrictions on the number of students entering medical training are gradually being lifted.

## Weaknesses

- The Government has no centralised register of health personnel working in the country and thus no way of managing the situation.
- Spain is currently implementing drastic cuts in public services that are likely to exacerbate shortages in health personnel.

62 Calculation based on the 'Catálogo de ocupaciones de difícil cobertura 3º trimestre de 2010', INEM.

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## 06 ARE MEMBER STATE DOMESTIC HEALTH POLICIES ADDRESSING THE HRH CRISIS IN THE DEVELOPING WORLD?

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### UNITED KINGDOM

The British National Health Service (NHS) was established in 1948. A recent study found that the UK is the only country in the industrialised world where wealth does not determine access to health care<sup>63</sup>. Nonetheless, in 2007 the UK had the lowest per capita spending on health as a percentage of GDP, at just 8.4 %<sup>64</sup>. The NHS is funded by taxation. Compared with its peers, the UK also has far fewer doctors and nurses. The ratio of doctors to population is just 21 per 10,000<sup>65</sup>. There are currently over 200,000 registered doctors working in the UK according to the British Medical Association<sup>66</sup>.

#### Overseas recruitment

Historically, the UK has always sourced nurses and health professionals from developing countries. As early as 1950s, two years after the NHS was established, nurses were recruited from the Commonwealth<sup>67</sup>. In the year 2000, the UK embarked on intensive international recruitment of health professionals following a directive from Department of Health to address personnel shortages. This staffing 'stock up' saw an active recruitment of health workers from the Philippines, India, South Africa and other Commonwealth countries. The recruitment of health workers was closely linked to English-speaking countries, those with historical ties to the UK, or where the UK has played a major role in development, supporting health systems of those countries through various initiatives including training doctors and nurses, construction and maintenance of health infrastructure and health policies.

In 2007, a Government commissioned report estimated that "at end of 2005 around 30 % of UK doctors and 10 % of its nurses had received their initial training overseas"<sup>68</sup>. The most recent UK NGO Migration Watch assessment of foreign health workers (2009) claims that there are currently 645,000 foreign nurses registered in the UK, of which 300,000 are working in the NHS, while 200,000 are working in private sector and the 145,000 are not practicing<sup>69</sup>. It is not possible to identify all the countries where nurses originate, however the main source countries are India, the Philippines, Australia, South Africa, Nigeria, the West Indies and Member States of the European Union.

### UK Code of Practice

In 1999 the UK introduced its first guidelines on the international recruitment of health care workers in recognition that the health systems in South Africa and the West Indies were being negatively affected. A Code of Practice for international recruitment for National Health Service (NHS) employers was introduced in 2001 and strengthened in 2004, and now covers all private recruitment agencies but not private sector employers<sup>70</sup>. The purposes of the code of recruitment were to prevent the NHS employers from active recruitment of international health personnel; however the code allows international recruitment of health workforce through government to government agreement.

The Code has been controversial, with some studies showing no impact on the arrival of nurses from Africa since its introduction, and others showing that Caribbean nurses simply move to the US instead. An estimated 7,000 foreign nurses registered to work in Britain in 2005 alone. The Code also does not prevent private agencies recruiting personnel into private care homes, from which they can enter the NHS at a later date<sup>71</sup>.

There is considerable overlap between the UK Code of Practice and the new WHO Code of Practice, with additional requirements on data collection, research and information exchange. The UK Department of Health already has in place a monitoring system to ensure that all recruitment agencies adhere to the Code, which may form a basis for other member states to emulate. In the UK responsibility for reporting on the WHO Code is shared between the Department of Health and DFID.

63 The Commonwealth Fund, 2010.

64 World Health Statistics, WHO, 2010.

65 World Health Statistics, WHO, 2010.

66 As per BMA website: [http://www.bma.org.uk/patients\\_public/checkingdocreg.jsp](http://www.bma.org.uk/patients_public/checkingdocreg.jsp)

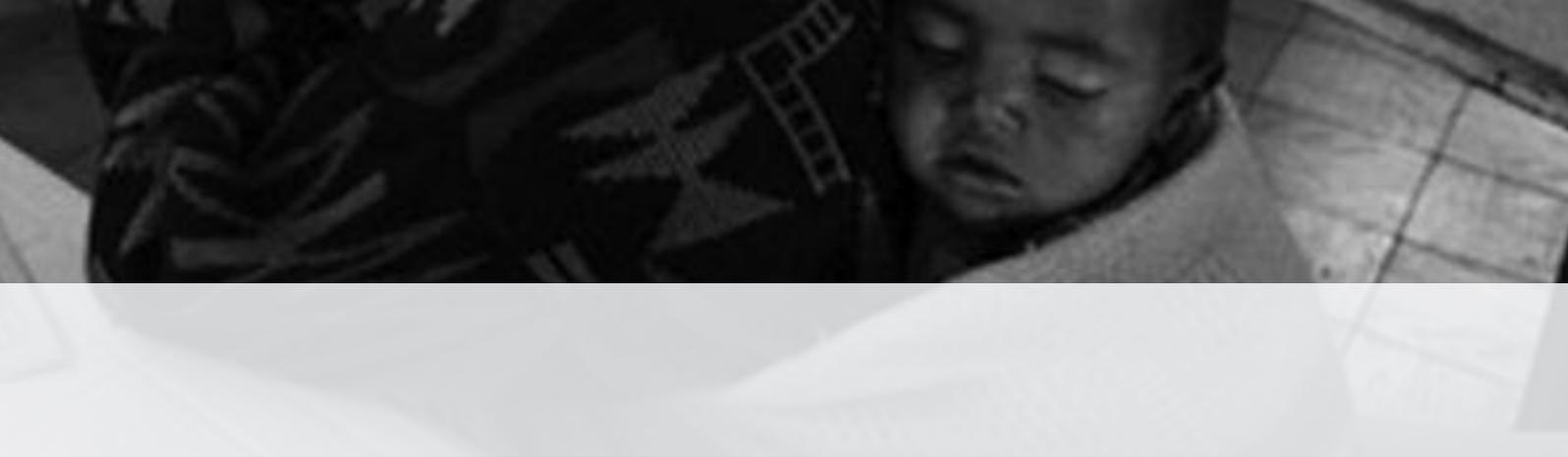
67 Buchanan J et al. (2006), Royal College of Nursing report to the Commonwealth on nurse migration.

68 Crisp, N. 2007, Global Health Partnerships: The UK Contribution to Health in Developing Countries. Available at: [http://www.suht.soton.ac.uk/sohmed/Crisp\\_report.pdf](http://www.suht.soton.ac.uk/sohmed/Crisp_report.pdf)

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## Conclusion

The UK has traditionally depended on overseas recruitment to staff its national health service. However it was only in the late 1990s that the impact of this on fragile health systems in developing countries was recognised. Efforts to ensure that such recruitment is ethical and in harmony with development policy have been only partially successful given the expansion in the number of private recruitment agencies that enable migrants to enter the NHS 'via the back door'. This highlights the limitations of Codes of Practice.

## Strengths

- The existence of the UK Code of Practice and a decade of experience in its implementation gives the UK a head start in terms of delivering on the WHO Code of Practice.
- The Government has pledged to preserve the NHS budget even as other public services are subject to major cuts.

## Weaknesses

- Due in part to colonial ties and NHS history, the UK is unlikely to change its status as a popular destination for migrant health workers.
- Until there is better regulation of private recruitment agencies, they will continue to stimulate migration in the developing world and exploit health care workers.

# 07

## 07 CONCLUSION AND RECOMMENDATIONS

It has been clear for many years that there are insufficient numbers of health workers in the world to meet the needs of the population, and not even to meet the minimum standards enshrined in the health MDG targets. As the cases of El Salvador and Madagascar show, for too long governments and the international community have overlooked the basic fact that health systems cannot function without health workers. European Member States have been able to assume that their own shortages will be met by means of immigration, without considering the impact down the care chain.

In this bizarre system, fully trained doctors find it preferable to relocate across continents at their own expense to take up positions that they are overqualified for. Strategies are made to provide dispensaries in every village, with no plans for who will prescribe. Incentive schemes are drawn up to encourage women to move to rural areas, where there are no jobs for their partners, and no schools for their children<sup>72</sup>.

The pace and scope of global health migration is increasing year on year. On the one hand, EU Member States are ostensibly boosting the health workforce in developing countries. On the other hand, they are taking the very same workforce away. The net result is that the beneficiaries of this manifestation of globalisation are almost exclusively rich nations, with poor countries, and naturally, the poorest of the poor, bearing the costs.

In a globalised world it is impossible to separate national or EU-wide actions from global policy, as global health issues have an impact on internal EU health policy and vice versa. The time has come for the EU and its Member States to ensure coherence between their internal and external health policies in attaining global health goals including the MDGs, the European Consensus on Development Cooperation and the 2005 Paris Declaration on Aid Effectiveness – particularly as they prepare for the High Level Forum in Seoul.

The five countries profiled in this report share a number of challenges and barriers to efficiently support the strengthening of the global health workforce in order to meet the health MDGs. In order to honour their pledges both in terms of quality and quantity of aid, donor countries should pay particular attention to the following areas:

### Development Cooperation Policy

#### As donors, EU Member States should:

- 1 Ensure that **50 %** of all new funding for health is directed towards health system strengthening, with **25 %** impacting directly on the retention and training of HRH, in line with WHO recommendations. Financing must be predictable, long-term and sustainable to allow for forward planning by Ministries of Health.
- 2 In line with the Kampala Declaration and Agenda for Action, support the development and implementation of comprehensive, evidence- and needs-based, fully costed and funded **national health plans and related health workforce strategies**. Additionally, they should pay particular attention to populations, groups or contexts where access to qualified health workers is challenging, including to women and adolescents, vulnerable and marginalized groups, discriminated populations, in rural or remote areas, and in fragile states.
- 3 Commit financially and politically to the global target for the training, deployment and management of at least **3.5 million new health workers by 2015** in countries with an acute shortage. Where appropriate, they should include the deployment of well trained, well paid and equipped community-based health workers alongside professional doctors, nurses and midwives.
- 4 Ensure **transparency and accountability** by publishing accurate and detailed figures on development cooperation policies targeting HRH and especially on spending dedicated to HRH within health ODA.
- 5 Promote the integration of a gender approach into health workforce policies and measures to increase recruitment and retention of female health care workers by addressing gender segregation, gender based violence and other discriminatory factors within the health system.
- 6 In line with the principles of complementarity and coordination as stated in the Paris Declaration on Aid Effectiveness, incentivise international NGOs and multilateral initiatives to reduce pull factors in health migration by requesting adherence to **voluntary codes of conduct**, such as the NGO Code of Conduct for Health Systems Strengthening.

<sup>72</sup> Examples taken from Madagascar, Tanzania and Spain.



## Domestic Health Policy

### At home, European Member States should:

- 1 Develop clear time bound national action plans with measurable goals and SMART and gender-sensitive indicators guiding the full implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel and the EU Programme for Action on the Critical Shortage of Health Workers at the national level, clarifying the respective roles of the various Ministries responsible and ensuring inter-agency coordination.
- 2 Develop coherent, sustainable and gender-sensitive national health workforce policies to enable self-sufficiency and remove the need for international recruitment. This includes:
  - a) Training **sufficient numbers** of health workers according to meet the health needs of the population.
  - b) Ensuring a **well balanced distribution** of the health workforce nationally. In the case of countries that have decentralised health systems such as Italy, Spain and the UK, improve and **strengthen coordination and collaboration between regions** by means of a common database and a monitoring and evaluation framework.
  - c) Increasing efforts to **retain existing health workers** through the improvement of working conditions and career opportunities.
- 3 Where they are lacking, institute as a matter of priority **national health workforce information systems** that allow the monitoring of migration trends and evidence based policy making.
- 4 Act to regulate the international recruitment of health workers by private agencies, not currently covered by the WHO Code of Practice.
- 5 Maintain levels of investment in the national health systems and adequate salaries for public sector workers, even in the face of budget deficits.

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### List of Acronyms

AfGH	Action for Global Health European NGO Network
AIDS	Acquired Immune Deficiency Syndrome
EU	European Union
GDP	Gross Domestic Product
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IHP+	International Health Partnership and Related Initiatives
IMF	International Monetary Fund
ILO	International Labour Organisation
MDG(s)	Millennium Development Goal(s)
NGO	Non-governmental organisation
ODA	Overseas Development Assistance
OECD	Organisation of Economic Cooperation and Development
UNAIDS	The Joint UN Programme on HIV/AIDS
UNDP	United National Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organisation





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