Limited resources, weak education, and weak management systems lead to a shortage of health workers.

Health workers and the MDGs: inextricably linked

Mubashar Sheikh, Executive Director of the Global Health Workforce Alliance, details the steps governments can take to improve the critical lack of health workers.

The shortage of health workers is a widely recognised fundamental constraint to achieving the health-related Millennium Development Goals (MDGs). Among the countries suffering from severe shortages of health workers, nearly one-third are members of the Commonwealth, and few are making progress with the international health targets. The situation can be reversed. Solutions require multi-sectoral and inter-sectoral collective action with the committed engagement of diverse stakeholders underpinned by unshakeable government support. The Agenda for Global Action (2008) provides governments with an overarching framework for health workforce initiatives and development efforts. Its six interconnected strategies focus on investment, policy, planning, organisation, education, management, information, and partnerships (see box overleaf).

Access to basic health services is a human right and human resources for health (HRH) are central to achieving the health-related MDGs. Yet the critical shortage of health workers works powerfully against improving the success rate. This message was conveyed firmly at the UN MDG Summit in September 2010.

Fifty-seven countries suffer from severe shortages of health workers (defined as fewer than 2.3 physicians, nurses, and midwives per 1,000 population), 16 of which are Commonwealth countries (Bangladesh, Cameroon, Gambia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Pakistan, Papua New Guinea, Rwanda, Sierra Leone, Tanzania, Uganda, and Zambia) according to the 2006 World Health Report.

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Few are on track to meet the health-related MDGs. The global shortage of health workers is estimated to be 4.3 million, with severe regional disparities in the availability of health workers. Africa, for example, bears 25 per cent of the world’s disease burden, yet has only 3 per cent of the world’s health workers, and only 1 per cent of the world’s financial resources to...
meet that challenge. In South-east Asia, health worker gaps are even greater in absolute numbers as a result of the large populations of India, Pakistan, Bangladesh, and Indonesia (Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals, Global Health Workforce Alliance, WHO, 2010).

The global health workforce crisis is not only characterised by the shortage of health workers; it is also a result of unequal distribution within countries, and poor motivation, performance, and quality of services provided by health workers. The main causes of these problems are structural: limited resources, weak education, and weak management systems. The widespread international migration of health workers further compounds the existing shortages. Over the past decade, the health sector has scored very well in mobilising funds internationally, but it has scored the worst in meeting the MDGs. Countries with weak health systems have been unable to deliver on achieving the health MDGs.

**Scaling up capacity**

Governments must invest in increased education capacity to effectively train and deploy between 2.6 and 3.5 million additional health workers to address the acute shortage by 2015; develop, fund, and implement costed, comprehensive, and evidence-based national health workforce plans; commit 25 per cent of additional investment on health MDGs towards HRH; and provide bold leadership to multi-sectoral and inter-sectoral collaboration at national and global levels.

The complex nature of these challenges and their international dimension – particularly related to cross-border disease transmission – make clear that the solutions require multi-sectoral collective action with the committed engagement of diverse stakeholders. Ministries of health tend to be the primary employers of health workers; but ministries of education should take the lead on health worker education and training. Ministries of labour and ministries of public services should be involved in developing financial and non-financial incentives for health workers in remote and hardship areas. Ministries of foreign affairs and ministries of international trade should broker agreements with other countries to address the international migration of health workers, and ministries of finance should ensure that requisite financial resources are allocated. Associations of health professionals and the private sector are essential partner stakeholders as well as all other relevant state and non-state actors.

**Governments need to work across sectors**

The Kampala Declaration and Agenda for Global Action (AGA) (adopted March 2008 in Kampala, Uganda) provides governments with an overarching framework for health workforce initiatives and development efforts. The AGA envisages forging global, regional, national, and local partnerships to implement six interconnected strategies to address the health workforce crisis:

1. Building coherent national and global leadership for health workforce solutions.
2. Ensuring capacity for an informed response based on evidence and joint learning.
3. Scaling up health worker education and training.
4. Retaining an effective, responsive and equitably distributed health workforce.
5. Managing the pressures of the international health workforce market and its impact on migration.
6. Securing additional and more productive investment in the health workforce.

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accelerated implementation. For example, using this approach, Cameroon has been successful in establishing an HRH co-ordination mechanism, in mobilising additional resources for health workforce development (from both domestic sources and external development partners), leading to the scale-up of training of midwifery personnel.

Health sectors are labour intensive. Increasingly governments are recognising that health is an investment for economic development and that an increase in domestic spending on health will result in increased productivity. The Government of Malawi (GoM) has recognised the value of health investment for economic development, as well as the benefits this can yield for national productivity. In 2004 Malawi’s health system was in a state of collapse. The GoM responded by developing and putting into action the Emergency Human Resource Programme. Its strategies included long-term and stop-gap measures to increase the numbers of health workers, including a 50 per cent increase in salaries, improved working conditions such as housing, re-enrolment of retired health workers, and increased investment in training institutes. The results were stunning: health facilities re-opened, obstetric emergency care increased, prevention of mother-to-child transmission coverage expanded, health worker migration virtually stopped, malaria control was strengthened, and there was a several-fold increase in the number of people put on anti-retrovirals (ARVs). An estimated 13,000 lives were saved. The job is not finished yet, but the GoM’s commitment remains strong, and the country is now on track to achieve MDG 4.

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With the 2010 adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel, governments acknowledged the global dimension and complexities of the HRH crisis and the interconnected nature of both the problems and the solutions. Supporting the WHO Code’s Guiding Principles and accelerating progress towards solutions to health worker migration, Ghana was recently awarded the Health Worker Migration Policy Council Innovation Award for their innovative approaches to addressing the health worker migration challenges.

Health worker shortages should be addressed by scaling up education and training capacity in order to meet the growing demand for health personnel. Strong national capacity is required in all countries to regularly collect, analyse and use data on health workforce availability, distribution, employment status, and migration, to inform policy-making and management. Beyond the density of physicians, nurses, and midwives, new benchmarks are required to set appropriate targets towards which policymakers can strive. Knowledge sharing, the creation of health information systems, and information system innovations have gained an increased level of importance. Intellectual support between countries such as Norway and Malawi, for example, is likely to be more important in the coming years than financial support.

Leadership by all state and non-state actors is required to strengthen commitment and focus action on the health workforce. Policy coherence across sectors is essential, as is the capability to plan and manage health workforce development. National health workforce co-ordination mechanisms should be established, or existing ones strengthened to foster synergies among stakeholders and include communities of purpose where best practices are shared. HRH development strategies and budgets

An overriding constraint

Health worker shortage is an overriding constraint to achieving health MDGs. Three of the eight Millennium Development Goals are specifically related to health:

- MDG 4: By 2015 reduce by two-thirds the mortality rate among children under 5;
- MDG 5: By 2015 reduce by three-quarters the maternal mortality ratio and achieve universal access to reproductive health;
- MDG 6: By 2015 halt and begin to reverse the spread of HIV/AIDS; achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it; halt and begin to reverse the incidence of malaria and other major diseases.

There is an undeniable correlation between countries facing the greatest burden of maternal and child deaths and those with health workforce shortages. Understanding the MDGs as the ‘What’ and the health workforce as the ‘How’, the message is clear: no health workforce, no health MDGs.
should be linked with national healthcare strategies, policies, and plans. At the local level, suitable policies and strategies should be adopted to attract and retain health workers with an appropriate skills mix in rural and other under-served areas, including the deployment of community-based and mid-level health providers. Innovative approaches may include tailoring education curricula and practices to work in rural areas, financial and non-financial incentives, regulation, management support, and improved career development opportunities. Indeed, innovations have demonstrated that much can be achieved beyond just increasing salaries.

The quality of care rendered by service providers should improve through the accreditation of health workers and training institutions, as well as through compliance with relevant national standards and regulatory systems. Performance should be enhanced through effective supervision, competency-based curricula, enabling practice environments and supportive management practices.

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An adequate level of financial investment for health workforce development should be attained through both domestic and international resources. Where the allocation of domestic resources is not sufficient, governments should increase it, if necessary by relaxing macroeconomic restrictions, with the help of international financial institutions.

**Smart policies and strategies**

Today we have the knowledge of what can actually work in getting health workers in place to make the fundamental transformational difference in the delivery of health services. Making these transformations leads to improved population health and creates more stable social and economic domestic conditions. Strategic intelligence on deployment, incremental differences in productivity per year, better use of evidence and business approaches, joint efforts to secure financing, close attention to systems, and spreading best practices will all secure these transformations. It is time to take action, to be accountable for needless lives lost, and to realise that success is imminent. More financial resources are needed, but equally critical are the better use of those financial resources, smart policies and strategies, better monitoring, stronger collaboration, and the highest level of political will.

“The message is clear: no health workforce, no health MDGs.”

The health-related MDGs are not mere numerical targets. They embody hopes for a global end to extreme disease. To achieve them requires a significant increase in health workers and unshakable government commitment to health systems. The Global Health Workforce Alliance envisions that all people, everywhere, shall have access to a skilled, motivated, and supported health worker.

**Contact Details**

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The Global Health Workforce Alliance is a common platform for action to address the crisis of the chronic shortage of health workers. 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.

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