

Global key messages

- There has been significant progress in tackling HRH challenges, but important gaps persist; a few countries are falling behind, and many countries will find it daunting to attain or sustain universal health coverage if the current trends continue.
- WHO identified in 2006 a minimum density threshold of 22.8 skilled health professionals/10,000 people to provide the most basic health coverage. new progress report *A Universal Truth: No Health Without a Workforce*, (2013) which examines evidence on the health workforce implications of universal health coverage shows that 83 countries still fall below this threshold. 100 countries fall below a density threshold of 34.5 skilled health professionals per 10,000 people, identified in the context of the universal health coverage discourse.
- The relative shortages of doctors, nurses and midwives are still most acute in sub-Saharan Africa. This is currently one of the major obstacles to achieving the MDGs and other international health goals including universal health coverage. Most countries with a density of skilled health professionals below 22.8/10,000 population and a coverage of births by skilled birth attendants (SBA) below 80% are in Africa (31 countries, 57.4%) and in South-East Asia (7 countries, 12.9%).
- Even though countries are reporting increases in health personnel in a few cases these gains do not correspond with population growth. Therefore, as part of the process of expanding coverage to a larger proportion, it is imperative that HRH planning takes in account demographic aspects.
- The current discourse on HRH needs to evolve from an exclusive focus on availability of health workers – i.e. *numbers* – towards according equal importance to accessibility, acceptability, quality and performance. *By availability*, we mean an adequate supply of health workers, with the required competencies to match the health needs of the population. *Accessibility* is also critical as it implies equitable distribution across urban and rural areas ensuring access to under-served populations. *Acceptability* refers to the health workforce characteristics (e.g. sex, language, culture, age, etc) and their ability to treat all patients with dignity and promote a demand for services. *Quality* refers to the skills, knowledge and behaviour of health personnel, assessed according to professional norms and as perceived by users of health services.
- (Without sufficient availability – accessibility to health workers cannot be guaranteed; if they are available and accessible, without acceptability, the health services might not be used, when the quality of the health workforce is inadequate, improvements in health outcomes will not be satisfactory.)

- Wide variations in availability and accessibility persist within countries. Serious efforts are needed to tackle health worker retention and to better balance the distribution of health workers geographically.
- Migration of health personnel continues to be a problem. Oman, the Emirates and Saudi Arabia have over 80% dependence on foreign trained health personnel. Renewed efforts are required to invigorate the implementation of the Global Code of Practice on the international recruitment of health personnel and fulfill its aspirational objectives. All WHO member states were requested to designate a national authority for tracking the Code implementation. As of 2013 a national authority was designated by only 85 countries; of these, 56 countries reported on the status of the Code implementation. The WHO-EURO region reported most progress in the Code implementation in 2013 with several countries proactively promoting the Code. (Belgium, Switzerland, Ireland, Finland, Norway, Thailand and Philippines). In Africa, there are only two countries taking steps to implement the Code (Cameroon and Rwanda).

FORECAST:

- A global deficit of 12.9 million health workers is estimated by 2035 against the threshold of 34.5 skilled health professionals per 10 000 people. To come to this figure, a new study estimated the number of additional skilled health professionals (midwives, nurses and physicians) required to reach, in all countries, a minimum density threshold of 34.5 per 10 000 population, - now (based on the latest available workforce data) and in 2035 (based on a population projection of 8.6 billion and no positive or negative growth in the stock of health professionals).
- While this estimate was produced for illustrative purposes and should not be seen as a planning target. What is needed is a move towards identification of needs and opportunities, so that countries can rather set their own benchmarks, assess progress, and revise them as required and as they broaden the scope of health services they intend to provide to the population.
- We need to rethink the traditional models of education, deployment and remuneration of the health workforce, long-term system-building, comprehensive labour market engagement and essential data and intelligence systems.
- In 2035, regions where the deficit would be the highest are South East Asia followed by Africa.

SOLUTIONS:

- Reasons why health workforce problems persist are diverse, but a key factor is that often only fragmented initiatives or simplistic solutions have been tried whereas HRH development continuously changes and evolves under the pressure of a variety of factors. Integrated and coordinated approaches are required that pay attention to every step in the “supply chain” of health workers and that recognize the role of different sectors and constituencies within the government.

- Increased political and technical leadership is needed at country, regional and global level. High-level political commitment is critical - which ensures the alignment and coordination of and across different sectors and constituencies in support of countries long-term human resource development efforts.
- Health begins with health workers. The empowerment of health workers is key. The voice, rights and responsibilities of health workers must play a central role in developing and implementing solid policies and strategies towards universal health coverage. Governments, trade unions, professional associations and civil society have a joint responsibility in improving and securing the working conditions of their health workers while empowering them in the decision making process.
- Health workforce production must be made a top priority. This necessitates political commitment, long-term strategic planning & forecasting and adequate financing to make a whole-of-government agenda on universal health coverage a reality. National stakeholders and development partners from education, finance and labour and other sectors have critical roles to play in in order to produce adequate quantities of the right mix of quality health professionals
- Implementing an HRH agenda conducive to the attainment of UHC requires more and efficient use of resources. Domestic spending on HRH is lower than is typically assumed and in many countries larger investments are necessary. In settings where external support is still required, more strategic targeting of development assistance for HRH development will maximize its impact.
- The role of mid-level and community health workers should be maximized in order to make frontline health services more accessible and acceptable in support of UHC. Strengthening of community health workers and other cadres of workers offering frontline health services should be integrated across programs and initiatives that are embedded in national strategies and plans, ensuring synergy and harmony among stakeholders' action, for effective delivery of health services.
- Countries must invest in the collection of reliable data and prioritize the strengthening of national HRH databases. Improving health workforce data availability, completeness and quality– is a critical factor for quality planning and forecasting.
- Labour markets alone do not ensure equitable access to quality health care services. Regulation of the health workforce remains a government responsibility. Effective governance and regulation is of prime importance, which can ensure the quality, and accessibility to health services, including the health workforce.

FAST FACTS - CURRENT DEFICIT

- Using two thresholds¹, out of 186 countries with available data²:

¹ 22.8 skilled health workers per 10,000 population - World Health Report 2006

34.5 skilled health workers per 10,000 population – International Labor Organization

It is important to emphasize that, just like for the WHR 2006, these thresholds should not be seen as planning targets but, rather, as tools to illustrate the magnitude of the challenges that lie ahead.

² Source: WHO Global Observatory workforce data (July 2013).

- 83 countries (**46.6%**) are below the threshold of 22.8 skilled health workers per 10,000 population;
- 17 countries (9.1%) are above 22.8 / 10,000 population threshold, but below threshold of 34.5 skilled health workers per 10,000 population;
- 18 countries (9.8%) meet the 34.5 / 10,000 population;

Summary: 83 countries (46.6%) are below the 22.8 / 10 000 population threshold and 100 countries (55.7%) below the 34.5 / 10 000 population threshold.

- The 22.8 threshold was identified in relation to the objective of delivering essential health services of relevance to the MDGs. The 34.5 threshold has emerged in the discourse on universal health access. The 34.5 threshold is not meant to be planning target, but rather is used to illustrate the variance in HRH availability, and the magnitude of challenges that lie ahead.
 - In the 100 countries³ (presently below the 34.5/10000 threshold), there is **currently** a total shortage of about 7.2 million health workers. The South-East Asia Region⁴ and the African Region are the most affected areas accounting for 47% and 25% of the total deficit, respectively.
 - Compared to South-East Asia, Africa has more countries affected by the crisis. However, the countries with severe shortages in South-East Asia are some of the most populous countries which explains the higher deficit.
 - The deficit is smaller in the in the Region of the Americas (4%), and the European Region, at 0.07 million (1%).

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³ with available data

⁴ According to WHO regional classification