

Health Workforce Advocacy Initiative response to the G8 2008 Hokkaido Summit's health workforce commitments

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The Health Workforce Advocacy Initiative (HWAI), a civil society-led network affiliated with the Global Health Workforce Alliance, urges the G8 countries to build on the health workforce commitments they made at the 2008 Hokkaido Toyako G8 Summit to turn imprecise and under-resourced promises into solid commitments backed by sufficient funding and a clear strategy. HWAI is especially concerned by G8 members' severely inadequate financial commitments to health and the health workforce.

Main 2008 G8 health workforce commitments: how do they measure up?

“The G8 members will 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.”

A meaningful effort to work towards this threshold commits the G8 to a significant increase in health worker numbers across many countries. The majority of African countries are currently well below this minimum threshold; many are not even at one third of this level. While the time it takes to reach this threshold will vary considerably among countries, it is critically important that countries achieve, and as required surpass, this level. Individual countries may require more health workers than this threshold; all G8 countries have ratios that are more than four times greater,¹ and many even find that they lack sufficient numbers of health workers to meet their own needs. Merely “work[ing] towards” this threshold, as stated by the G8, is not enough.

Skills mix

Support will be needed for health workers of all types, including professionals, paraprofessionals, and community health workers, along with management and other non-clinical staff. The actual WHO threshold is 2.3 doctors, nurses, and midwives per 1,000 population; this ratio does not include all health workers, as the G8 communiqué implied. The comparable ratio for all health workers is at least 4.1 per 1,000 population, though again, more may well be needed.² In the Toyako Framework for Action on Global Health (the report of G8 health experts), the G8 members correctly recognize the need to take into account skills mix,

¹ This is based on data in the WHO Global Atlas of the Health Workforce, available at: <http://www.who.int/globalatlas/default.asp>.

² World Health Organization, *World Health Report 2006* (2006), at 11-13. Available at: <http://www.who.int/whr/2006/en/index.html>.

regional disparities, and individual country needs. There is no single blueprint for the mix of health workers required for every country.

Limited country focus

HWAI is concerned by G8 indications that they will only focus, at least initially, on a limited set of countries. It is vital that G8 efforts to increase the number of health workers in countries suffering critical shortages reach all such countries.³ The health goals that will require more health workers – such as the Millennium Development Goals and universal access to HIV treatment, prevention, care, and support by 2010 – and the right to the highest attainable standard of health extend beyond any initial set of countries. Support from wealthy countries must be inclusive, not selective.

An analysis of those countries in Africa in which G8 countries are engaged in health workforce strengthening (as laid out in the annex to the Toyako Framework for Action on Global Health), suggests that up to 10 of the 36 countries in WHO's African Region that are below the WHO threshold (along with, in Africa, Somalia)⁴ will not be among those initially receiving G8 support. The actual number is likely to be lower, since several G8 countries did not specify where they are providing health workforce support, including Japan, which is supporting an unspecified 26 countries in Africa. Also, G8 countries may be engaged in some health workforce support that the annex does not capture. In any case, no country should be left without adequate support.

Adequate levels of support?

In many cases, only one G8 country is named in the annex as being engaged in health workforce strengthening in a given country. Will only the G8 members presently engaged in a particular country contribute to expanding the health workforce there, or will other G8 countries also contribute? While the former approach creates a clear division of responsibility and framework for G8 accountability, it also creates a risk. If each G8 member views its commitments as being limited to a certain set of African countries, and one G8 country fails to provide adequate support, other G8 countries might not step up to fill the gap. This is a real danger in the present context of inadequate levels of foreign assistance and inadequate financial commitments at the Hokkaido Summit, as well as the commitment only to “work towards” rather than to “achieve” the WHO threshold.

“We will also support efforts by partner countries and relevant stakeholders, such as Global Health Workforce Alliance, in developing robust health workforce plans and establishing

³ The exception would be for developing countries that are receiving sufficient levels of support from wealthy nations not part of the G8.

⁴ Somalia is in WHO's Eastern Mediterranean (EMRO) Region, and so not included among the 36 sub-Saharan African countries facing critical shortages.

specific, country-led milestones as well as for enhanced monitoring and evaluation, especially for formulating effective health policies.”

Robust health workforce plans are central to countries’ response to the health workforce crisis; the G8 recognition of this is most welcome. Plans will be robust if they are comprehensive, costed, needs-based, and grounded in human rights principles. Plans should be designed to achieve the MDGs and other health goals and obligations, and to enable everyone to access skilled and motivated health workers within a functioning health system. In recognizing the importance of these plans, the G8 also recognizes the need for an approach to health workforce strengthening that includes far greater numbers, but also addresses other issues, such as equitable distribution, skills mix, securing the well-being of health workers themselves, and improving planning (and management) capacity, as referenced in the Toyako Framework for Action on Global Health. The G8 is also well-advised in recognizing the importance of specific milestones and improved monitoring and evaluation.

Important as it is for the G8 to support countries and other stakeholders in developing these plans, it is not enough. The G8 must also support countries in fully implementing these plans, which will require tens of billions of dollars of new investments. And as with reaching WHO minimum thresholds, the G8’s support must extend to all developing countries, except where support from other partners is adequate.

“[W]e encourage the World Health Organization (WHO) work on a voluntary code of practice regarding ethical recruitment of health workers.”

WHO is working on developing a code of practice on international health worker recruitment, which is expected to be on the agenda at the May 2009 World Health Assembly. It will be critical for G8 countries to support a code that covers both the public and private sectors, and that both respects health workers’ right to emigrate and countries’ obligations not only to fulfill the right to the highest attainable standard of health at home, but also to respect and help fulfill this right abroad.

HWAI is concerned about the G8 emphasis on this being a “voluntary” code. This suggests a potential reluctance to adhere to such a code and to take measures to enforce ethical recruitment practices. As it is, codes of practice in the UN system are not legally binding;⁵ the code that WHO is working on would therefore not be legally binding, even as the human rights principles that would inform the code are. The main concern of the G8 (and other countries) should not be whether or not they will be required to follow the code, but rather on how best to develop an effective code and carry out the measures required to implement it.

⁵ World Health Organization, 55th World Health Assembly (May 22, 2004), Res. WHA 57.19, International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries. Available at: http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf.

Indeed, G8 countries should take measures now that will enable them to develop self-sustainable health workforces to meet their own health workforce needs in an ethical manner, including by expanding their domestically trained workforce and not actively recruiting health workers from developing countries facing shortages, except in the context of an agreement that protects the right to health.

What is missing

The money, the money, the money: The G8 countries failed to commit to any specified level of resources for health workforce strengthening. While exact needs will be determined by the robust health workforce plans that the G8 has committed to help develop, estimates derived from WHO and the GHWA Education Task Force figures make clear that the cumulative financing need from the G8 members, for Africa alone, will be tens of billions of dollars by 2015. In their communiqué, the G8 countries committed “to work towards the goals of providing at least a projected US\$60 billion over 5 years, to fight infectious diseases and strengthen health.” Yet investments in AIDS, tuberculosis, and malaria, and the health workforce, will require far more than \$60 billion over just the next three years,⁶ raising grave concerns as to whether G8 countries will make investments consistent with their commitments. They must do so.

The G8 took note of the Agenda for Global Action adopted in March 2008 at the First Global Forum on Human Resources for Health. The Agenda recognized that overcoming the health workforce crisis will require donors to provide funding to “contribute significantly and adequately to alleviate financial shortfalls that prevent countries from fully implementing their health workforce plans.” If this acknowledgment is to be meaningful, the G8 countries should follow the roadmap presented by the Agenda for Global Action, including by providing adequate resources. If the G8 does not provide the resources needed to enable countries to fully implement their health workforce plans, the plans that the G8 has committed to help develop will be of limited value, and the health workforce crisis will persist far into the future.

Clear benchmarks and commitments to overcoming the overall health workforce shortage in Africa: In the lead-up to the G8, HWAI called for G8 leaders to commit to a doubling of the number of health workers in sub-Saharan Africa by 2015, based on WHO estimates that this is required for countries in that region to meet basic health needs. The G8 failed to make this commitment. This remains an important goal, and a way to benchmark progress in scaling up the health workforce through national plans. HWAI also continues to believe in the value of a nearer-term benchmark for expanding the health workforce in sub-Saharan Africa to measure and drive progress, such as the expansion of the region’s health workforce by 600,000 new health workers by 2012.

⁶ An estimate that uses figures from and calculations derived from UNAIDS, WHO, the GHWA Education Task Force, and the World Bank places the 2008-2010 global resource needs for AIDS, TB, and malaria, along with health workforce strengthening in African countries suffering critical shortages, at \$89 billion. See Africa Japan Forum, Health GAP, et al. press release, *Reaction by HIV/AIDS and Health Groups to G8 Development and Africa Communiqué: G8 RETREATS ON SAVING LIVES*, July 8, 2008.

The rest of the world: The G8's commitments on health workforce, most clearly with respect to the WHO threshold, are particularly focused on Africa. This is appropriate insofar as the crisis is the most severe in Africa. However, many countries outside of Africa also have severe health workforce challenges that must be overcome if all people are to have access to skilled and motivated health workers; 21 of the 57 countries that WHO has identified as having critical shortages are outside WHO's African Region.⁷ G8 support must reach countries outside of Africa as well.

G8's next steps

If the countries facing severe health workforce shortages are to have a chance of achieving global commitments to the MDGs and to universal access to HIV treatment, prevention, care, and support by 2010, the G8 must greatly accelerate its efforts to support developing countries in creating health workforce plans so that all countries have such plans by the end of 2009.⁸ These plans must be costed, comprehensive, needs-based – designed to meet the MDGs and other health goals and obligations – and grounded in human rights principles.

As these plans are developed, G8 countries and other partners should commit to the long-term, predictable financing needed to cover the funding gaps to the plans' full implementation. This is vital, even as developing countries themselves increase their own health spending, including in Africa by meeting the Abuja Declaration commitment to spend at least 15% of their budgets on health. National governments, along with the G8 and other development partners, need to ensure that macroeconomic policies are consistent with, rather than acting as obstacles to, the spending requirements of these strategies. And even as the plans are being developed, the G8 should immediately and significantly scale-up their health workforce investments to meet already identified priorities.

The G8's commitments on health workforce in Hokkaido were a step forward, but did not go far enough. The absence of financial commitments was particularly glaring. The G8 and developing countries should use the High-Level Event on the Millennium Development Goals in New York in September, and the Follow-up International Conference on Financing for Development in Doha, Qatar, in November, to make firm commitments, accompanied by a strategy to meet them. These commitments and the strategy should ensure that all countries can develop needs-based health workforce plans and have them fully funded, through increased domestic resources and international assistance, and to ensure that macroeconomic policies are consistent with the needs of these plans. A skilled, motivated, equipped, and equitably distributed health workforce is too central to improving health and saving lives for any further delay.

⁷ World Health Organization, *World Health Report 2006* (2006), at 13. Available at: <http://www.who.int/whr/2006/en/index.html>.

⁸ The African Union itself has set a similarly ambitious timeline. Its May 2008 strategy on implementing the African Health Strategy 2007-2015 calls for all AU countries to have health workforce plans developed by 2010.

*To learn more about the Health Workforce Advocacy Initiative and ways to get involved,
please contact Eric Friedman (efriedman@phrusa.org).*

You can learn more about HWAI at:

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