

Overcoming donor and international barriers to increase the health workforce

Gorik Ooms

Institute of Tropical Medicine, Antwerp, Belgium

August 2008

Overview

Which barriers?

- Overarching 'sustainability' paradigm
- Consequences (barriers) in practice

How to overcome these barriers?

- Practical solutions
- Need to challenge the paradigm

The overarching 'sustainability' paradigm

Quote from a recent discussion about health sector salary reform in Mozambique:

“Sustainability is an important issue in the sense that in the longer run the national economy should be able to pay for the increased level of salaries.”

From the WHO National Health Accounts about Mozambique:

	2001	2002	2003	2004	2005
Per capita government expenditure on health at average exchange rate	US\$6	US\$7	US\$7	US\$8	US\$9
External resources for health as% of total expenditure on health	30.7%	37.9%	44.7%	50.2%	66.5%

Consequences (barriers) in practice

Donors are reluctant to make the long-term commitments needed by Ministries of Health (and Education) to:

- Increase training capacity (2-3 years)
- Train more health workers (3-7 years)
- Hire and retain more health workers (10-15 years)

Consequences (barriers) in practice

Ministries of Finance (and Governments) are reluctant to allow increased recurrent expenditure, because they fear long-term dependency on 'unreliable' donor funding, even when increased donor funding is available in the short run

Consequences (barriers) in practice

And even if Donors and Governments of developing countries (Ministries of Health, Education and Finance) would agree to launch an ambitious health workforce plan, the International Monetary Fund (IMF) might still disagree...

The IMF has different tools to limit recurrent health expenditure:

- Ceilings on the government wage bill
- Ceilings on the domestic primary deficit
- Medium-Term Expenditure Framework
- Programming the saving of foreign assistance 'windfalls' and the use of reserves to compensate 'shortfalls'

How to overcome these barriers? Practical solutions

Ideally, concerted action would take place between:

- The Ministry of Health, developing a long-term vision and plan
- The Government and the Ministry of Finance, supporting the plan (challenge: what about the salaries of other civil servants?)
- Several donors, making long-term commitments, preferably through health sector budget support (allowing the recruitment of civil servants)
- The IMF, allowing the increased expenditure

This is not wishful thinking, it is happening in Malawi...

How to overcome these barriers? Practical solutions

The International Health Partnership (IHP) could be the perfect tool to promote such concerted action: one health sector compact, supported by all stakeholders

However, the IHP remains very vague about the 'sustainability' paradigm and IMF policies

Quote from a briefing note about the IHP and Mozambique (written by DFID): "This plan needs to be integrated into the country macro-economic framework."

Will the macro-economic framework be adapted to accommodate the plan, or will the plan be adapted to the macro-economic framework?

How to overcome these barriers? Practical solutions

Far from ideal, but perhaps the only solution in some countries, might be to by-pass the 'system': recruitment outside of the health sector, but in addition to the health sector

A recent critique on PEPFAR by DFID: "They have to get so many people on treatment by the end of Year Two, Year Three, Year Four. How do they do it? They put an advert in the paper in Lusaka and they hire 400 health workers. Where do they take them from? They move them from one part of the health system, where they are delivering children and providing general health services looking after kids, to work just on AIDS."

But if the Ministry of Health of Zambia is not allowed to hire more health workers, this kind of practice at least creates 'space' for additional health workers...

Challenging the paradigm

What level of health expenditure is sustainable? It all depends on your perspective...

- If one looks at the national economies of poor countries, the average economic product per inhabitant can be as low as US\$ 500 per year, and sustainable health expenditure might be as low as US\$ 15 per person per year
- If one looks at the global economy, the average economic product per 'inhabitant' is US\$ 7,500, and sustainable health expenditure would be at least US\$ 225 per person per year

Challenging the paradigm

In itself, the challenge of overcoming the health workforce crisis is not different from the challenge of access to AIDS treatment: too expensive (= 'unsustainable') for national economies, long-term commitment required, needing to increase recurrent expenditure beyond macro-economic space

AIDS activism challenged and changed the paradigm: if poor countries cannot afford AIDS treatment, the global economy can

Can we expand 'AIDS exceptionalism' and make it the standard for health (and other essential social rights)?