

A proposal for measures under Norwegian foreign and international development policy to combat the global health workforce crisis

Report by the workgroup headed by the
Ministry of Foreign Affairs, with
representatives from the Ministry of Labour
and Social Inclusion, the Ministry of Health
and Social Affairs, the Ministry of Education
and Research, the Norwegian Directorate of
Health and Norad

Summary

The shortage of health workers is a serious obstacle to the ability of many countries to provide public health care and promote economic development, and the poorest countries are the hardest hit. There are considerable inequities at the global level between the need for qualified health personnel and the number of health workers available. Generally speaking the crisis is caused by several factors: too few health workers are being trained, many of those who are qualified take jobs outside the health sector, demographic trends are making new demands on health care and advances in medicine require increasingly specialised personnel (Chapters 1 and 2).

Another factor contributing to this situation is that the numbers of health workers are unevenly distributed and in many cases their skills are not being utilised appropriately. Market forces and international migration are creating a situation where countries with the least developed health services, the lowest pay and the poorest working conditions are facing a health workforce crisis, while those that can offer better conditions are making use of their competitive advantage to import foreign workers to meet their own needs. The crisis is reducing health security for the entire world community and increasing its vulnerability. International cooperation as well as efforts by individual countries are needed to address the crisis and ensure access to basic services for all. Without this it will not be possible to achieve the health-related Millennium Development Goals, to which all UN member states have committed themselves (Chapter 3).

Norway is also a party to the global health workforce crisis, and the Government wishes to promote a coherent and comprehensive health workforce policy at the national and international levels. In March 2008 two workgroups were therefore appointed to provide recommendations. The present report was compiled by the workgroup that addressed the issue of human resources for health (HRH) in Norway's foreign policy and development cooperation. After considering the relationship between national and international challenges in this area, the group considered a range of appropriate instruments for Norwegian foreign and development policy (Chapters 4 and 5).

In accordance with its terms of reference, the workgroup has given weight to measures that will increase HRH coverage and promote functioning health care services in low-income countries. The group has paid particular attention to measures for supporting education and research cooperation, support for the global consultation process to develop a Code of Practice for international recruitment of health workers and devising agreements and schemes for mitigating negative effects on sending countries when qualified health workers are recruited across national borders (Chapter 6).

The group found that in low-income countries with a critical shortage of health workers, a weak health care system with poor financial resources, equipment and low capacity for government stewardship are deciding factors. Migration is also a contributory factor, and is in many cases a prominent symptom of the crisis. Training of health workers has been given insufficient priority, both by the countries themselves and by their development partners. Health workers have been regarded as an expense instead of an investment.

The workgroup was headed by the Ministry of Foreign Affairs and contained representatives from the Ministry of Health and Social Affairs, the Ministry of Education, the Ministry of Labour and Inclusion, the Directorate of Health and Norad. The group confirmed the

importance of the measures already being implemented in Norwegian foreign and development policy, but it also pointed out that these measures may be placed in a wider context and intensified, supplemented and given a more strategic focus.

Finally, the workgroup proposed that the responsibility for follow-up, coordination and reporting should be assigned to the Ministry of Foreign Affairs in order to ensure that further efforts are based on a coherent strategy.

Recommendations

The workgroup stressed that although the health workforce crisis is a global phenomenon, its causes are complex and are made up of a number of different factors that interact in different ways in the various countries. This means that solutions must be tailored to the situation in the individual country, and must be based on an analysis of the market, the health system and disease status, educational capacity, the relationship between public and private services, and the organisation, financing and regulation of the health system and its stakeholders.

In its foreign and international development policy, Norway should seek to:

- **raise awareness of the fact** that qualified health personnel are vital to a country's health security and to its efforts to achieve the health-related Millennium Development Goals,
- **contribute to international framework conditions** for enabling every country to secure sufficient human resources for health (HRH) to provide basic health care services for all its inhabitants,
- **ensure institutional cooperation and partnership between countries** based on reciprocal commitments and agreements relating to education and training, exchanges and research, and encourage Norwegian institutions to take an active part in these efforts,
- **make use of its development assistance to strengthen the capacity of individual countries** to train, recruit, allocate, administer and retain the necessary health personnel.

The workgroup pointed out that Norwegian foreign and development policy would obtain better results in its HRH efforts by combining the various instruments and measures and applying them in a strategic and consistent way.

The recommendations are grouped into six priority areas, taking account of the need for influence on policy making, knowledge exchanges and financial transfers. The following is a summary of the group's recommendations for a focussed foreign and development policy and for the use of development assistance through global initiatives and bilateral and multilateral channels.

I. Political and strategic leadership and advocacy

The global health workforce crisis and global inequities in resource distribution and countries' ability to safeguard public health and health security are primarily a challenge to political and strategic leadership at the national and international levels. Given Norway's already prominent role in the efforts to achieve the health-related Millennium Development Goals, the country could make greater and more systematic efforts to ensure that solutions to the health workforce crisis are given high priority on the international agenda.

The workgroup proposes that Norway should support international leadership efforts to address HRH challenges, which must be based on **knowledge** of the facts, **coherence** between policies/policy instruments and **coordination** of measures across sectors and arenas.

- Effective political and strategic leadership will require better underlying data for assessing HRH status and a knowledge base with better documentation concerning which actions yield optimal results. These efforts need to be coordinated at the international level and should allow for accurate documentation of HRH status and evaluation of the results achieved.
- An outcome-oriented policy for addressing the health workforce crisis at national level while at the same time assisting the most vulnerable and hardest-hit countries to find solutions will require coherence between national trade, foreign and development policy instruments.
- Norway should pursue a more coherent policy in the international forums that address HRH issues, such as WHO, the WTO/GATS, the G8 and the Global Health Workforce Alliance (GHWa).

Norway can be particularly active as a leader in the following arenas:

1. The Foreign Policy and Global Health Initiative launched by seven foreign ministers in 2006 to put public health security on the foreign policy agenda. HRH is one of the 10 focus areas of the initiative.
2. Norwegian efforts to achieve the health-related Millennium Development Goals with an emphasis on maternal mortality. Adequate HRH is vital for results in this field.
3. International/Norwegian efforts to improve coordination and safeguard the interests of developing countries, with a particular focus on their health sectors, in the WTO/GATS negotiations.
4. Promoting greater knowledge of regional approaches/perspectives and better communication between regional organisations as part of Norway's negotiating position in WHO, the WTO, ILO, the EU/EEA and other multilateral forums in this field.

II. Improving the underlying data as a basis for policy-making and monitoring progress

There is no doubt about the reality of the global health workforce crisis, but the details are poorly documented. Data on the distribution of the various categories of health personnel and public access to services run by qualified personnel in individual countries are inadequate and fragmented. There is little information on training capacity and salaries, incentives and market factors, and the international migration of health personnel is poorly documented.

In order to find solutions and conclude reciprocal agreements/memorandums of understanding solutions, it is essential to obtain agreement on the kind of information needed and how it is to be obtained and systematised. Norway should be a driving force in the efforts to address these issues in multilateral forums.

The workgroup proposes specifically that Norway should:

1. Become involved in the co-operation in WHO, ILO and the IOM on developing better reporting procedures and data collection mechanisms on health personnel migration and in the relevant policy dialogues in the EU.

2. Support existing Norwegian expertise relevant to developing countries (at the University of Oslo) by means of development assistance funds specifically targeted at designing an HRH model for/including an HRH model in health information systems.

III. Measures to address health personnel migration

Health work is a universal profession and is the occupational sector with the highest degree of international migration. Although most health workers would prefer to work in their own countries, job opportunities, incentives and professional career opportunities are poor in low-income countries, and in an increasingly globalised labour market, rich countries with an inadequate self-supply of health workers are attractive destinations for health personnel. In addition, many countries are experiencing a drain of health personnel from the public to the private sector (in cases where the pay and working conditions are better) and from rural districts to cities.

Compensating sending countries for migrating health personnel is a global responsibility, and could be provided by taking measures to protect and strengthen the sending country's health system. It would be difficult to develop an agreed set of rules for a compensation scheme calculated per individual, and this would also involve major administrative transaction costs. However, in cases where a bilateral agreement is being negotiated, it would be natural to include specified forms of compensation. In the meantime Norway will make systematic use of foreign and development policy instruments to strengthen developing countries' health systems, and will refrain from active recruitment of health personnel from countries with poor HRH.

The workgroup proposes that Norway take steps in the following *three focus areas*:

1. Refraining from actively recruiting health personnel from countries with a shortage of HRH but seeking to influence the global consultation process on the Code of Practice for the international recruitment of health personnel. Norway wishes to strengthen the emphasis in the Code on the right to health services, which will depend on better health systems and strengthened HRH in developing countries. The Code of Practice will be the most important normative instrument in the field of HRH when it is hopefully adopted at the World Health Care Congress in 2010.
2. Making use of bilateral agreements on circular migration as part of development assistance activities, such as Norway's MDG 4 & 5 Initiative and the Migration and Development project. The workgroup does not consider bilateral health personnel exchange agreements with developing countries to be relevant as long as Norway is not a destination country for health personnel from developing countries.
3. Making use of the WTO as an international arena for developing an international framework for the temporary migration of health personnel across national borders based on GATS, and to facilitate closer coordination by destination countries of their recruitment policy/immigration programmes with developing /sending countries, particularly countries with a shortage of health personnel.

IV. Measures to strengthen countries' capacity for effective HRH policy and implementation

The main measures recommended here are not designed for any particular country but can be tailored in support of and by any of Norway's partner countries. They cover both planning and financing for implementation, and include financing models, health information systems, training and research. Norway supports global joint initiatives through organisations such as WHO, the World Bank and the GHWA that promote research, knowledge generation and the

development of models and tools for implementation by individual countries. Norway also supports the World Bank's Human Resources for Health Trust Fund, which conducts research on the labour market and fiscal issues related to improving health workforce capacity. The research results will be made available to the relevant countries to increase the knowledge base for their efforts to develop health personnel and retention policies.

In many low-income countries, HRH plans and working conditions for health personnel are an important part of retention policies. The fact that some of the key measures for meeting the health workforce crisis are outside the decision structure of the health sector itself implies that both developed and developing countries must aim at greater coherence between policies and sectors at the national level, for example through cross-disciplinary cooperation between sectors involved in labour market issues, training of health personnel, financing schemes and macroeconomic factors. Norway has already established programmes for supporting developing countries in higher education training, and the workgroup recommends that these be expanded and targeted more specifically at health personnel.

The workgroup has focussed on the following areas:

- encouraging embassies to play a facilitator role at national level in partner countries,
- earmarking and expanding Norwegian support for health personnel training through programmes at college and university level,
- concentrating Norway's efforts on particular countries in the fields of health, AIDS and higher education to allow long-term planning and promote synergies and effectiveness.

The workgroup recommends that Norway:

1. Plays a facilitator role at country level

Norway could serve as convener in multi-partner cooperation at country level in areas such as education and training, health, research or HIV/AIDS. Each embassy should obtain information on the HRH status in the country and use the information as a basis for its strategy in the same way as for example is done on macroeconomic factors. It would be possible to support to the embassies through the existing health expertise and tools possessed by the Ministry of Foreign Affairs, Norad and the Norwegian health administration.

2. Supports research and health personnel training

The following two approaches should be considered:

- a. The Norwegian Programme for Development, Research and Education (NUFU) and Norad's Programme for Master Studies (NOMA) could be given a grant component earmarked for measures for the health sector in line with section 2.2 of their respective programme agreements. Because many vital health services depend on personnel with education at Bachelor level, corresponding programmes for institutional cooperation on basic education in the field of health could be established. This could be linked with research by for example coordinating such studies with existing research.
- b. A comprehensive independent health programme could be established on the model of the NUFU and NOMA programmes that would cover all higher education levels (Bachelor, Master, PhD) and research.

Before a decision is made the two approaches should be designed and appraised by experts with a view to assessing their effectiveness in achieving the relevant impacts.

V. Strategic use of development assistance funds

Development assistance through multilateral channels and global initiatives

Today Norway's support for HRH is channelled mainly through multilateral agencies and organisations. Norway's resources for health development are relatively small, about 3% of the total international development assistance to the health sector, and must therefore be used in contexts where they yield optimal results. The workgroup considers that channelling the largest part of Norwegian development assistance through these organisations is making good use of the funds and should be continued.

In the last few years various global health initiatives have been established in addition to the existing multilateral organisations, many of which have joined the initiatives together with bilateral and private donors and foundations. In order to ensure an optimal outcome, the allocation of assistance to HRH through multilateral organisations must be evaluated regularly, for example annually, in relation to context and performance. While some organisations, especially WHO, serve an important normative function, other organisations and joint health initiatives have a greater direct impact in terms of development assistance.

The workgroup recommends that:

1. Norway should continue to channel development assistance through multilateral agencies. The most important of these will continue to be WHO, GAVI, GFATM, UNAIDS, INGOs, GHWA-initiated activities and other global health initiatives and trust funds.
2. **Results-based financing (RBF)**
 - NOK 5 million per year to be allocated to a review exercise of the HRH-specific implications of RBF implementation in the various countries and to research in this field. Some of this should be normative process research, which would provide up-to-date knowledge concerning the programme impact and possible distortion effects so that the effects on the total HRH situation in the respective countries can be monitored.
 - RBF should also be considered for supporting research on other labour-market-related consequences for health personnel, in the same way as for example Norway's support for the World Bank's Human Resources for Health Trust Fund, which is NOK 5 million per year for six years.

Bilateral financial assistance to partner countries

Norway is currently involved in cooperation with Malawi in the health sector, in which HRH is a main focus area. In addition, Norway's MDG 4 & 5 Initiative in Tanzania is being included in the health sector cooperation with other health sector donors. The workgroup recommends that this should include an explicit HRH component, which is already being developed and could be further supported by providing RBF to the MDG 4 & 5 Initiative.

A large proportion (approximately 30%) of Norway's bilateral development assistance is channelled through civil society and NGOs. The health portfolio is substantial and should be maintained. Norwegian NGOs and private health organisations are also encouraged to engage in partnerships based on the model of for example the ESTHER programme for institutional cooperation. Finally the workgroup recommends a review of the humanitarian assistance portfolio with a view to supporting crisis training for health personnel in selected developing countries.

The workgroup recommends:

1. Support for capacity-development:
 - i. in countries with which Norway has a health sector cooperation (Malawi) and in partner countries for Norway's MDG 4 & 5 Initiative (Tanzania, Pakistan, India, Nigeria),
 - ii. in countries where Norwegian institutions and hospitals engage in institutional cooperation (such as Ethiopia, South Africa, Malawi),
 - iii. in countries with which we have partnership exchange arrangements through FK Norway and the ESTHER programme,
 - iv. in countries where Norway can contribute through its membership in the International Health Partnership,¹
 - v. by including HRH in its health and HIV/AIDS support,
 - vi. by examining ways to provide more systematic support to regional health worker training over the budget allocation to humanitarian assistance, as part of crisis preparedness.

VI. Facilitating more targeted efforts by Norwegian institutions

Many Norwegian health institutions have for many years been involved in partnerships and institutional cooperation in developing countries. Their activities are concentrated on a variety of thematic areas and countries, but they have great potential as a foundation for future efforts to strengthen HRH and health systems. The Norwegian organisations and health institutions have expressed interest, and requests are regularly received from developing countries, for participation and partnership in this field.

In order to exploit the interest and utilise the resources of Norwegian health institutions, a financing scheme has been established under the health institution cooperation programme ESTHER, where strengthening of HRH is the main criterion for support. The workgroup recommends that the institutions be encouraged to set up a health network for development through which experience could be generated and exchanged, and members could be informed of best practices in the field.

The workgroup recommends:

1. That a coordinating body (a Norwegian health for development network) should be established and supported to improve coordination and assure the quality of the institutional partnerships engaged in by Norwegian health institutions and organisations, and as part of the efforts to improve international coordination.
2. That financial support should be given to partnerships and institutional cooperation, primarily through the ESTHER programme, in order to ensure predictability in the cooperation relations between the partners.

¹ The International Health Partnership, which was launched in 2007, is an inter-agency coordinated mechanism established to respond to the health-related MDG challenges that includes financing of activities. The process was initiated by the Norwegian and UK Prime Ministers together with the prime ministers of a number of other countries. The first countries selected for cooperation are Mozambique, Burundi, Ethiopia, Kenya, Mali, Nigeria, Zambia, Nepal and Cambodia.