

Facing the health worker crisis in developing countries: a call for global solidarity

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There is no doubt that health workers are the cornerstone of functioning health systems. Chronic under-funding of health systems in developing countries has led to the current health worker crisis, which threatens the achievement of the Millennium Development Goals. In recognition of this, WHO has devoted *The world health report 2006* to health workers.¹

WHO calls for national leadership supported by global solidarity to face this crisis. The report notes that wage ceilings should not constrain workforce expansion and recommends that a status of exception be accorded to public spending; it exhorts donors to ensure immediate and long-term financing — with emphasis on support for the health workforce coordinated and aligned with emergency national strategies — and rich countries to enhance the adoption of ethical recruitment codes to manage migration.

According to the report, the global deficit is nearly 4.3 million health workers: a critical shortage is faced by 57 countries, 36 of which are in sub-Saharan Africa. Paradoxically, these shortages coexist with underutilized talent. The cost of training health workers to eliminate the shortfall by 2015 is calculated as US\$ 136 million per year for an average country. The additional cost of paying health workers once the shortage is met is estimated at US\$ 311 million per country. Resource-poor governments are reluctant to take on such commitments without clear support from the international community. The report therefore urges donors to undertake immediate financial investment and sustain it over the next 10 years. While the report recognizes that inadequate salaries play a pivotal role in the fatal outflow of health workers, it does not analyse the major causes for such failure so its recommendations do not take account of them.

Throughout the 1980s and 1990s, the World Bank and the International Monetary Fund (IMF) introduced structural adjustment policies (SAPs) to induce economic stability. These policies led to cuts in public expenditure that diminished governments' ability to expand and maintain infrastructure, to provide necessary supplies and equipment, and to train and sustain competitive salaries for the workforce.² To exacerbate matters, the World Bank portrays health workers as lazy, inept and prone to absenteeism.³

The World Bank and other donors have actively pursued market-based restructuring of the public sector in poor countries, often imposing these reforms as conditions for their loans. Sanders et al.⁴ state that public health services have been dangerously compromised through rationalization of staff.

Failing to learn from the failures of SAPs, and despite most poor countries having achieved broad macroeconomic stability, the IMF continues to insist on punitive and ill-conceived restrictions on public spending. Unrealistic ceilings on the public sector wage bill result in poverty-level wages and the restriction of recruitment of health workers at a time when Africa is in desperate need of more workers to combat acquired immunodeficiency syndrome (AIDS) and other diseases.

Though its official policies recognize that "traditional market responses are not usually effective when applied to human resources for health",⁵ the World Bank's answer to the crisis is to introduce competition between workers for better salaries and working conditions, rather than to focus on enhancing the ethos of public service through more and better-paid workers participating actively in service reform.

Donors also play an important role in the health workforce crisis. For decades, most donors accorded low

priority to spending in the health sector in developing countries:⁶ their support was limited, short term and unpredictable, focusing on projects that ran parallel to the national systems and did not fund recurrent costs such as salaries. Meanwhile, government budgets suffered from a lack of adequate domestic resources, coupled with debt services, aid conditionalities and unpredictable aid with delays or even incomplete disbursements.

There have recently been some positive changes. Overseas development aid is expected to rise by over 60% between 2004 and 2010, with aid to Africa being doubled.⁷ The debt cancellation promised by the G8 summit in Gleneagles in 2005 will release vital long-term resources to be spent on key workers: Zambia is already using savings from debt reimbursements to the IMF to support salaries.

On the migration of the health workforce, the report calls for "cooperative agreements" and "ethical recruitment practices" to protect the rights and safety of migrant workers. The investment that sending countries forego in the outflow of their health workers has been termed a "perverse subsidy", estimated to be in the region of US\$ 500 million annually.⁸ Migration needs to be sensitively managed, however, so as not to infringe individuals' right to move freely.

The WHO report is timely and represents much needed evidence and clear recommendations. Unless governments and donors make a strong political and financial commitment to implement a double strategy of short-term and long-term solutions, the crisis is likely to worsen. ■

References

Web version only, available at: <http://www.who.int/bulletin>

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