VALUE FOR MONEY, SUSTAINABILITY AND ACCOUNTABILITY IN HEALTH:
A NEW GOVERNANCE FRAMEWORK FOR AFRICA TOWARDS AND BEYOND THE MDGs
Conference of Ministers of Health and Ministers of Finance, Tunis, 4-5 July, 2012.
Technical Paper: Financing Human Resources for Health

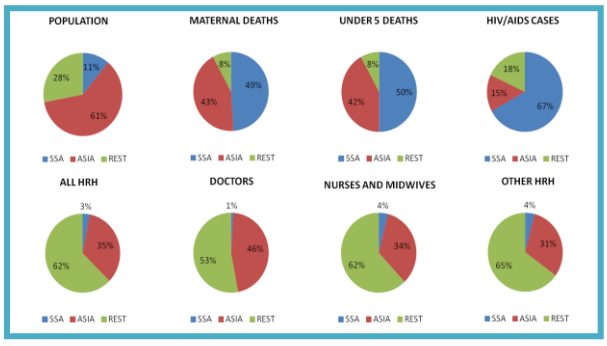
More money for HRH: more HRH for the money

Health costs are spiralling out of control all over the world in context of global financial crisis while some countries are still struggling to offer basic health services. The health sector in Sub-Saharan Africa is most often unfunded, including the health workforce, which represents the single largest item in health budgets. On the other hand, countries do not meet the minimum health staffing levels to provide essential care. Ministries of Finance and Health need to jointly identify and allocate additional financial resources - for HRH - to maximize the efficiency and effectiveness of current capital and recurrent expenditures.

Financing Human Resources for Health to improve availability, accessibility, acceptability and quality of health care. Ministries of Health and Finance have shared obligations to adopt appropriate promotional, legislative, administrative, budgetary, judicial, and other measures towards the full realization of the right to health for their citizens.[1] The right to health explicitly identifies the role of Human Resources for Health (HRH) including, *inter alia*, the education, management, remuneration and continuing development of a quality health workforce in sufficient numbers and equitably deployed, retained and supported to serve population needs. Economic efficiency in the production and utilization of health workers to deliver health services is a shared challenge. It involves the identification of additional resources (*more money for HRH)* and maximizing the efficiency and effectiveness of current capital and recurrent expenditures (*more HRH for the money*). A 2011 labour market perspective for Africa suggests there are five main areas to be overcome: limited production, low financial investment, underutilization, mal-distribution and poor performance. [2]

Limited production/supply and high burden of morbidity/mortality. New data from the WHO, UNFPA, UNICEF, UNAIDS and the World Bank provide examples across Africa where individual countries are making progress in improving population health outcomes.[3,4] In particular the average annual percentage decline in under-five mortality is encouraging, linked in part to overall economic growth. [5] Such trends are evidence of how national leadership, investments and commitment can enable and sustain comparatively rapid gains. However, the region continues to record a high burden of avoidable mortality and morbidity. Regional data (see Figure 1) identifies Africa recording approximately half of all maternal and under-5 deaths, but with only 3% of the global health workforce. In 2006 WHO estimated that approximately 1.5 million additional health workers are required in Africa to meet the minimum density of 2.28 health workers per 1,000 population to provide essential care and 36 countries don't meet that requirement[6]. Population growth, production capacity and attrition will all impact on revised projections for 2015 onwards.

Figure 1: Population health outcomes and health workforce supply in Africa.



Source: adapted from Harmonization in Health in Africa 2011,

More money for HRH: key messages

- **Increase external aid for HRH**
- **Improve planning and targeting of external aid from in-service training to pre-service training and expansion of employment capacity**
- **Develop better and transparent tracking mechanism for HRH expenditures and donor contributions to HRH**
- **Collaborate with the private sector to contribute services to supplement public sector services**
- **Utilize Country Coordination and Facilitation Process(CCF) for increased investments and improved sustainability for HRH**
- **Use labour market analysis and other tools to improve efficiency**

World Health Report 2006 and the Global Atlas of the Health Workforce 2012.

"More money for HRH".

Health sector in general and HRH in particular are severely underfunded in most Sub-Saharan Africa countries.[7] As of March 2011, 32 countries were investing half or less of the US$ 40 per capita recommended by WHO.[8] This situation is further exacerbated by the global financial crisis and the growing middle class in Africa that place increasingly greater demands on already strained health systems

The proportion of public expenditure committed to HRH is difficult to measure within and across countries, thus weakening governance, transparency and informed decision-making. Health sector on average accounts for 10% of all public sector employees. The proportion that the wage bill for the health workforce represents from the overall health budget is variable, and even with low absolute numbers it may represent up to 80%.[9]

Increasing production and improving efficiency are the two main front lines to address the current HRH crisis, and require a detailed appreciation of the stock, distribution and competencies of the practising workforce that is often absent. Estimations from 2006 about the cost of scaling up training of health workers to achieve globally accepted density standards was US$ 136m per year for an average country [1.6m – 2bn] requiring an increase in per capita health expenditure of US$ 2.80 per person annually [0.40 – 11]. Paying these new health workers till 2020 would cost around US$ 311m per average country or an increase of US$ 8.30 per capita.[10]

Official Development Assistance (ODA) for health has witnessed rapid growth in the last decade. Total ODA for Africa in 2010 was US$ 48 bn (around 48% of total global ODA) with US$ 9.7 bn (20%) invested in health[11]. However, it is recognised that the efficiency of ODA in general and the effectiveness of ODA for HRH can be improved. Limitations in the coding structure of the OECD's Creditor Reporting System make it difficult to identify and track investments in HRH[12] but a 2011 study by WHO suggests that HRH receives a very small percentage of the total ODA for health. Much of this is spent on in-service training for donor-preferred interventions with a limited impact on scaling up the workforce and relatively little is spent on the two most important areas: pre-service training capacity, and the expansion of employment capacity.[13] A 2011 report by the World Bank, GFATM and GAVI identified similar findings.[14] Productive and constructive interactions between Global Health Initiatives and country health systems are required, as concluded in a WHO convened meeting in Venice in 2009.[15] These can build on current initiatives including the Joint Health Systems Funding Platform and the International Health Partnership +.[16]

The Agenda for Global Action adopted during the First Global Forum on Human Resources for Health in 2008 highlighted the importance of the coordination between stakeholders involved in the resolution of the HRH crisis in order to achieve effective results[17]. Along with the government institutions, the role of the private sector in responding to the health workforce crisis is critical. In 2005 about 60% spent on health in sub-Saharan Africa was private. According to a 2012 study by GHWA, a

majority of the population In many low- and middle income countries seeks care from the private sector[18]. The private sector partners along with all relevant stakeholders need to be convened into an agreed national effort on the Health Workforce[19] using a process such as Country Coordination and Facilitation (CCF) advocated by GHWA[20] . The approach has contributed in a number of countries to improved coordination and sustainability of HRH funding at country level as well as increased investments in HRH[21].

"More HRH for the money".

More HRH for money: Key messages

- **Improve skill mix and task shifting to reduce production costs of health services**
- **Use health workers from the communities increase rural retention and health outcomes**
- **Improve motivation and retention of health workers by implementing appropriately designed financial and non-financial incentives**
- **Usage of continuous professional development and performance assessment reviews improve existing HRH productivity**
- **Information and Communication Technology has a positive impact on education and motivation of health workers**

Technical efficiency problems in the health workforce persist across Africa, including mismatch of supply and demand, poor performance of health workers, unbalanced workforce skills, inequitable deployment between rural and urban areas, poorly motivated workers and poor HR and financial management contributing to the wastage of funds.

Linking pay to performance is an option introduced in some African countries. Early studies show some success of this strategy on improving outputs, service quality and outcomes. [22] [23] Appropriately designed packages of financial and non-financial incentives proved to successfully address poor health workers' motivation and performance in several African countries.[24] [25] [26]

Appropriate skill mix of the workforce warrants review. Changing the ratios of doctors to nurse/midwives or to other health cadres can reduce the production cost of health services. [27] Lower skilled cadres or even non-professional workers undertaking tasks previously performed by more skilled colleagues (task shifting) can achieve productive efficiency when the appropriate mix is reached within a budget constraint[28]. The strategy proved to be successful for example in reducing clinic operation cost in Uganda and South Africa, increasing access to HIV services in Botswana and Zambia, and improving health outcomes in Zambia, Uganda, South Africa, Mozambique, Uganda and Malawi[29]. Evidence from Tanzania and Mozambique about producing and deploying non-physician surgery technicians shows improved access to emergency obstetric care [30] and cost effectiveness.[31] Also, according to 2010 study by the Global Health Workforce Alliance, the services offered by Community Health Workers have helped in the decline of maternal and child mortality rates (Bangladesh, Ghana, Brazil) and have also assisted in decreasing the burden and costs of TB (Ethiopia, South Africa) and Malaria (Uganda, Cameroon)[32].

Use of information and communication technology (ICT) to support distance learning has proven to have a positive impact not only on education but also on the motivation and retention of rural health workers in Tanzania.[33] [34]

The low number of health workers is further exacerbated by their inequitable deployment as attracting and retaining health workers in rural and remote areas is a particular challenge. Country experience suggests that health workers with a rural background are more likely to work in rural settings as observed in Ethiopia and Rwanda[35] and that targeted admission policies in health professional schools to increase the selection

of students with a rural background is a successful strategy.[36] Similarly, locating schools outside of capital cities is facilitating rural deployment in Mozambique and DR of the Congo.[37]

Salary is perceived as the most important factor for retention by many senior HRH managers. Increasing wages was associated with decreases in annual attrition from public health workforce by 1.5% among younger workers in Ghana. [38] Similar results were obtained in Liberia. However, other financial and non-financial strategies have showed positive impact on retention using new more effective methodologies such as discrete choice experiments[39]. WHO's 2010 evidence-based guidelines on improving retention offers solutions, advocating for "bundles" of incentives (financial and non-financial). [40] However, in planning to introduce incentives, sustainability is key, as health workers may consider the withdrawal or termination of incentives as variations in the conditions of services with counterproductive effects on their motivation.[41]

Developing mutually beneficial partnership

Partnership between the Ministries of Health and Finance for developing evidence based policies and plans and mobilizing adequate financial resources for their implementation is the key to achieve improved health outcomes.

The role of the Ministry of Finance in articulating the necessary budgetary decisions to support scaling up of the health workforce requires a deep understanding of the importance of having a "healthy" health workforce and its strong association with economic and overall development. The association between health and economic development is well documented. One year increase in life expectancy raises GDP by 4%.[42] There is also strong evidence about the association between density and distribution of health workers and health outcomes. [43] A Labour Market Analysis (LMA) in Ethiopia enabled informed decisions about how to improve the productivity of their workforce.[44] A workforce audit in Sierra Leone was able to identify a 12% error rate in the 7,000 payroll records that freed resources for the MoH to recruit 1,000 new workers.[45]

Continuous and sincere engagement between Ministries of Health and Finance can ensure savings and improve efficiencies in health budgets, and lead to improved health outcomes and achieving health related to MDGs.

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