Ekspertmøte om helsepersonellkrisen, Soria Moria, 24 February 2005.

"Mobilising for Action – Political and strategic challenges"
Hilde F. Johnson, Minister of International Development, Norway

Check against delivery

Good morning, and welcome to Oslo. I am pleased to see so many senior experts here at this consultation. Here, we will address one of the most pressing problems facing developing countries today: the health personnel crisis. I have high hopes for the outcome of your discussions – as do many others around the world.

As all of us know, the health personnel situation is a crisis of enormous proportions. It is in effect a public health crisis, a problem that threatens not only to undermine our goals on improving health, but to prevent our progress in the fight against poverty as a whole.

This crisis is a recurring theme in developing countries. In Zambia, health officials are struggling to keep hospitals running in spite of the fact that half of the doctors educated in the country since 1960 have left for greener pastures. In Malawi, overworked and underpaid nurses and doctors have seen a majority of their colleagues disappear to better-paying jobs abroad or in local NGOs. In many of our partner countries, aids brings in an increasing number of patients to hospitals and health care centers that struggle to keep its staff healthy enough to keep on working.

This is a grave situation. It calls for urgent and large-scale measures.

The problems

The reasons behind today's health personnel crisis are not new. We are very familiar with some of them:

- Long-term lack of investment in the health sector in developing countries - both in services and in personnel. The goal of the 20/20 initiative adopted at the Social Summit, i.e. that 20 per cent of the spending of national governments and of international donors should be allocated to basic social services, has not been reached.
- The devastating effects of HIV/AIDS on institutions, on services, on local communities, on national economies.
- The effect of globalisation, such as the increasing need for health personnel in the developed world, due to a greying population and an insufficient numbers of doctors and nurses being trained at home. This is leading to aggressive recruiting on the part of OECD countries, particularly from English-speaking countries like Malawi and Zambia.

This has created a situation where we have gone from bad to worse:

- In Africa, there are on average 0.8 health care workers per 1000 citizens. The equivalent number in Europe is 10.3.

- In Africa, almost 20% of all health personnel is lost to aids. Last year, 440 000 aids patients were receiving treatment – this year the number is 700 000. Almost 2/3 of all people living with aids live in Africa south of the Sahara.
- In Malawi, only one of four doctors and nurses will make it into the country's overburdened public health system.

MDGs

This has grave consequences, and influences the countries' overall ability to reduce poverty, develop and move forward. Resolving the health personnel crisis will be essential to our success in reaching the MDGs.

If we do not resolve the health care crisis, we cannot hope to reach the goals directly related to health, such as reducing child mortality, improving maternal health, and reversing the spread of HIV/AIDS and malaria.

Nor can we hope to reach the goals of eradicating extreme poverty and achieving primary education for all, given the effects of inadequate health care on productivity, local communities and family life.

If we do not find sustainable solutions to the personnel crisis, I believe our prospects of reaching the MDGs are grim.

It does not help to negotiate affordable prices for drugs if there are no health professionals to deliver services.

It does not help to increase investment in health and education unless we ensure the necessary investment in the workforce.

The health crisis clearly illustrates the importance of building sustainable national systems, whether health systems or systems for good governance.

Human resources for health in context

Why is it so hard to get through the bottlenecks and barriers and do something about the problem of under-investment?

Human resources for health, when translated into projects, sector programmes and budget support, appears as a "recurrent expenditure", and when the issue is raised, the debate is largely devoted to the size of the public sector.

The human resources issue does not fit under a specific budget line. It is *not* infrastructure, *not* capital investment, and it creates problems as a recurrent expenditure.

Another problem is that the health sector often does not have the mandate to decide the terms of service and incentives for the health work force.

This means there is a mismatch between the ownership of *problems* and the ownership of *solutions*.

We, the donors, have also failed in the training of health workers. Our focus has been primary education, not vocational or professional education.

We have also failed in that we have not done enough to prevent the exodus of health care personnel from the developing to the developed world. Aggressive foreign recruiting to hospitals and nursing homes, coupled with local recruiting to NGOs and UN organisations, has not helped.

The political nature of the problem

The greatest challenges we are facing are not just technical or financial, they are also political.

This is about the public sector, and public sector reform. It is about the health systems, national and local. It is about work force issues, salaries, public sector size, distribution priorities, equity, access. These are all political question. This applies to all countries, all governments and all political parties.

In countries like Norway, these issues form the core of the political debate and constitute a large part of the basis for choice in democratic elections.

This is much less the case in young democracies, where the political nature of these challenges is often blurred by the external aid agenda.
External conditionalities and the donor agenda may become more important than debate on macropolicy. This would be unfortunate. It may also be tempting for developing countries to turn their attention to donors, rather than face the necessary negotiations and debate on political priorities that these work force challenges require.

These issues are also political at the global level. We are talking not only about levels of support to health and human resources, but also about aid performance and aid reform. We are talking about policy coherence. Millennium Goal 8 says something about that. A global partnership for development must give e.g. attention also to migration policies. None of this happens in a vacuum.

The gross mismatch recently identified between financial resources allocated in support of the health MDGs, and the personnel available to transform these resources into services and results, makes it even more important for us to strengthen the political momentum of our national and international efforts to deal with the health personnel crisis.

Let me address national action first:

National level action

Skilled manpower cannot be developed overnight. It is a long-term process that calls for long-term commitment. Not everything can be done at once. But it is urgent that we address and act on the problems urgently.

The hiv/aids-pandemic demands exceptional action with regards to health workers - because of their special status in the global labour market and their critical importance in fighting and coping with AIDS and other poverty-related diseases. We must actively seek to gain acceptance for this among the public. We have to agree that health care must come first.

We need solutions carefully tailored to each country. There are some general principles we know will apply everywhere – but a workable and sustainable solution must be country- and community specific. This is also the focus of this consultation.

However, a number of critical issues must still be tackled at the national level.

Securing adequate human resources in the health sector must be at the centre of the national agenda. Human resources for health must therefore, as part of the broader human resources agenda, be integrated into the PRSP framework and the national budgets in order to enhance national ownership.

Education of health workers, nurses and doctors is essential to solve the crisis. This will be beneficial for example as part of a SWAP on health. But we know that educational capacity is limited in many countries. Capacity must be expanded significantly. In the intermediate phase, South-south cooperation in the use and recruitment of health personnel can also be a solution. This would be a better and less expensive solution than using expat personnel from developed countries.

However, we also have to address the following three flows - all currently moving in the wrong direction:

The flow of resources from rural to urban areas. We must reverse this trend. Here, we need to consider such measures as scholarships – educational support tied to a commitment to serve for an agreed period in a particular area. It works quite well in Northern Norway – I think it could work equally well in the South.

The flow of resources from the public sector to better-paying private organisations such as UN agencies and NGOs.

The flow of resources from developing to developed countries - i.e. the retention problem. Here, we must focus on policy coherence. I will say more about this later.

It is important to provide a national policy framework for dealing with the public/private personnel mix. This policy framework should specifically address mutual accountability, predictable relations and agreements among stakeholders on ways to establish "fair play" management of the pool of *all* skilled health personnel in the country in question. Agreements on national codes of conduct may be one way to go.

There is an urgent need for pay reform and right sizing. Action on these issues is pending, largely because of the political implications of decisions on such action and

the lack of a political constituency or platform that can justify and carry through these decisions. If the advancement of the broad public service reform agenda is seen as too complex to find solutions in the short to medium term, the question is whether the AIDS emergency and the public health crisis can provide justification for "exceptional action", in order to advance the necessary decisions.

Finally, we need to explore the flexibility of macroeconomic policies in order to cope with the impact of AIDS on the economy and on the health sector. I hope we have some sharp macroeconomists with strong mandates attending this consultation, to help us move forward on this key issue.

We need to ensure that macroeconomic policies harmonise with properly financed and scaled human resources for health initiatives. Here, the IMF in Malawi can suggest interesting solutions.

A possible tool *could* be a "medium-term personnel framework", along the lines of a Medium-Term Expenditure Framework.
This could facilitate a linkage between the right-sizing of personnel for critical public sectors and the planning of public expenditure.

In general, I believe political dialogue with other countries in the region and through regional political mechanisms and platforms may be necessary and useful for building a platform for action. However, this should supplement national political debate and the accountability of governments to their people.

What can we do at the global level?
The health personnel crisis is a global issue. National-level efforts will not be sufficient. We need international solutions.

Some are already being considered by donors. These need swift attention:

- The human resources for health agenda can be enhanced by political leadership and advocacy at the international level. There are many opportunities to do this in 2005 (MDG events, OECD DAC meetings, AIDS replenishment and financing discussions, IDA replenishment, the High-Level Plenary Meeting in September).

- We should focus on the efficient use of *existing* financing mechanisms. We should avoid establishing new mechanisms that bring additional bureaucracy and new reporting requirements.

- We need to increase long-term predictable donor funding in support of national initiatives (a process we have started in Norway)

- We must ensure that the funding is sufficiently flexible to deal with the complexity of the crisis. This entails budget support funding or basket funding that could be used for both the public and the private sector.

We also need global solutions to other challenges:

We need political agreement on the interpretation of flexibility of macroeconomic policies and the conditions for debt relief, to enable countries to cope with the implications of pay reform and the right sizing of the public sector.

We need to address the issue of policy coherence and an appropriate response to the challenges posed by the international migration of health personnel. Aggressive recruitment of such personnel by private companies should be strongly discouraged. This includes an agreement on a range of options for reducing the negative impact of migration on countries of origin whose health systems are under severe strain. The WHO is currently working on a "Code of Practice" on such recruitment.

Furthermore we need agreement on a more general framework for short and medium-term measures that can address the negative impact of the personnel crisis without undermining long-term solutions. At the international level, we need

- A common global platform. We need to agree on a common action framework. We need an institutional response in the multilateral system that builds on, and further clarifies mandates and comparative advantages, and ensures an "organisational anchor" for human resources for health. This organisational anchor should serve as a convenor and clearing house for an aligned response across agencies,
- We need to make better use of regional institutions in Africa that have political, economic, financing and health mandates.

At the country level, we need to see

- inclusive, multi-stakeholder alliances that can align their action within a common action framework, under national leadership, formalised in a Country Action Team that has access to relevant decision-makers and is recognised by all partners.

This is a very important meeting. With all of you senior experts gathered here, in this room, we have a unique opportunity to move forward, to create a forum that can produce concrete recommendations for finding solutions that will work. We have high expectations for this meeting – and we are not alone.

The outcome of this meeting matters.

It will matter to partner governments, donors and recipients alike, who are now preparing for DAC High Level and harmonization meetings in Paris next week. I plan to report on the outcome of this meeting in Paris.

It will also matter in the preparations for the UN High Level Summit in New York with Heads of State and Governments in September. Last week we were challenged by SG Annans office to report from this meeting in Oslo - to come up with two or three immediate - and doable - steps to reduce the human resources crisis. They would like input on how the human resources issues could be better integrated in a broader implementation of the health MDGs, including the issue of migration. The SG's Office, now busy preparing the background report the SG will present to member governments in March, also would like a ten-year vision on how capacity-building in health systems can help us reach the Millennium Development Goals by 2015.

Most of all, it matters to the people on the ground whose health, well-being and prospects for the future suffer from the human resource crisis. They must be our first priority. They matter the most.

I pass this challenge on to you, and ask you to help us identify concrete next steps, to help the world community translate the MDG vision into concrete and doable action. We will meet again tonight, and I will look forward to hearing the outcome of today's debate.

Thank you.