付　属　資　料

Global Action for Health System Strengthening

G8 Hokkaido Toyako Summit Follow-Up

Global Action for Health System Strengthening

Policy Recommendations to the G8

Task Force on Global Action for Health System Strengthening

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List of Abbreviations

AIDS	acquired immune deficiency syndrome
CBHI	community-based health insurance
DHS	Demographic and Health Surveys
EHRP	Emergency Human Resources Program (Malawi)
EU	European Union
G8	Group of Eight
GAVI	Global Alliance for Vaccines and Immunization
GDP	gross domestic product
GHWA	Global Health Workforce Alliance
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
H8	Health Eight
HEP	Health Extension Program (Ethiopia)
HEW	health extension workers (Ethiopia)
HIV	human immunodeficiency virus
HRH	human resources for health
ICN	International Council of Nurses
IHP+	International Health Partnership and Related Initiatives
ILO	International Labour Organization
IMF	International Monetary Fund
JCIE	Japan Center for International Exchange
JLI	Joint Learning Initiative
MDG	Millennium Development Goal
MMR	maternal mortality ratio
NGO	nongovernmental organization
NHS	national health services
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
P4H	Providing for Health
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PHC	primary healthcare
SHI	social health insurance
U5MR	under-five mortality rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization
WHS	World Health Survey

The G8 and Global Health: Emerging Architecture from the Toyako Summit

*Keizo Takemi and Michael R. Reich**

The declaration of the G8 Toyako Summit, held in Japan in early July 2008, covered global health issues under the topic of "Development and Africa." The official summary made the following statement on health:

> The G8 leaders welcomed the *Report of the G8 Health Experts Group*, presented along with its attached matrices showing G8 implementation of past commitments, and set forth the Toyako Framework for Action, which includes the principles for action on health. Furthermore, regarding the G8 commitment to provide $60 billion for health agreed at last year's G8 Heiligendamm Summit, the G8 leaders agreed to provide the said amount over five years. In addition, with regard to malaria prevention, leaders agreed to provide 100 million mosquito nets by the end of 2010.[1]

The *Report of the G8 Health Experts Group* was prepared by government officials in health and foreign policy from the G8 countries, with leadership from Japan, and covered a number of critical issues in global health.[2] The report reflected growing policy attention to health system strengthening by Japan and the global health community more broadly.[3] Prior to the summit, Keizo Takemi and a group of leaders from diverse sectors in Japan organized a Working Group on Challenges in Global Health and Japan's Contributions,

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run by the Japan Center for International Exchange (JCIE)—a nonprofit and nongovernmental organization in international affairs and global issues—and involving key actors from government ministries, Japan's development agencies, academia, and NGOs. At the summit's conclusion, the government of Japan decided it needed a mechanism for following up on the new policy initiatives to which the G8 leaders had committed and engaged in a Track 2 process with the study group and JCIE to explore policy options. Those efforts were designed to identify action-oriented policy recommendations for the G8 on health system strengthening and to maintain momentum and continuity for future G8 summits, especially the 2009 meeting to be hosted by Italy.

This chapter provides an overview of Japan's activities on global health to follow up on the Toyako Summit declaration and presents the context for three chapters with policy recommendations for G8 action. Below, we review the emerging focus on health system strengthening and discuss the unique role of the G8 in global health governance and architecture. We then discuss the three policy chapters and conclude with a discussion of future directions.

A Growing Focus on Health Systems

The world is currently experiencing a shift in the global health agenda from an emphasis on disease-specific approaches to a focus on health system strengthening. These two approaches are often called the "vertical" and "horizontal" approaches to health improvement. In this debate, some have argued for a third compromise strategy that would combine the two into a "diagonal approach."[4] Others have called for this debate to "rest in peace."[5] We believe that a better balance needs to be found between the two approaches so that efforts at fighting specific diseases and strengthening health systems can support each other more effectively. But balance is difficult to define with precision, especially when the knowledge base is thin and contested about how vertical programs affect horizontal efforts; there is no good evidence that this is a zero-sum game, where improving one necessarily injures the other. Yet, clearly the disease-focused programs are nervous about shifts in global resources to health systems.

The growing attention to health systems can be attributed to several factors. First, the development of disease-specific approaches over the past decade has created various unintended consequences.[6] The disease-specific approaches have contributed greatly to health improvement, particularly since existing multilateral and national health agencies could not deal with the devastating

effects of diseases like HIV/AIDS in many developing countries. But, now recipient countries are confronted with a fragmented array of uncoordinated disease control programs promoted by multiple donors. The opportunity costs of servicing the disease-specific programs have been recognized as reducing the effectiveness of health ministries. In addition, the disease-specific programs attract financial and human resources away from government agencies and may be contributing to a weakness of health systems. Two of the major disease-specific programs—the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Global Alliance for Vaccines and Immunization (GAVI) Alliance, a consortium of organizations to promote immunization and vaccination—have launched significant efforts to strengthen health systems in recipient countries. While those programs have encountered problems in implementation, they nonetheless reflect recognition of the need to develop both disease-specific and health-system-strengthening approaches.[7]

A second factor contributing to the focus on health systems is recent efforts by the World Health Organization (WHO) to restore policies for primary healthcare (PHC). The PHC approach was officially launched on the global stage through the Alma Ata Declaration of 1978.[8] Implementation of PHC at the country level, however, confronted many challenges in poor countries. The WHO is now seeking to resurrect the PHC approach with the *World Health Report 2008*, issued in October on the 30th anniversary of the Alma Ata Conference,[9] and with a renewed emphasis on the principles of universal coverage, people-centered approaches, and effective delivery of primary care.[10]

A third factor is growing recognition about the difficulties that health system weaknesses present in achieving the Millennium Development Goals (MDGs).[11] Problems in health system performance are considered major causes for the delays in achieving key targets of the health-related MDGs—those related to child mortality (MDG 4), maternal mortality (MDG 5), and the prevention of HIV/AIDS, malaria, and other diseases (MDG 6). These delays are particularly pronounced in countries in sub-Saharan Africa.

Fourth, the growing demand for aid effectiveness and donor harmonization at the country level, based on the principles of the Paris Declaration, reflects concerns about system-wide impacts of global health initiatives. The increase in resources devoted to health worldwide, however, has focused more on inputs (especially human and financial resources) rather than outputs or health impacts (such as effective coverage and improved health). Yet, there is limited evidence that previous attempts to achieve strong donor coordination (through poverty reduction strategies and sector-wide approaches) have helped improve health system performance.

Advocates of single-disease control programs are concerned that the renewed emphasis on health systems could move resources away from their programs and undermine progress achieved to date. The risk of allowing infectious diseases to increase should be carefully monitored as efforts develop to strengthen health systems. A community-based approach, with attention to collective quality of life, could help avoid undesired consequences of a focus on health systems.

Health System Strengthening

No consensus exists on the operational definition of health system strengthening. Several competing approaches are currently popular in the global health community, promoted by different agencies.[12] We briefly present several of the main approaches here.

The WHO's *World Health Report 2000* raised a broad international debate on issues related to health systems.[13] The report defines a health system as including "all the activities whose primary purpose is to promote, restore, or maintain health." The main focus of the report and the ensuing debate, however, was on how to measure different aspects of health systems rather than on how to strengthen health system performance.

The WHO presents its updated approach to health system strengthening in *Everybody's Business*. This 2007 report, however, does not provide a clear definition or boundary for a health system. Indeed, the report states, "There is no single set of best practices" for health system strengthening because "health systems are highly context-specific."[14] In addition, the report's framework is not easy to apply in practice. The book identifies six "building blocks" for a health system: service delivery, health workforce, information, medical technologies, financing, and leadership/governance. But it is not clear how they fit together, how they relate to one another, or how one builds a health system with the blocks.

The World Bank describes its approach to health system strengthening in its 2007 strategy document on "healthy development."[15] The document recognizes that the bank needs a "collaborative division of labor with global partners" (p. 18), including the WHO, UNICEF, and the United Nations Population Fund (UNFPA), which are viewed as providing technical expertise in disease control, human resource training, and service delivery. The bank considers its comparative advantages as broader systemic issues, especially health financing and health economics, as well as public-private partnerships, public sector reform and governance, intersectoral collaboration for health, and macroeconomics

and health. A major challenge for the bank is implementing its strategy at a time when the bank's own financing is becoming a smaller proportion of global health funds, when the substantive problems encompass more than the bank's areas of comparative advantage, and when the previous bank strategy of 1997 has not been effectively evaluated (p. 38).

With the growth of interest in health system strengthening, the world now confronts a proliferation of models, strategies, and approaches. The WHO and World Bank efforts represent just two approaches; other frameworks also exist. How do we evaluate these different conceptual models and select an appropriate one? Unfortunately, there is no cookie-cutter approach to health system strengthening, no single formula that can be applied to all countries. Improving health system performance is a process, and that process must be adapted to the situation of each country—its political and economic circumstances, its social values, and its national leadership.

From a policymaker's perspective, a strategic framework on health system strengthening should help in deciding what to do, how to do it, and what results to expect. In addition, the framework should relate to appropriate theories while it helps to produce practical results. The framework should also provide guidance on how to implement the ideas in real-world political conditions and how to relate the objectives to different ethical perspectives. We believe that one approach to health system strengthening proposed by Marc J. Roberts, William Hsiao, Peter Berman, and Michael R. Reich[16] takes important steps in meeting these criteria and can help sort through the diverse concepts promoted by different agencies.

Global Health Architecture and the G8

The G8's role in global health

The global health architecture is undergoing fundamental structural changes. As noted in the World Bank's strategy document, the once-dominant players are increasingly marginal and less influential. This is true for both the World Bank's prior financial dominance and the WHO's prior normative dominance. Global health policymaking has become a multi-stakeholder process but without an explicit institutional process and with competition and confusion at global and national levels. The proliferation of overlapping yet opposing frameworks for health system strengthening reflects this disorganization. We believe that

the G8 can play a major role in catalyzing efforts to reframe the global health architecture in a more coherent direction.

The rise of the G8 coincides with rapid changes in global health governance in the 21st century, especially the declining role of the WHO as the sole international health agency. In the past decade, new stakeholders have entered the decision-making arena of global health, including the Bill & Melinda Gates Foundation, the Global Fund, and GAVI. At the same time, public-private collaboration has become a maxim of health policy at both the global and country levels.

One traditional strength of the WHO has been its constitutional mandate to represent member states through the World Health Assembly. In the new era of global health, however, the WHO is limited by its legal framework in its interactions with the private sector and NGOs. Another major strength and constraint of the WHO is its nature as a technical agency that mainly offers information and technical advice but cannot substantively influence how national governments allocate financial and human resources to strengthen health systems.

Calls to reform the WHO have a long history. Each new director-general has pursued change at the organization, but implementation of new ideas remains a challenge.[17] Recent calls for the reform of the WHO reflect broader attempts to reform the UN, and these appeals have gained increasing persuasiveness and priority on the global agenda.[18] It is imperative for the WHO, as the world's principal agency for global health policymaking, to clarify and strengthen its core functions and improve its technical and organizational competencies.

Into this increasingly crowded field of global health has emerged a new entity known as the Health 8 or H8—comprised of the WHO, the World Bank, GAVI, the Global Fund, UNICEF, the UNFPA, UNAIDS, and the Gates Foundation. This meeting of global health leaders resembles the meeting of global political leaders, providing a locus for discussion with limited organizational capacity. At their inaugural meeting on July 19, 2007, the H8 leaders stated they "met informally" with the objective of "strengthening their collaboration in global health in order to achieve better health outcomes in developing countries."[19] Among the five themes discussed was "the renewed interest in health systems."

The H8 leaders agreed that health system strengthening should be judged by its ability to deliver health outcomes, and they urged the WHO and the World Bank "to fast-track the completion of the normative framework for health systems strengthening." The H8 thus creates an opportunity for enhanced

communication, collaboration, and consensus building on global health policy, including interactions with the G8.

The national leaders of the major market economies began meeting on an annual basis in 1975, creating a new generation of global institutions. The G8 has considered global health issues at every meeting since 1996, according to a systematic analysis of the G8 and global health governance.[20] The study found that the G8 has emerged as an "effective, high-performing centre of global health governance across the board." Japanese and Italian leadership have been important in pushing the G8 to address global health issues, exemplified by the 2000 Kyushu-Okinawa Summit that led to the formation of the Global Fund.

The nature of the G8 provides a highly personal, visible, and flexible mechanism for addressing global health policymaking. The once-a-year meeting of national leaders allows for focused discussions with key stakeholders from outside the G8 circle. For example, the G8 has included four core African partners at several meetings to discuss critical issues of development and health. The emergence of the G8 in global health governance reflects the need for a more flexible mechanism than the existing multilateral health institutions in order to tackle emerging global health threats that require collective action. The G8 can think and act outside of the existing global health bureaucracies and stakeholders and is thus uniquely positioned, through its power and vision, to help shift the global health agenda and priorities. Yet, at the same time, the G8 does not have its own implementation capacity and therefore must depend on existing organizations or new entities for action.

The rise of the G8 and the H8 in global health reflects a power shift in global politics. The globalization of health issues means that common agendas stretch across national boundaries, so individual states cannot focus solely on their own geopolitical issues. Nation states with the ability to deal with transnational challenges will consequently have more influence in international politics. The G8 process encourages the eight political leaders to tackle global issues and at the same time provides incentives for stakeholders outside the G8—in the private sector, NGOs, and international agencies—to find ways to influence what happens inside the G8. This power shift is restructuring the architecture of global health policymaking. The H8 members are seeking to define their own roles in the new architecture. But where this restructuring will lead remains uncertain.

The emergence of global health as foreign policy has contributed to the rising interest of the G8. In March 2007, the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued the Oslo Ministerial Declaration on the "urgent need to broaden the scope of foreign

policy" to include global health. They declared, "Together, we face a number of pressing challenges that require concerted responses and collaborative efforts. We must encourage new ideas, seek and develop new partnerships and mechanisms, and create new paradigms of cooperation."[21] This initiative by foreign ministers on global health calls for new forms of global governance to address health challenges and asserts a set of common values, including the belief that "every country needs a robust and responsive health system." The UK and Japanese governments have embraced the global-health-as-foreign-policy strategy with particular enthusiasm.[22]

Global health and human security

The agenda for global health thus encompasses more than population health; it now intersects with foreign policy, economic development, and human rights and human dignity. Nations ignore these broader dimensions at their own peril. Such people-centered approaches have converged into the concept of human security over the past decade. Human security complements the traditional concept of national security and has been defined as protection of "the vital core of all human lives in ways that enhance human freedoms and human fulfillment,"[23] with particular attention to freedom from want and freedom from fear. Human security is achieved through two kinds of strategies: protection strategies that shield people from critical and pervasive threats, and empowerment strategies that enable people to develop the capacity to cope with difficult situations. This approach has particular relevance for health system strengthening because human security focuses on individuals and communities, represents a demand-driven process, and seeks to promote a comprehensive view of how to improve well-being.

Japan is one of the strongest advocates for human security. This approach provides a context for reframing Japan's postwar pacifism, which is reaching a turning point under a new generation of leaders. Human security provides a conceptual foundation for a renewed Japanese pacifism and a new form of global citizenship. For the past decade, the Japanese government has used global health as an entry point for its policy on human security and given global health high priority on its foreign policy agenda.[24] Within the human security framework, the global health agenda offers a field for developing concrete strategies that can be implemented through both bilateral and multilateral agencies and through G8 processes.[25] The dual strategies embedded in human security—protection and empowerment at the community level—are consistent with the WHO's

renewed commitment to PHC and with Japan's postwar efforts to strengthen its own national health system.

Policy Recommendations for the Toyako Follow-Up

To continue the momentum on health system strengthening created by the Toyako Summit, the Japanese government asked for policy recommendations on how to follow up on the commitments made in Toyako, encouraging the Takemi Working Group and JCIE to launch a new project to explore concrete recommendations. Since its inception, the Takemi Working Group has enjoyed the participation of leaders of diverse sectors in Japan, including the strong continuing involvement of the three relevant government ministries: foreign affairs; health, labor, and welfare; and finance. The project prepared three policy papers on themes highlighted in the Toyako Framework for Action on Global Health: health workforce, health finance, and health information. The project has been conducted outside the formal channels of government agencies as a Track 2 diplomatic effort with the informal participation of Japan's ministries of health, finance, and foreign affairs, plus representatives from H8 agencies, G8 governments, and civil society organizations. This Track 2 strategy provides flexibility for the project organizers to listen to various experts and consider ideas outside the conventional wisdom, while assuring collaboration with key stakeholders. The strategy is designed to identify innovative approaches to health system strengthening that can gain acceptance by the G8 and the relevant implementing agencies.

The chapters—on people, money, and data—address three necessary components of health system strengthening. They cover topics that are important inputs to health systems: managers and policymakers need people, money, and data to make decisions on what a health system should do. At the same time, health information is an output, providing assessments of different health system activities (how money and people are used and what they produce in terms of health outputs and health outcomes). The three components are also related to each other: money is required to hire people; those people work in the health system where they collect, analyze, and interpret health information; and the data are used by people to decide how to spend more money. The chapters' main findings and specific recommendations for G8 action outlined below.

Health workforce

Human resources for health has been a long-standing concern in health planning and management, and there are currently monumental shortages of health workers around the world. But Professor Masamine Jimba, who heads the research team on health workforce, identifies other major challenges beyond the sheer number of health workers, including inadequate payment, motivation, training, and supervision, as well as poor working environments. Professor Jimba also identifies a massively unequal distribution of health workers within and among countries and across specialties and skills. In response, his paper recommends three major actions by the G8 to address these problems:

1 Strengthen the capacity of countries to plan, implement, and evaluate health workforce programs so that they can more effectively use the existing health workforce and implement the G8 commitments
   - 1.1 Develop mechanisms for evaluating health workforce progress at the country level
   - 1.2 Identify ways to change macroeconomic policies to reduce constraints on expanding the health workforce
   - 1.3 Strengthen international networks of higher education institutions to provide access to health and medical education in areas with limited resources

2 Address the demand-side causes of international health worker migration
   - 2.1 Clean their own houses by increasing the number of health workers in their own countries using their own resources
   - 2.2 Support the WHO code of practice to address migration issues
   - 2.3 Seek practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people

3 Conduct an annual review of actions by G8 countries to improve the health workforce
   - 3.1 Assess what the G8 countries are doing, what has worked, and evidence to support this, using a standard set of common measures
   - 3.2 Use this review to evaluate how health systems are performing, to identify gaps in financing and information, to develop evidence-based best practices, and to increase knowledge on how to improve health system performance through strengthening of human resources, as well as to see how well G8 countries are carrying through on what they have pledged to do

Health financing

There are no fully accurate estimates of health financing in developing countries, but recent trends show that external and domestic sources of funding for health have been increasing. Yet, in his chapter on this topic, Dr. Ravindra P. Rannan-Eliya emphasizes that "more money has not necessarily meant better results." Some countries are able to achieve better health system performance with limited financial resources, while others that have made high investments in health have been less successful. This wide variation in country performance provides an opportunity for understanding the conditions under which some health systems work better with limited financing. There is a growing global consensus that public financing represents an important necessary condition, although the form of public financing (i.e., tax financing versus social health insurance) remains a point of debate. Better performance also depends on how the available funds are used and how health system coverage is expanded to hard-to-reach populations. Dr. Rannan-Eliya recommends three major actions by the G8 to address these challenges of financing for health systems in the developing world:

1. Complement efforts on increasing money for health with efforts to improve the value of health spending through support for better country-led health financing and systems policies.
2. Build on the existing consensus among technical experts with an explicit G8 commitment to prioritize support for country health financing policies that place public financing for health, in the form of tax financing and/or social health insurance, at the core of efforts to expand coverage for poor people and vulnerable groups in society.
3. Invest in the ability of developing country partners to make better financing policies. This will require increased investments in building national capacity for health systems policy assessment and in the mechanisms to understand and share the lessons of best practice countries.

Health information

The chapter on health information, written by Professor Kenji Shibuya, identifies two major types of challenges in this area: technical and allocative inefficiencies. In the former, he explains that appropriate data do exist but are not used by policymakers or policy analysts, either because they do not have access to the information or because they do not have the capacity to analyze and

use the data to answer questions about health system performance. Professor Shibuya describes the allocative inefficiency as uncoordinated data collection and compilation without well-defined measurement strategies. To correct these inefficiencies, he recommends three major actions by the G8:

1 Implement a G8 annual review to assess the G8's commitments to health systems and programs
   1.1 Define a standard set of metrics and measurement strategies for monitoring and evaluating aid effectiveness, health programs, and systems
   1.2 Plan and assess future health-related activities by the G8 and its partners using a common framework and metrics
2 Establish a digital commons using a network of global and regional centers of excellence to improve access to—and the quality of—datasets and analyses at the country and global levels
   2.1 Promote the principles of open access and data sharing in the public domain
   2.2 Develop a global databank for common indicators (starting with MDG targets, human resources, and resource tracking) and a data exchange and quality assurance mechanism
   2.3 Establish a Cochrane-type process for global health monitoring to generate empirical evidence for health policy
3 Pool resources for health metrics at the global and country levels to create a Global Health Metrics Challenge
   3.1 Develop capacity and create an incentive structure for countries and data producers to collect, share, analyze, and interpret better-quality data
   3.2 Make health funding contingent upon third-party evaluation that is compliant with agreed principles, including developing a standard measurement strategy, putting data in the public domain, strengthening local capacity, and making appropriate use of information technologies
   3.3 In countries with incomplete or inexistent civil registration, prioritize development of civil registration systems
   3.4 Invest in a series of nationally representative household surveys for multiple diseases and risk factors

Discussion

The three chapters on health workforce, health financing, and health information express several common themes on global health policy. While these three components (people, money, and data) do not constitute a complete model of health system performance, they do represent areas that are high on the global health agenda and are important elements of any model.

First, all three chapters stress the need for the G8 to address the quality of resource use as well as the quantity of resource provision. The authors agree on the need to make more effective use of existing resources (people, money, and data) in addition to the need for more resources from both external and domestic sources. The G8, for example, could promote efforts to identify best practices and the conditions under which existing resources are effectively used to improve health system performance.

Second, all three chapters call on the G8 to enhance country capacity and ownership for health system strengthening. The G8 can help ensure that countries have adequate human and financial resources in order to collect, analyze, and interpret data and evaluate their own health system performance. The G8 can help countries build their capacity to use their health system resources more effectively.

Third, all three chapters agree that the G8 should implement an annual review on global health commitments, with a standard set of common measures to assess how resources are being provided and used to improve health system performance. Japan started the process for an annual review of commitments at the Toyako Summit; this process should be expanded and institutionalized.

Actually strengthening health systems will require the G8 to move from summitry to accountability, and it will require collaboration with H8 organizations and national institutions in both donor and recipient countries. The G8 Summit is a thin body, effective in reviewing critical global problems and setting priorities for global policy agendas. The G8-H8 relationship is still evolving, as is the nature of decision making within the H8 itself. Both entities are informal networks rather than formal institutions. As a result, effective G8 action on health system strengthening will require creativity at the global and national levels and more interactions across levels. The G8 does not have the capacity to become a global health apex institution, but the G8's special leverage can help move health system strengthening forward in new ways.

The specific recommendations, therefore, adopt different strategies on health system strengthening. Some seek to clarify and strengthen existing institutions and frameworks. Others seek to create new entities but without proposing a new

global funding mechanism. We have sought innovative solutions to problems in health systems and attempted to articulate ideas not stated elsewhere, including ideas that may be unpopular or uncomfortable for existing organizations. We seek to provoke creative thinking and action on health system strengthening. Yet we also seek to avoid unnecessary politicization of the global health community, focusing on substantive functions rather than political questions. Another overarching objective of this report is to contribute to strengthening the capacity and clarifying the role of the WHO in the global health architecture.

These activities to follow up on the Toyako Summit declaration mark a concerted effort by Japan and its partners to enhance their substantive contributions to global health policymaking, rather than just providing financial donations. The nature of global problems in many spheres now outruns the capacity of global governance institutions. This institutional gap represents both an opportunity and an obligation for the G8 countries as a new leverage point for global health policymaking. The world has witnessed a remarkable growth in global flows of health workers, health finances, and health data. In our increasingly globalized world of health, the G8 Summit provides a setting for personal engagement by national leaders who can shape policy responses to meet critical problems. This project has identified concrete actions, in the context of the revived approaches of human security and PHC, to be pursued by the G8 nations. These actions will necessarily require collaboration with the H8 organizations, other sympathetic developed and middle-income countries, and recipient countries. We believe that the government of Japan, for its part, should integrate global health more fully into its bilateral and multilateral diplomacy and that it can enhance its diplomacy by working more closely with international civil society networks and encouraging their further development.

The global financial crisis makes it all the more important for the G8 to address health system strengthening and deliver on existing commitments to global health. Fears are rising about potential cutbacks from rich countries in official development assistance as well as private giving to NGOs.[26] But as Prime Minister Gordon Brown of the United Kingdom stated in September 2008, the international community should do more, not less, to help the world's poorest people in this time of economic crisis.[27] The G8 can play a catalytic role in assuring that pledged funds are delivered in ways that create tangible benefits for the world's poorest people. We recommend that the G8 also consider promoting the development of innovative financing mechanisms for health system strengthening. The G8 can also work to protect government budgets for social welfare in developing countries

from being squeezed by the financial crisis, and to avoid a repetition of the cuts that occurred under the structural adjustments and economic turmoil of the 1980s and 1990s.

Notes

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Opportunities for Overcoming the Health Workforce Crisis

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Why Now?

The health workforce—the people who actually deliver clinical and public health services—is a fundamental element of any functioning health system. All countries have to deal with the challenges of ensuring an appropriate supply and distribution of health workers, maintaining adequate levels of training, retaining health professionals, and managing their motivation and performance. However, policymakers in low- and middle-income countries face particular challenges, and there is a dearth of evidence to help guide and support their decisions.[1] For decades, human resources for health (HRH) was neglected by donor agencies and global health initiatives in favor of easier, more targeted areas, such as provision of vaccines and other medical products. Increasing awareness of these many challenges, such as migration, HIV/AIDS, and constraints on scaling up interventions, has underlined the importance of investing in health workforces and helped to move HRH onto the global agenda.

Two major documents successfully defined and helped elevate the role of the health workforce on the global health agenda. First, in 2004, the Joint Learning

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Initiative (JLI) published a monumental work, *Human Resources for Health: Overcoming the Crisis*. The JLI identified three major forces assailing the health workforce: the devastation caused by HIV/AIDS, the acceleration of labor migration, and the legacy of chronic underinvestment in human resources.[2] Second, the World Health Organization (WHO) published its 2006 *World Health Report*, in which it estimates that more than 4 million health workers will be needed to meet the shortfall, including 2.4 million physicians, nurses, and midwives. It also identifies 57 countries as having a critical shortage, and of these, 36 are in sub-Saharan Africa. By calling it a "crisis," the JLI and 2006 *World Health Report* were successful in gaining more attention for the health workforce at the global level. These developments helped to bring about the establishment of the Global Health Workforce Alliance (GHWA) in May 2006, which is directed by the belief that, as the late WHO Director-General J. W. Lee stated, "every person, in every village, everywhere should have access to a skilled, motivated and supported health worker."[3]

However, labeling something a crisis can only accomplish so much. What has done more to put the health workforce on the global agenda is clear evidence that donors are having trouble achieving their program objectives without increasing the number of qualified health workers. This is especially true of HIV/AIDS projects. Not only the disease itself but also its treatment can have detrimental impacts on HRH, where vertical HIV/AIDS programs drain human resources from the rest of the health system, presenting problems both for the existing health system and for scaling up of new initiatives.[4] Additionally, focusing on the numbers alone neglects the more complex issues of distribution of workers within countries, performance of workers, and the poor working conditions that can impact that performance.[5]

To cope with the health workforce crisis, the First Global Forum on Human Resources for Health issued the Kampala Declaration and Agenda for Global Action in 2008, which identified 12 immediate and urgent actions to be taken.[6] Four months later, the world leaders taking part in the Toyako G8 Summit voiced their support for the declaration, making more specific financial and technical commitments for the health workforce than they did for any of the other five building blocks of the WHO health system framework: health services; health information; medical products, vaccines, and technologies; health financing; and leadership and governance.

In the Toyako Framework for Action on Global Health, the following recommendations were proposed as actions to be taken for the health workforce: act as a whole to narrow the gap between existing workforces and what is needed; increase the use of skilled health workers; encourage treat, train, retain

strategies and task shifting; encourage the WHO's work on developing the code of practice; and encourage further development of the GHWA.[7]

As the 2006 *World Health Report* states,"the moment is ripe for political support as problem awareness is expanding, effective solutions are emerging, and various countries are already pioneering interventions."[8] The health workforce is now receiving unprecedented inputs such as funding, technical assistance, and new policy initiatives from various stakeholders. The challenge is making the best use of the inputs to improve outputs and outcomes. Whether this momentum lasts depends on what actions are taken to overcome this challenge.

In this report, we seek to identify the most important and immediate recommendations and actions to be taken by the G8 countries to strengthen the ability of the health workforce to improve the performance of the health system and health outcomes. In order to do this, we first analyze the role of health workforces in strengthening health systems and improving health outcomes. Then we explore the major challenges and opportunities that can be leveraged to strengthen health workforces. Finally, we provide policy recommendations as to what the G8 should do to improve HRH.

Health Workforce and Health Systems: Major Issues

Of the six health system building blocks in the WHO health system framework, there are three input-related blocks: medical products, vaccines, and technologies; health financing; and the health workforce. Of these three, the health workforce is one of the key inputs to drive the health system as a whole; however, we have little knowledge about how health workforce improvement can result in an improved health system. The relationship between the health workforce and health outcomes is just as complex. In this section, we analyze these relations so that we can make better recommendations for action with the objective of creating better outcomes through the use of existing inputs and future increased inputs to the health workforce.

Human resources and health systems

The WHO has emphasized the need to have sufficient numbers of health workers to achieve the basic objectives of the Millennium Development Goals (MDGs). It has suggested that a minimum of 2.3 doctors, nurses, and midwives

per 1,000 people should be a basic numerical target.[9] This target may be useful for advocating greater attention to human resource issues in low-density countries; however, in many countries it is not a realizable objective in the short term given the finances available in the national budgets. For example, in 2006 Ondo State, Nigeria, had 0.71 health workers per 1,000 people with annual wage implications of US$14.3 million out of a total health budget of US$22.6 million.[10] If Ondo State were to reach the WHO's 2.3 target, the annual wage implications would be a staggering US$50.1 million.[11] The target also does not address the issue of developing a workforce with the appropriate mix of skills, especially the use of paraprofessionals and nurses. In addition, it does not address the problem in several countries (for example, Egypt, some states in India, and many former Soviet bloc countries) of over-supply of doctors.[12] It also ignores the other system factors that are necessary for health workforces to be effective.

Human resources are only effective if the system in which they function is able to do the following:

- educate sufficient numbers of adequately trained and appropriate health workers;
- provide sufficient financing for their salaries, supplies, and transportation;
- effectively motivate them and manage their administrative, information, logistics, and supply needs;
- establish appropriate physical infrastructure and delivery models; and
- provide safe working conditions.[13]

In other words, human resource improvements require more than just appropriate numbers of the right types of health workers; improvements are required in how the health system creates and supports health workers and in the political context that is needed to achieve and implement reforms so that they can achieve improvements in health objectives.[14]

In many countries, interventions focus on one aspect of human resources or another, with some degree of success; however, very few take the comprehensive, integrated approach seen in Malawi's Emergency Human Resources Program (EHRP), which can multiply single-issue benefits.[15] An effort to mitigate one of the severest human resources shortages in sub-Saharan Africa, the six-year program focuses on retention, deployment, recruitment, training, and tutor incentives for 11 priority cadres of health workers. The EHRP includes attracting unemployed or retired staff back into service, using expatriate staff to fill gaps temporarily, expanding domestic training capacity, and initiating salary top-ups and in-service incentives (particularly for rural services).[16] The plan

includes strengthening information and monitoring systems, and preliminary results demonstrate that the program is having a positive impact. There is some evidence to suggest a reduction in nurse migration and an increase in medical school applications, potentially due to improved future salaries.[17] This can be seen as a groundbreaking model to link the health workforce to health system strengthening as a whole. The government of Mozambique is similarly trying to undertake a comprehensive approach with its Health Workforce Development Plan for 2008–2015; however, it still needs partners to support and collaborate with the project for it to be successfully implemented.

To improve health workforce management at the country level, the WHO has recently published a guide to strategic planning for human resources. This tool focuses on the health system approach, suggesting indicators for assessing the financing, education, and management components of a health system that are needed to provide for an effective health workforce.[18] It also offers political strategies for gaining sufficient support for reforms designed to improve health workforce effectiveness. In particular, it recommends a careful analysis of the levels of financing available within the country resource envelope, appropriate levels of salary relative to other labor markets, an education system with the ability to provide sufficient qualified graduates in different categories, appropriate management, and system supports for health management information systems and logistics. To provide safe working conditions, the Joint Programme on Workplace Violence in the Health Sector—developed by the International Labour Organization (ILO), the International Council of Nurses (ICN), the WHO, and Population Services International—and the ICN itself have also issued practical guidelines.[19] Such efforts are critical to retaining health workers, particularly in developing countries.

Health workforce and outcomes

As the Toyako Framework for Action on Global Health acknowledges, there is a need for greater evidence to support recommended changes in health systems and the numbers and types of health workers who are needed to achieve improvements in health outcomes. Recent studies suggest an association between higher densities of health workers and both lower maternal and infant mortality rates and higher immunization rates.[20] These aggregate studies are not sufficient for causal analysis and do not account for different health systems and different skill mixes. These cross-country studies also do not take into consideration the distribution of health workers within a country and therefore do not account for

disparities in types of existing health workers, particularly between urban and rural areas. Indicative of the problem is the relative success of some countries with low densities of health workers in successfully moving forward toward achieving the MDGs. For example, data for the 2008 countdown cycle showed that 16 of 68 priority countries (24 percent) were on track to meet MDG 4.[21] Out of those 16 countries, 8 (Bangladesh, Eritrea, Haiti, Indonesia, Lao PDR, Morocco, Nepal, and Peru) are identified as experiencing health workforce crises in the 2006 *World Health Report*. This suggests that a health workforce crisis does not always create a crisis for achievement of the MDG 4 targets. Another example serves to illustrate that it takes more than numbers to improve health outcomes. Nigeria has 1.45 health workers per 1,000 people and Ghana has 0.93, two of the highest numbers in West Africa; however, while Ghana has some of the region's best health indicators, with a maternal mortality ratio (MMR) of 590 and under-five mortality rate (U5MR) of 100, Nigeria's are lagging with an MMR of 1,100 and U5MR of 183.[22]

Clearly, additional studies are necessary to understand the relationship between health outcomes on the one hand and health workforces and health system characteristics on the other. However, it is likely that in countries with low health status, low density of health workers, inadequate supply of low-level health workers, and low levels of financing, we need initiatives to increase an appropriately skilled health workforce and improve the financing, management, and education systems. By understanding these relationships, we can take better action to use health workforce inputs to gain better health outcomes.

Challenges for Health Workforces

While the WHO and the JLI have advocated increasing the numbers of doctors, nurses, and midwives, the challenge involves more than just increasing the number of health workers. Only increasing the number of health workers will not always improve health system performance or health outcomes, and there are broader systemic challenges to improving both the quantity and quality of HRH.

Inappropriate quantity and quality of the existing health workforce

Overcoming shortages: The target of 2.3 health workers for every 1,000 people is unrealistic in many countries while other countries face high

unemployment among certain cadres within the healthcare sector. Nonetheless, there is still clearly a need for increases in specific types of health workers in many low-income countries. Shortages can be caused by a variety of factors, including insufficient pools of high school graduates, lack of medical schools or other training facilities, HIV/AIDS, labor markets, and migration.

The first challenge is in the education system. Some countries do not have a sufficiently large pool of high school graduates to provide applicants to nursing and medical schools, and in many countries there is a deficiency in educational infrastructure to train health workers of the appropriate type and with adequate skills.[23] This is an area where the link between the health and education sectors must be strengthened.

Second, HIV/AIDS presents HRH challenges on multiple levels. HIV treatment increases workloads for health workers, and of the workers themselves are impacted by the disease, which increases sick leave and decreases their numbers.[24] The lack of qualified health workers is increasingly being recognized as a major constraint in scaling up of antiretroviral therapy in many low-income countries with high burdens of HIV/AIDS.[25] In addition, there is growing fear that the demand for increases in health workers for HIV/AIDS programs is shifting staff from other priority programs, suggesting a need for a comprehensive approach to addressing human resource needs.

Third, the market for human resources is often influenced by a range of political, economic, and social factors. Supply and demand of HRH is shaped not just by health needs and the number of workers trained but also by current wages and working conditions relative to other occupations. Shortages can result when governments lack the budgetary resources to hire workers at a competitive salary and provide them with the supplies and working conditions necessary for them to perform their jobs. To ensure that health workers actually work in the health field may require an increase in incentives to retain them and to improve equity of distribution, especially in rural areas.[26]

Finally, global market demand for HRH can lead to migration from countries that already have severe worker shortages to wealthier countries with higher wages and better working conditions. This issue of migration is discussed below, as it is one of major focuses of this chapter.

IMPROVING SKILLS OF APPROPRIATE HEALTH WORKERS: In addition to a deficiency in the number of health workers, the quality of key service providers is still lacking, especially in areas needed to address the MDGs. Continuing professional education is crucial to providing quality care, but recent studies have indicated that health workers in developing countries may

be particularly vulnerable to unequal distribution of continuing professional education opportunities due to small budgets, rural location, and biased selection processes. This unequal distribution can contribute to unequal quality of care and lower morale.[27]

In order to achieve health outcomes, such as the MDGs—particularly MDG 5—health workers require additional skills and supplies that are often not available, especially in rural areas. Higher-level health professionals, such as doctors, take longer and are more costly to train, and many resist rural postings. Lack of emergency obstetric care and blood banks in remote areas contributes to high levels of maternal and infant mortality. General physicians and paraprofessionals often do not have the obstetric skills necessary and, therefore, apparent access to services is not effective. One solution for this has been to train health workers who would otherwise be considered auxiliary to perform other tasks, from primary care to major surgery.

Task shifting from doctors, nurses, and pharmacists to assistants has met with some resistance from professional groups and with concerns about quality and safety.[28] However, several trials with community health workers have shown substantial reductions in child mortality.[29] In a more extreme example, clinical officers in Malawi and técnicos de cirurgia in Mozambique are able to perform caesarian sections. Studies in these two cases found no substantial difference in outcome between surgeries performed by doctors and those carried out by surgically trained non-doctors.[30] This kind of task shifting may be a short-term solution, but what is less clear is if it will prove to be an effective long-term solution. It may be necessary to reevaluate the skills and tasks assigned for each level of health worker to best fit the needs of each country and context.

More examples of effective use of community health workers are given in the 2008 *World Health Report*, in which the primary healthcare approach is reappraised. Examples include Malaysia's scaling up of 11 priority cadres of workers, Ethiopia's training of 30,000 health extension workers (HEW), Zambia's incentives to health workers to serve in rural areas, and the 80,000 Lady Health Workers in Pakistan. Of them, Ethiopia's innovative actions are unique in transferring responsibilities to community health workers. The Ministry of Health in Ethiopia launched the Health Extension Program (HEP) in 2003. The HEP is an innovative community-based program that aims to make essential health services available at the grassroots level. Its target is to train 30,000 HEW by 2009. The HEP is designed to provide services at the community level covering 16 health extension packages categorized under three major areas: disease prevention and control (i.e., HIV/AIDS, sexually transmitted infections, tuberculosis, and malaria); family health services; and

hygiene and environmental sanitation.[31] As of January 2008, a total of 24,000 HEW had been trained and deployed to communities.[32]

Using an example from Uganda, where HIV/AIDS requires a large amount of human resources, community health workers have taken on the responsibility of nurses in delivering HIV/AIDS services, while nurses have taken on that of doctors. This is said to have relieved the country's burden due to the health worker shortage to some extent.[33] In Tanzania, the lowest level skilled workers have taken on roles in achieving the MDGs. A case study of expanding priority interventions in Tanzania claims that a considerable number of tasks could be delivered by occupational categories with lower skill levels or other individuals at the community level.[34] For instance, drugstore staff might be authorized to dispense drugs for common conditions such as malaria.[35]

Overcoming macroeconomic policy constraints

Many of the above challenges are the result of the broader need for strategic planning for human resources and increased health system strengthening. Low salary levels, as well as inadequate management skills and key management systems (e.g., logistics, management information systems), are common systemic issues that need strengthening. As described above, low salaries can make it a challenge to hire and retain qualified health workers. In some countries, government spending on health workers' pay has been constrained by macroeconomic factors, such as the recruitment freezes and limits on the public sector wage bill that were often part of structural adjustment programs imposed as a condition of loans from the World Bank. In many countries, the macroeconomic policies do not allow governments to pay the salary levels that would retain health workers.[36] The Kampala Declaration and Agenda for Global Action takes up this issue and suggests that financial institutions take actions such as "country-specific analysis of macroeconomic conditions that impact wage ceilings, health spending, and constrain civil service hiring arrangements necessary for meeting established priority needs in the health sector."[37] It is important that dialogue between governments and institutions such as the World Bank and the International Monetary Fund (IMF) take into consideration the need to scale up the health workforce while ensuring that prospects for overall economic growth and long-term fiscal sustainability are maintained. The main problem, at this stage, is the total lack of transparency. The IMF and the World Bank talk about "fiscal space constraints," but nobody knows how they are estimated or applied.

Improving country capacity

As the JLI report states, country-led strategies constitute the primary engine for driving workforce development.[38] Country strategies have five key dimensions: 1) engaging leaders and stakeholders, 2) planning human investments, 3) managing for performance, 4) developing enabling policies, and 5) learning for improvement. Developing countries, alone or in collaboration, must strengthen their capacity for strategic planning, management, and policy development, but most low-density-high-mortality countries lack the capacity to do it alone.

As countries' roles are so crucial, the Kampala Declaration identified seven actions for them to take. However, the actions suggested in the declaration are for what each country *should* do, which is not the same as what each country *can* do. In most low-density-high-mortality countries, lack of capacity to carry out these seven actions will mean that little progress will take place. Each country should be better able to cary out these actions if they are supported by local or international consultants.

For example, in one low-income country in Southeast Asia, the Department of Personnel and Organization in the Ministry of Health made a draft strategic framework and implementation plan for the development of HRH in October 2007, assisted by the local WHO office. However, one year later, the draft remained a draft. The Japan International Cooperation Agency has tried to launch a skilled birth attendant program in the country, but because the implementation plan has not been finalized, the program is stuck in the planning stage. This case shows that, due to a lack of capacity in making decisions and in implementation, a "strategic framework and implementation plan" made little progress for more than a year. The same may happen in many low-income-high-mortality countries in Africa as well.

This example also suggests that only making a declaration or giving recommendations is not enough. There needs to be much more attention given to building capacity and converting good program design or good planning into actual programs. Even sending short-term experts in health systems may have limited utility. What is needed is a facilitator to move the actions forward for a sufficient period of time. This facilitation work is not the role of the G8. However, the G8 can contribute by proposing the formation of a framework to make it happen. As we saw in the Kampala Declaration, it is easy to understand what each country *should* do, but the understanding of what each country *can* do is more difficult. Each action needs midwifery support. Each country's ability to undertake these actions will emerge step by step as a

result of supporting efforts by locally available consultants, whether they are local or international.

To strengthen country capacity for health workforce management, the ILO's "social dialogue" approach may be useful. This approach includes negotiation and consultation, starting with the exchange of information between and among representatives of governments, employers, and workers on issues of common interest relating to economic and social policy.[39] This is one of the existing midwifery methods that facilitators may consider adopting, as its role is now widely recognized in advancing and sustaining reform processes in many areas of the health sector, thus improving healthcare and mitigating any negative impact on public health. An example of its implementation can be seen in Ghana, where social dialogue was initiated in 2002. For instance, to address retention and brain drain issues in the country, representatives of the government, employers, regulatory bodies, the private sector, training institutes, hospitals, and labor groups were brought together. The social dialogue involved bargaining and negotiations for incentives to retain healthcare workers, such as offering better working conditions and creating a committee for distribution of cars. As a result, tangible incentives were offered, including allowances for additional duty hours and cars for health workers.[40]

Tackling migration of human resources

Health workforce issues should be looked at not only within a single country's health system but also through the broader global lens of the international labor market. In an ideal world, the level of HRH would be determined by what is needed to maintain or improve the health status of the population. In reality, the market for human resources is often influenced by a range of political, economic, and social factors. Supply and demand of HRH is shaped not just by health needs and the number of workers trained but also by current wages and working conditions relative to other occupations.[41] A major concern in African and Asian countries is the migration of health workers to higher wage countries. Migration produces significant strains on the health system of many countries, often by taking away the more skilled workers in any category, producing shortages in specific categories and specialties and requiring increased production of health workers.[42] There are financial strains as well, as countries invest in training new health workers only to have these workers migrate. It has been estimated that Ghana alone has lost at least £35 million of

its training investment, while the UK has saved £65 million in training since 1998 by recruiting from Ghana.[43]

Health worker mobility is influenced by a range of "push" and "pull" factors. Deficiencies in the human resources components of a health system, such as training, appropriate staffing, competitive salaries, effective management, and safe working conditions, all serve to push health workers toward migration. Pulling workers toward the destination countries are opportunities for professional development, better wages, improved working conditions, and higher standards of living.[44] Ultimately, migration is driven by a shortage of workers in middle-income and wealthy countries and is likely to continue until destination countries address their own underlying causes of health worker shortages. Some of these causes include aging populations, feminization of the workforce, caps on enrollment in training programs (physicians), and periods of pay depression leading to a decline in enrollment in training programs (nurses).[45] While in the UK efforts to expand medical school output and change immigration policy have resulted in a surplus of applicants over available post-graduate training opportunities, in the United States inaccurate predictions of physician surplus have led to policies that will result in even greater shortages.[46] Both developed and developing countries need to establish policies to manage migration by improving data collection to facilitate good workforce planning, providing financial and non-financial incentives to encourage worker retention, and making agreements between countries to encourage professional development and exchange while limiting the possible detrimental effects of losing workers.[47] These efforts should be made to "anchor" health workers to resist the push and pull factors, particularly in low-income countries.

There is some evidence that migration may have a positive economic effect by providing remittances back to the supply countries.[48] Recent studies assessing the impacts of migration on availability of health workers and health status indicators have not found a negative association, suggesting that there is insufficient understanding of the impact of human resources supply on health systems and health outcomes.[49] This positive aspect of migration makes the migration issue more complex and urges us to deal with the health workforce issue not only as part of the health system but also as part of the lives of people in the low- and middle-income countries.

However, while there are significant gaps in knowledge about the causes and effects of migration, health system reforms designed to increase retention and reduce incentives to migrate—especially of the more skilled workers—should be promoted.

Facilitating donor coordination

Lack of coordination among donors and "bandwagoning" of donors all ganging up on one problem presents a more complex challenge to HRH. In 2008, the Global Economic Governance Program at Oxford University brought together a group of current and former health ministers and senior health officials from developing countries to discuss gaps and challenges they face in dealing with current global health financing and governance arrangements. According to their report, "a constant deluge of new initiatives, focusing on specific diseases or issues, makes it extremely difficult for governments to develop and implement sound national health plans for their countries."[50] In other words, donors frequently shift their attention from one "fashion" to the next without regard to continuity or sustainability. The report also detailed widespread views that the inclination of donors to repeatedly create new initiatives, such as the parallel priorities and delivery of care by donors, weakens national strategies.[51] This difficulty was exacerbated by the absence of transparency among donors and restricted awareness by health ministries about where donors were directing funds. As one minister said about donors, "they like to monitor activities, but they do not like to be monitored and evaluated."[52]

Sridhar and Batniji argue that "the global health community should now move toward incorporating the concept of ownership into health assistance and realizing the principles of the Paris Declaration. Without systematic attention to the articulated needs of developing countries through consultation and real partnership, donors for global health will not achieve informed and inclusive decision making."[53] It is true that such incorporation of country leadership is inevitable, but not all countries have the capacity to perform the task.

The G8 has claimed that "acting as a whole" is important. Acting as a whole means acting together between donor agencies and recipient countries, but it also means the UN agencies, NGOs, and other civil society organizations acting together. However, in this context, it is crucial that the G8 countries first act as a whole. In a sense, this has been achieved by their funding for UN agencies; the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); and other global health initiatives. In addition to the WHO and other UN agencies, each bilateral agency has a project office in most countries. Documents show that it is only the UK and the United States that are currently working together to achieve a common goal of health workforce strengthening. The UK and the United States are working together to strengthen the health workforce in Ethiopia, Kenya, Mozambique, and Zambia, but they are not coordinating with other countries in the same way. Bilateral and multilateral support do not

orchestrate common action even if they might have a common goal. Although each country has committed to overcoming the health workforce crisis together, no strong mechanism exists to allow all of them to work together at both the global and country level. Changes are needed to increase complementarity, avoid duplicated efforts, and ensure communications and transparency among donor agencies.

Opportunities for Improving the Health Workforce

Although there is not yet a cooperative force that works together toward a certain goal, and each country has its own agenda, there are currently many resources that can be utilized for health workforce strengthening. These resources include recommendations and guidelines from different health organizations; country commitments, particularly those from G8 countries; several global health initiatives; the GHWA; and the human security approach. This section intends to provide an overview of these resources and their overlapping, yet independent, inputs that can be synthesized into a valuable driving force to propel us toward better solutions to the current health workforce crisis.

Recommendations and guidelines (see Annex 3)

Several organizations have published documents and codes that provide guidelines and recommendations targeting different topics and challenges for the health workforce crisis. In addressing potential negative impacts of health worker migration from developing countries to developed countries with higher salaries, the WHO is in the process of publishing a *Code of Practice on International Recruitment of Health Personnel.* The first draft was reviewed throughout September 2008. It provides ethical guidelines and principles for international recruitment by developed countries, while also acknowledging the basic rights of health workers. The code is said to be the first of its kind on a global scale for migration. Although it is not legally binding, the recommendations in the code can serve as powerful suggested "rules of the game" for countries' policy development on international recruitment of health workers.

The WHO published the report *Task Shifting—Global Recommendations and Guidelines* to propose an option for relieving the shortage of health professionals

in regions that have low health professional densities and high mortality rates by using trained paraprofessionals. It is an alternative consideration for some applicable countries that do not have sufficient human resource capacity yet wish to seek short-term relief for their health workforce crisis. Additionally, the GHWA and the WHO published *Scaling Up, Saving Lives* to address the shortage of health workers by drawing up proposals for scaling up education and training of health workers. Finally, the Kampala Declaration and Agenda for Global Action called on governments to commit to its proposed strategies to work as a whole in solving the health workforce crisis.

It is impossible for governments, donors, and facilitators to act as a whole without a set of "common denominators." These guidelines and policies from authoritative organizations, such as the WHO, provide an opportunity to improve policies for strengthening health systems, particularly human resources.

G8 political commitments (see Annex 1)

During the Fourth Tokyo International Conference on African Development in May 2008 and the Toyako G8 Summit in July 2008, Japan committed to helping increase and enhance the quality and quantity of HRH for 26 countries in Africa in order to increase health workforce coverage and fulfill the pledge of training 100,000 health workers. Later in July 2008, the United States added a human resources component to the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR II), committing to a target of training and retention of at least 140,000 healthcare professionals and paraprofessionals. In September 2008, during the UN High Level Meeting on MDGs, the prime minister of the UK pledged to spend an estimated £450 million over the next three years to support national health plans for eight International Health Partnership countries, which would include the increased training of health workers. Although these commitments do not fill the gap in health workforce needs at the global level, they offer great opportunities to show how increasing inputs can produce output and outcomes. Success in these efforts could be leveraged to trigger more inputs in the coming years.

Global health initiatives

Global health initiatives such as the Global Fund, PEPFAR, and the Clinton Foundation provide assessment, financial, and technical assistance to tackle

various health challenges in developing countries. Although most of the funds are used to control specific diseases such as HIV/AIDS, malaria, and tuberculosis, the funds have also begun to be used for strengthening health systems. The global initiatives may have their own targets, but they all have a common understanding of the importance of strengthening health systems with respect to HRH. The detailed actions and commitments from these organizations are outlined in Annex 2.

In addition to financial assistance, by expanding the health workforce, these global initiatives are helping target countries build their capacity to strengthen health systems as one of the side effects of their activities. For example, the Clinton Foundation, whose objectives vary from fighting HIV/AIDS to supporting HRH programs, focused in its annual meeting in September 2008 on efforts to train and manage the largest expansion of health workers in history to improve global health. In addition, PEPFAR committed to funding and training a considerable number of healthcare professionals and paraprofessionals in 15 developing countries as part of its HIV/AIDS initiative. Furthermore, the Clinton Foundation and the US Agency for International Development (USAID) even provide all-around assistance in some areas that include not only financial and technical assistance but also assessments and analytical support.

Global Health Workforce Alliance

G8 countries themselves can act as a whole much better if an innovative mechanism is created. The GHWA has the potential to take on such a task at the global level, but it needs more powerful mechanisms to work at the country level. At the global level, all of the G8 countries except Japan support the GHWA, although Japan is also becoming a member. The GHWA operates in two strategic directions: accelerating action in individual countries and addressing global constraints that impede country-level action. In its two-year lifespan, the GHWA has developed programs and guidelines that enable countries to plan and manage health workforce issues. Task forces have been set up to advise on advocacy, workforce education, training, management, migration and retention of staff, universal access to HIV prevention and treatment, and the role of the private sector.[54] Although the GHWA is trying to accelerate actions at the country level, it may face implementation difficulties as it does not have country offices. The WHO's country offices might support its work, but health workforce or health systems experts are not always available in all

of the WHO offices. The opportunities that the GHWA can offer should be used more practically.

Taking a human security approach to overcoming the health system crisis

The health workforce crisis is not only a crisis of health workers but also of health systems, particularly among low-density-high-mortality countries. In these countries, more than one building block is not functioning appropriately, and these blocks are synergistically worsening the health system as a whole. As a result, most of these countries have shown little progress in achieving the health-related MDGs.

According to data compiled by the MDG monitor, 52 low- and middle-income countries are off track on MDGs 4 and 5. Most of these countries are low-density-high-mortality countries, which have shown little improvement in health outcomes over the years. Under such conditions, just increasing the density of health workers will improve neither health system performance nor health outcomes. We may need a health system repair package program, similar to a comprehensive humanitarian support package, that includes a basic package of systems interventions. Malawi's EHRP is one such example.[55] The Capacity Project by USAID is also similar to this approach, and it may be a better option in some countries. Another potential strategy is what has come to be known as the human security approach.

Over the past 15 years, the concept of security has moved beyond a focus solely on the security of nations to include a focus on the security of individuals and communities. To support them, the human security approach covers economic, food, health, environmental, personal, community, and political security. The human security approach has the potential to contribute to improved health for several reasons. First, as a human-centered approach, human security focuses on the actual needs of a community, as identified by the community. Second, human security highlights people's vulnerability and aims to help them to build resilience to current and future threats and to help them to create an environment in which they can protect their own and their family's health even in the face of other challenges. Third, human security aims to strengthen the interface between protection and empowerment. In the context of public health, a protection approach aims to strengthen institutions in a society to prevent, monitor, and anticipate health threats. On the other hand, an empowerment approach aims to enhance the capacity of individuals and communities to assume responsibility for their own health. Human security also looks at the

interface between these two approaches and encourages those with political and economic power to create an enabling environment for individuals and communities to have more control over their own health.[56]

The last aspect of the human security approach is similar to one of primary healthcare reform, namely "public policy reforms to promote and protect the health of communities."[57] The other three sets of primary healthcare reforms—"universal coverage reforms to improve health equity,""service delivery reforms to make health systems people-centered," and "leadership reforms to make health authorities more reliable"—are also closely related to the human security approach, as they all put focus on individuals and communities.

Although the momentum of global health is still strong, such momentum has not sufficiently benefited people living in most low-density-high-mortality countries. Now is the time to achieve a breakthrough for these countries. The human security approach has the potential to overcome this challenge.

Policy recommendations

To take advantage of the opportunities, the G8 should take the following actions:

1) Strengthen the capacity of countries to plan, implement, and evaluate health workforce programs so that they can more effectively use the existing health workforce and G8 commitments
   a) Develop evaluation mechanisms for health workforce progress at the country level
   b) Identify ways to change macroeconomic policies to reduce constraints on expanding the health workforce
   c) Strengthen international networks of higher education institutions to provide access to health and medical education in areas with limited resources
2) Address the demand-side causes of international health worker migration
   a) Clean their own houses and increase the number of health workers in their own countries using their own resources
   b) Support the WHO code of practice to address migration issues
   c) Seek practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people

3) Conduct an annual review of actions by G8 countries to improve the health workforce
   a) Assess what the G8 countries are doing, what has worked, and evidence to support this, using a standard set of common measures
   b) Use this review to evaluate how health systems are performing, identify gaps in financing and information, develop evidence-based best practices, and increase knowledge on how to improve health system performance through strengthening of human resources, as well as on how well G8 countries are following through on what they have pledged to do

Annex 1: G8 Commitments

Country	Target	Type of Assistance	Details	Other health system support
Japan	26 African countries	Training of 100,000 health workers	• Supports increasing/enhancing the quality and quantity of HRH	
Italy	African countries	Human resource development and financial assistance	• Supports health system and human resource development in collaboration with NGOs • Major investments often in the form of sector budget support in 6 African countries	
Canada	Mozambique, Mali, Tanzania, Zambia, Nigeria, Ethiopia, Malawi, Niger, and Ghana	Financial assistance	• Supports the implementation of national health sector strategic plans, which enables it to recruit, train, and retain additional health workers at all levels of their health systems and to expand coverage of front-line health services for their populations	
France	20 African and 3 Asian countries	Human capacity development and financial support	• Trains people in developing countries in health • Makes annual contribution of €300 million to the Global Fund (See Global Fund in Annex 2)	
US	Ethiopia, Kenya, Mozambique, and Zambia	Assessment	• Identifies best way to maximize support to strengthen human resources and health systems	USAID works with governments to expand the reach and improve the quality of care of community-based health insurance and supports development of pharmaceutical management systems in more than 20 countries

UK	Ethiopia, Kenya, Mozambique, and Zambia	Financial assistance	• Plans to spend at least US$420 million on health, including health workforce, over the next three years	
Russia	4 African countries	Training and education	• Trains and provides education to support strategies to control malaria and a framework for a debt-relief initiative	
Germany	7 African countries	Human capacity development	• Health worker–related programs: assists with reintegration upon return to home country after training in Germany	Spends €500 million annually to fight HIV, malaria, and tuberculosis and to strengthen health systems

Reference:

G8 Health Experts Group, *Toyako Framework for Action on Global Health—Report of the G8 Health Experts Group*, http://www.g8summit.go.jp/doc/pdf/0708_09_en.pdf.

Annex 2: Existing Health Workforce Strengthening Resources from Global Health Initiative

Organization	Target	Type of Assistance	Details	Other
Global Fund	Fight HIV/AIDS, tuberculosis, and malaria	Financial assistance: international health financing	• Committed US$11.3 billion in 126 countries to date, 23 percent for human resources and 9 percent on infrastructure and equipment	57 percent of the approved funding was contributed to Africa
World Bank	Developing countries	Financial and technical assistance	• Provides low-interest loans, interest-free credit, and grants • Invests in education, health, public administration, infrastructure, financial and private sector development, agriculture, and environmental and natural resource management in developing countries	
PEPFAR	15 countries: Botswana, Ethiopia, Haiti, Mozambique, Nigeria, South Africa, Uganda, Zambia, Côte d'Ivoire, Guyana, Kenya, Namibia, Rwanda, Tanzania, and Vietnam	Financial assistance	• Estimate investment of US$309 million for training health workers in 2008 • Plans to support 2.7 million trainings to target training and retaining of 140,000	Heaviest focus is on HIV/AIDS-related actions; however the sideways approaches also benefit health workforce strengthening
Clinton Foundation, Clinton Global Initiatives (CGI)	In partnership with 10 African countries for HRH programs	Health system assessments and financial assistance through fund raising	• Interventions include training, clinical mentoring, recruiting, capacity building, and curriculum development	Clinton HIV/AIDS Initiative works with markets and governments to make treatments more accessible in the developing world

DFID	6 African countries, Cambodia, and Nepal	Financial assistance	• Invests £450 million over the next three years to support national health plans, incorporating training of more nurses, midwives, and doctors	
USAID Capacity Project	Developing countries; build and sustain the health workforce (Latin America, Africa, Eastern Europe, and Asia)	Assessment, financial, and technical support Global leadership; generating, organizing, and communicating knowledge about HRH Provides country-level support to implement effective and sustainable HRH programs	• Supports improved workforce planning and leadership • Assists in developing better education and training programs • Assists in strengthening systems to support workforce performance • Encourages health workers to remain at their posts	Participated in the development of the HRH Action Framework, published in the 2006 *World Health Report*

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Annex 3: Existing recommendations

Code of Practice on International Recruitment of Health Personnel

Upon recognizing the significance of migration of health workers for health systems, the World Health Assembly adopted resolution WHA57.19, which called for the development of a Code of Practice on the International Recruitment of Health Personnel. Web-based public hearings on the first draft code of practice were held by the WHO on September 1–30, 2008. Those who were invited to contribute to the hearing included member states, health workers, recruiters, employers, academic and research institutions, health professional organizations, and relevant sub-regional, regional, and international organizations. The initiative provided all members concerned with international recruitment of health personnel an opportunity to comment on the draft. Input has been received and published on the WHO website.

Objectives of the code

The code of practice has four main objectives:

1. Establish and promote voluntary principles, standards, and practices for the international recruitment of health personnel
2. Serve as an instrument of reference to help member states establish or improve the legal and institutional framework required for the international recruitment of health personnel and in the formulation and implementation of appropriate measures
3. Provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments, both binding and voluntary
4. Facilitate and promote international discussion and advance cooperation on matters related to the international recruitment of health personnel

Key elements of the code

The key elements of the first draft of the Code of Practice on International Recruitment of Health Personnel can be summarized into five categories: ethical and fair recruitment, partnership and mutuality of benefits, safeguarding the health workforce, monitoring of international health worker migration flows, and accession to and withdrawal from the code.

Although it is not legally binding, the framework is anticipated to promote ethical recruitment, the protection of migrant health workers' rights, and remedies for addressing the economic and social impact of health worker migration in developing countries. While several other codes of practice for the international recruitment of healthcare professionals already exist on a regional level, the WHO Code of Practice is expected be the first of its kind on a global scale for migration (WHO 2007, WHO 2008).

Source:
Resolution WHA 57.19
http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf
WHO Code of Practice on International Recruitment of Health Personnel
http://www.who.int/bulletin/volumes/86/10/08-058578.pdf
Summary of comments on the code of practice
http://www.who.int/hrh/public_hearing/comments/en/print.html

Kampala Declaration and Agenda for Global Action

Endorsed by the participants of the first Global Forum on Human Resources for Health, held in Kampala, Uganda, on March 6, 2008, the Kampala Declaration and Agenda for Global Action serves to bring global attention to the worsening health worker crisis.

The contents of the Kampala Declaration consist of 12 elements calling upon:

1. government leaders to provide the stewardship to resolve the health worker crisis, involving all relevant stakeholders and providing political momentum to the process;
2. leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans;
3. governments to determine the appropriate health workforce skill mix and to institute coordinated policies, including through public-private partnerships, for an immediate, massive scale-up of community and mid-level health workers, while also addressing the need for more highly trained and specialized staff;
4. governments to devise rigorous accreditation systems for health worker education and training, complemented by stringent regulatory frameworks developed in close cooperation with health workers and their professional organizations;

5. governments, civil society, the private sector, and professional organizations to strengthen leadership and management capacity at all levels;
6. governments to assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of the health workers;
7. while acknowledging that migration of health workers is a reality and has both positive and negative impacts, countries to put appropriate mechanisms in place to shape the health workforce market in favor of retention. The WHO will accelerate negotiations for a code of practice on the international recruitment of health personnel;
8. all countries to work collectively to address current and anticipated global health workforce shortages. Richer countries will give high priority and adequate funding to train and recruit sufficient health personnel from within their own countries;
9. governments to increase their own financing of the health workforce, with international institutions relaxing the macro-economic constraints on their doing so;
10. multilateral and bilateral development partners to provide dependable, sustained, and adequate financial support and immediately to fulfill existing pledges concerning health and development;
11. countries to create health workforce information systems, to improve research, and to develop capacity for data management in order to institutionalize evidence-based decision making and enhance shared learning; and
12. the GHWA to monitor the implementation of this Kampala Declaration and Agenda for Global Action and to re-convene this forum in two years' time to report and evaluate progress.

Besides the Kampala Declaration, the Kampala Agenda for Global Action proposed six fundamental and interconnected strategies that intend to translate political will, commitments, leadership, and partnership into effective actions in addressing the health workforce crisis:

1. Building coherent national and global leadership for health workforce solutions;
2. Ensuring capacity for an informed response based on evidence and joint learning;
3. Scaling up health worker education and training;
4. Retaining an effective, responsive, and equitably distributed health workforce;

5. Managing the pressures of the international health workforce market and its impact on migration; and
6. Securing additional and more productive investment in the health workforce.

Source:
Kampala Declaration and Agenda for Global Action:
http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf

Task shifting to tackle health worker shortage: global recommendation and guidelines

The WHO, together with PEPFAR and UNAIDS, has developed global guidelines for task shifting. These guidelines were formally launched during the first ever Global Conference on Task Shifting held in Addis Ababa on January 8–10, 2008. The conference convened health ministers and other senior government officials, opinion leaders, United Nations agencies, and NGOs from both industrialized and resource-constrained countries, and, concluded with an endorsement of the Addis Ababa Declaration on Task Shifting.

Task shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving healthcare coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programs are expanded.

Example: task shifting in Uganda

In Uganda, task shifting is already the basis for providing antiretroviral therapy. With only one doctor for every 22,000 patients and an overall health worker deficit of up to 80 percent, Uganda is making a virtue of necessity. Uganda's nurses are now undertaking a range of tasks that were formerly the responsibility of doctors. In turn, tasks that were formerly the responsibility of nurses have been shifted to community health workers, who have training but not professional qualifications. As part of the approach, Uganda has expanded its human resources for delivering HIV and AIDS services by creating a range of non-professional types of healthcare

workers. These people receive specific training for the tasks they are asked to perform.

Source:
Addis Ababa Declaration on Task Shifting
http://www.who.int/entity/healthsystems/task_shifting/Addis_Declaration_EN.pdf

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Strengthening Health Financing in Partner Developing Countries

*Ravindra P. Rannan-Eliya**

The Health Challenges Confronting Developing Countries

Three serious health challenges confront developing countries and require health to remain a core issue in global development: 1) many partner developing countries are not making adequate progress toward the health-related Millennium Development Goals (MDGs), 2) large gaps in social health protection make a major contribution to impoverishment in many countries, and 3) deficiencies in health systems increasingly impair human security not only in partner developing countries but also in middle- and high-income countries.

The centrality of health in the development agenda is reflected in the fact that three of the eight MDGs are health related (MDGs 4, 5, and 6) and that G8 members have made substantial commitments in previous meetings. Nevertheless, while substantial progress is being made toward most MDGs, the most serious shortfalls that have emerged are clearly in human development and health.[1] Despite substantial progress toward the disease-focused MDG 6

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(HIV/AIDS, malaria, and other diseases), much of the developing world is off track to achieve the more general, and ultimately more important, MDGs 4 and 5 (child and maternal mortality respectively). In sub-Saharan Africa and South Asia, most people live in countries that are actually doing worse in terms of progress than before the 1990s, despite the MDG commitments.[2] Improving progress toward the health-related MDGs will require substantial increases in access to services and the performance of health systems, which is simply not possible until more effective financing policies are established in partner developing countries.

The past decade has seen growing evidence that households are likely to be confronted with catastrophic expenses when they are forced to pay out-of-pocket for healthcare. Globally, more than 100 million people each year fall into poverty because of the cost of medical treatment,[3] exacerbating and perpetuating poverty in the poorest countries. Health-related expenses remain the most important reason for households being pushed back below the poverty line, even in some of the fast-growing countries of Asia, such as China, Vietnam, and Bangladesh.[4]

The recent increased awareness of the need to improve financial risk protection from catastrophic health expenditures has forged a convergence between the previously separate agendas for health and social protection. It places the issue of health coverage directly within Japan's guiding framework of human security, and it coincides with the joint interests of EU member states to make social health protection a second pillar in EU strategies to strengthen health systems.[5] At the same time, moving toward social health protection is central to the World Health Organization's (WHO) renewed emphasis on the primary healthcare approach to strengthening health systems.[6] This shift in attention to the social protection aspects of health policy also marks an alignment in global health policy with core motivations of social protection and solidarity that have always guided health financing in the G8 nations themselves.

Alongside these developments, the growing interconnectedness of G8 members and partner developing countries as a result of globalization forces a broader view of human security that takes into account emerging transnational threats to health. With the poorest economies often being the likely foci of future pandemics,[7] as well as presenting new risks to global food and supply chains,[8] the G8 countries have a keen interest in ensuring that partner countries adequately and effectively finance core public health functions in their health systems.

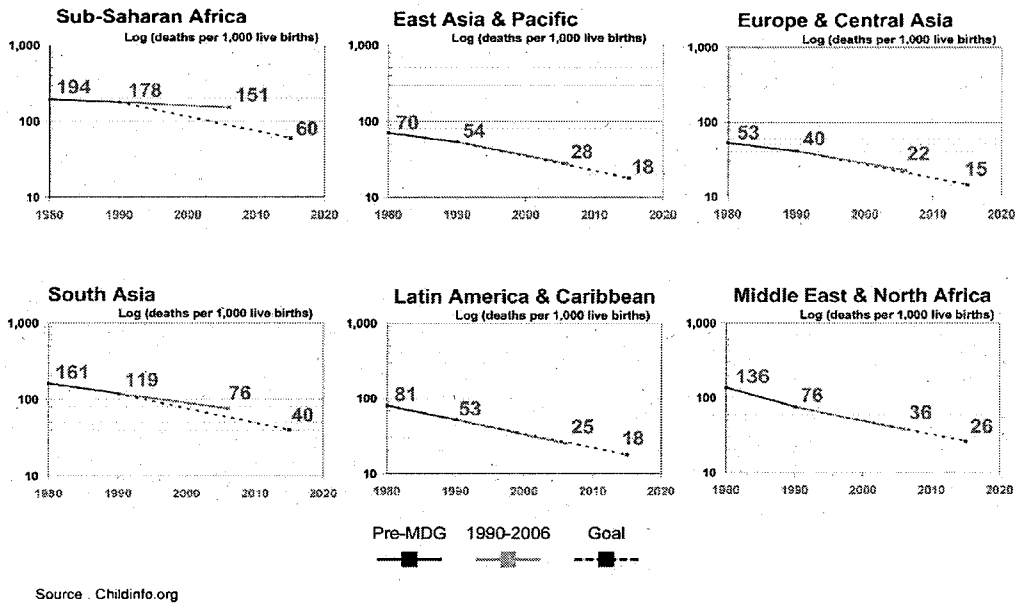
What Drives these Problems?

Progress to date

The G8 has responded to the health-related MDGs in the past decade by committing significant new resources for health sectors in developing countries. Since the 2002 Monterey Summit, external financing flows for health have been scaled up from both official partners and private sources, especially for HIV/AIDS and maternal and child health.[9] Partner developing countries have also increased domestic financing, with significant increases in Africa achieved through a mix of fiscal expansions and increased prioritization of health in government budgets.[10] Indeed, as Dr. Margaret Chan, the head of the WHO, observes, "health has never before seen such wealth."[11]

Yet, despite this scaling up of both external aid and domestic financing, rates of progress toward attaining MDGs 4 and 5 have not significantly changed, especially in the most critical regions of sub-Saharan Africa and South Asia,[12] where the recent data suggest even a slowing of progress in the years since 1990 (fig. 1).[13] In no developing region has performance dramatically improved. Money alone has proved sufficient neither to achieve better health gains, nor to reduce impoverishment from catastrophic medical bills.

Figure 1: Progress toward MDG 4 by region, 1980–2006[14]



Source . Childinfo.org

Key reasons

There are several reasons why partner developing countries have often failed to improve progress toward health goals or social protection. In failed states, the explanation is undoubtedly the lack of any functioning health system and the general disruption of normal life. In these conditions, where we may have to accept that attaining the MDGs is not feasible, the only effective response will often be external humanitarian assistance, including donor-led delivery interventions.

In the case of other developing countries, the critical problems lie at the level of the health system for the most part and require concerted policies and action by and with partner developing countries. It is no coincidence that the greatest lags in progress occur with those MDGs—4 and 5—that require improvements at a broad level across the whole health system and which are not as susceptible to disease-focused interventions as is the case with MDG 6. There are several key reasons for this:

- inadequate funding for health in many countries
- ineffective and inefficient health financing and delivery systems that give rise to significant shortfalls between what is achieved and what was potentially feasible with the funding that was available
- lack of integration between funding for vertical and horizontal programs, resulting in competition for resources and undermining national strategies and
- lack of information on what countries know about the operation of their health systems and potential solutions

Inadequate funding is critical, but how much is needed?

Despite the considerably higher burden of disease and ill health in developing countries, overall health spending in partner countries is significantly less than that in developed countries. The average G8 nation spent more than 10 percent of GDP on health in 2007, compared with 5 and 6 percent in low- and middle-income partner countries respectively.[15] Even after adjusting for purchasing differences, health spending in the poorest countries, at US$20–50 per capita, is one-thirtieth the level of that in developed countries, and less than US$30 in most of the partner countries of greatest concern. This lower level of spending buys developing countries lower levels of coverage by effective health

interventions. For example, in the typical developing country the average person is able to see a doctor only one or two times a year, while the much healthier citizens of G8 nations visit a doctor five to seven times a year on average.[16] Increasing spending can clearly help to improve coverage and access.

The clear emphasis on increasing official development assistance (ODA) for health since at least 2000 demonstrates the G8's recognition of this constraint.[17] While both G8 and partner countries have certainly delivered in terms of increased funding for health, especially in areas linked to MDGs 4, 5 and 6,[18] it is worth pausing and asking whether this has been enough.

There have been many efforts since the early 1990s by the UN, World Bank, WHO, and others to answer how much financing is required either to scale up access to basic minimum services or to achieve some or all of the health-related MDGs. Their estimates suggest that the required public and external financing in low-income countries ranges from US$30 to US$50 per capita (and higher in middle-income countries).[19] In contrast, actual public spending in low-income countries is less than US$15, of which up to 40 percent, on average, is from external financing.

Although further increases in external financing are needed, it has to be accepted that even without the current global financial crisis, achieving levels of US$30–50 per capita from both public and external sources in the poorest countries was never realistic by 2015. Such target levels of expenditure represent 10–20 percent of GDP in the poorest countries, and are, on average, much higher than their overall tax revenues, implying that the shortfall could only be met by external flows. That level of external flows would, in most countries, present serious challenges in terms of absorption and macroeconomic stability.

However, the likely shortfalls in funding compared with the global targets do not necessarily eliminate any likelihood of substantial progress toward key health goals. There are three reasons for thinking this.

First, most of the global cost estimates appear to be overestimated, when estimated using actual country data. Recent efforts have responded to such criticism by applying methods that use country-level data. Such projects by the UN, UNICEF, the World Bank, and others have tended to produce much lower estimates on required funding, of the order of US$20–35 per capita.[20]

In addition, current global cost estimates assume that future expansions in health service coverage will cost as much as current service delivery. This ignores the potential for countries to partly fund expansions in coverage by improvements in the technical efficiency of service delivery, i.e., by reducing the average unit cost of a service. This assumption not only runs counter to histori-

cal experience in Organisation for Economic Co-operation and Development (OECD) nations, where efficiency gains have typically reduced costs,[21] but it also ignores evidence of similar 1–2 percent efficiency gains in developing countries.[22] Developing countries that have been able to generate such efficiency gains in the past have been able to expand services considerably with only modest increases in spending, since a 2 percent annual increase in efficiency implies a doubling of service delivery every 20 years without any increase in funding. Past examples include Botswana, which doubled service coverage during 1960–1980 without increasing health budgets as a share of GDP, and Uganda, which financed a tripling of service delivery during 1955–1969, half through increased spending and half via efficiency gains.

Finally, several low-income and lower-middle-income developing countries have been able to achieve universal access to basic health services and also stay on track to achieve their health-related MDGs, but almost all of them have done so by spending far less than the global targets for spending. For example, Sri Lanka, a low-income country, had largely achieved universal access by 1990, with government and private spending being less than US$10 per capita each. Vietnam today is well on track with similar levels of financing.

This suggests that even if funding does not attain currently identified global targets, it does not mean that countries cannot make substantial progress toward the MDGs and in expanding access to health services. More attention, therefore, needs to be given to increasing the value obtained from current and future spending on health in developing countries.

Inefficient and ineffective health financing and delivery systems

The notion that health spending is often inefficient and that more spending does not necessarily result in better outcomes is well known to G8 nations. For example, in the United States, health spending per capita varies more than three-fold across the country, and yet higher spending does not necessarily result in better outcomes, nor does lower spending translate into lower quality, with such centers of medical excellence as the Mayo Clinic able to deliver high-quality care at half the cost or less of other centers.[23] Problems of how money is transformed into effective, accessible, quality healthcare are also well documented in many developing countries.[24] These problems of inefficiency fall into two types: allocative and technical. Allocative inefficiency is the sub-optimal distribution of available public resources across the potential uses or programs. For example, in many developing countries, preventive health services

may be underfunded, while another service, such as family planning, may receive disproportionately more resources despite there being a similar need.

Technical inefficiencies further impair the effectiveness of money invested in programs or interventions. Such inefficiencies might mean that providers do not use the least-cost method for delivering a service or provide the best quality for any given level of resources. Examples include the use of antibiotics when oral rehydration solution is sufficient for cases of diarrhea, procurement systems' failure to purchase medicines at the lowest available prices, or an inefficient mix of medicines and personnel being used to provide a service. Technical inefficiencies can also be due to low productivity of healthcare workers, who see fewer patients than they might. The impact of such inefficiencies can be large, and, in some countries, can be seen in as much as a tenfold variation in the unit cost of delivering similar services at different facilities.[25]

The existence of such inefficiencies, and the potential they imply for improving the results from health spending, have been recognized since the early 1990s, for example in the World Bank's *World Development Report 1993* and by the WHO Commission on Macroeconomics and Health.[26] However, not much weight was placed on addressing this problem—in contrast to that of inadequate funding—since it was felt that not enough was known about what actions could be taken.[27] While this may have been a sensible strategy in the 1990s, it has not been without consequence. The problem of inefficiency has largely been neglected for the past decade, with minimal efforts being made to understand the problem and identify possible solutions. Now that funding levels have improved, and the variation in the value that different countries achieve for their spending is even clearer, the time is long overdue focus attention on this area.

Lack of integration between health systems and vertical programs

Frustration at the difficulties of rapidly expanding health systems coverage, considerations about the efficiency of different approaches to delivering critical interventions, as well as changing priorities in health, have led to the development of vertical health programs in many countries. However, while these initiatives have certainly been successful in promoting specific communicable diseases on the global health agenda, vertical programs have themselves created three major problems. First, the selective, external financing of such programs often leads to distortions within health systems, as better-funded vertical programs compete for and deprive other parts of the health system of critical

inputs, such as staffing. Second, vertical programs often make it harder for countries to effectively plan the development of an integrated health service delivery system, which must remain at the core of any sustainable expansion in overall health services coverage. Third, such programs may fail to benefit from the synergies of integrated services.[28]

These problems are not new. The original Alma Ata Declaration of 1978 with its commitment to integrated health service delivery, a commitment that is encapsulated in the WHO concept of primary healthcare, was a reaction to the perception that investments in selective primary healthcare and other vertical interventions had undermined the development of developing country health sectors. In the 1990s, the pendulum swung back, as growing frustration with actual progress in developing primary healthcare, and the apparent inability to deal with increases in devastating and costly communicable diseases, led to increased investments in vertical programs. The G8 has been on both sides of this debate, committing to supporting overall health systems but also investing heavily in vertical programs through such channels as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR). However, it is now readily apparent that greater focus is needed to assist countries to strengthen their overall health systems and integrated delivery, as the Global Fund and other initiatives run up against the limitations of weak health systems with often restricted capacity for scaling up. This is a significant motivation for the WHO's new call to refocus on primary healthcare in its *World Health Report 2008* and is reflected concretely in the International Health Partnership and Related Initiatives (IHP+) and Providing for Health (P4H) initiatives that stress harmonization and health system strengthening.

Lack of information and evidence to manage health systems effectively

Inadequate information and evidence are critical constraints to improving the performance of health systems. Problems exist in two areas. First, health information systems in most developing countries continue to be weak and cannot provide health managers with the information required to effectively monitor and improve service delivery and financing strategies. Common deficiencies include 1) the lack of reliable information systems, such as national health accounts, to track overall spending, whether it be public financing, external resource flows, or private spending;[29] 2) the lack of routine information systems to track equity in health services, which are

vital both to identify inequities and to develop responses;[30] and 3) the lack of information systems that provide managers with data to understand the operational efficiency of their health services, and which can support improvement of overall service delivery. It must be stressed, though, that in most developing countries, the lack of such systems is not due to the lack of information tools or platforms but to the severe lack of domestic capacities to implement and sustain such tools.

Second, as countries face the challenge of improving their health systems and financing strategies, we often know which countries have done well and might be good models for emulation, but we know far less about the operational details of how they did it. Such a lack of easily accessible knowledge about best practices in financing and delivery, and the lack of mechanisms to share such knowledge among developing countries, mean that good performance is rarely shared and learned from.

The Importance of Health Financing Policies

The half-way mark in the 15-year timeframe for achieving the MDGs, which began in 2000, has already passed. Yet, it is hard to demonstrate that increased investments in partner countries have accelerated progress toward MDGs 4 and 5. Even after allowing for the fact that HIV/AIDS seriously slowed or reversed health gains in Africa, progress in other regions has not appreciably improved, and in some it has even slowed (fig. 1).

Money is essential for delivering healthcare, but it alone does not translate into better health or effective risk protection. In developing countries, as in the G8, there is little, if any, relationship between the amount that countries spend and health outcomes, or indeed, between total spending and risk protection.[31] In the coming years, the fiscal pressures facing G8 members and partner developing countries will be severe. It will require significant efforts to increase expenditures for health, but there will be constraints on how much spending can be further increased. In this context, and given what we already know about the often poor correlation between total spending and health outcomes, it is critical to complement the G8 focus on increasing spending with an emphasis on improving the value of health spending in partner health systems.

Health financing is the most important control knob that policymakers have to influence the operation of a health system. Health financing includes not

only the processes that mobilize funding but also how funds are channeled and applied to obtain health services. Other than the need for more money, there is broad consensus among technical agencies and experts that developing countries face three key challenges in their health financing strategies:

1. how best to expand risk pooling
2. how to improve efficiency in the use of resources and
3. how to ensure access of the poor to needed services[32]

The first challenge is shifting from out-of-pocket financing to public or private pooling arrangements that ensure effective financial protection and coverage. Out-of-pocket payments remain a dominant source of healthcare financing in developing countries, accounting for 30–85 percent of total health spending in the poorest countries. Large out-of-pocket payments to obtain needed care often impoverish households. The global evidence shows that the extent to which households face such catastrophic expenses is directly related to the extent to which health systems rely on out-of-pocket financing.[33] Without significant risk pooling, developing countries are unable to prevent a high incidence of financial catastrophe associated with sickness or achieve basic social protection objectives.

The second challenge countries face is ensuring that financing mechanisms support better allocation and use of inputs. When provision is direct, governments can simply plan the allocation of resources, but whether the allocation of resources is efficient and equitable cannot be guaranteed. When provision is indirect, in the sense that governments purchase services from independent providers—as can occur in insurance-based systems—the allocation of resources depends on how providers are paid and on what basis. How resource allocation is linked to financing and the details of actual implementation matter for the overall efficiency of the health system.

The third challenge is expanding access by the poor to needed and effective medical services, which are critical to health improvements. In most countries, the poor lack adequate access, either because they cannot overcome the financial barriers or because funding fails to bring services close to them. Unless this gap is addressed, overall health indicators will not improve substantially. Whether they are public sector user fees or payments made to private providers, out-of-pocket payments are significant barriers to health improvement. They discourage use and reduce coverage of available preventive and personal curative services, both of which are needed to improve health outcomes. A principal justification for removing public sector user fees is that it provides a

free alternative to private provision, thus expanding the availability of services that are affordable to the poor. Recent work in Africa has shown how even small payments associated with the social marketing of mosquito nets reduce uptake and make such social marketing investments far less cost-effective than free public distribution.[34] By increasing utilization of critical services, abolition of user fees can also improve their cost-efficiency.

Health financing policies in partner countries thus must serve three key functions:

1. Revenue collection—This refers to how funds are mobilized, e.g., general revenue taxation, social health insurance (SHI), out-of-pocket payments, etc. This determines the overall level of funds mobilized and how sustainable these levels are. In general, revenue collection capacity depends on a country's economic and institutional development, which is least in the poorest countries
2. Risk pooling—This is critical for financial protection. It depends on the ability to prepay and share across the population the expenses involved in medical treatment. Both tax and insurance financing can serve this function, but, as with revenue collection, country capacity for risk pooling increases with income, with capacity being weakest in the poorest countries
3. Resource allocation and purchasing—This involves how resources are allocated to inputs, services, and patients and how providers are paid. When provision is directly organized through government-operated services, it can be difficult to ensure efficient allocation. Yet, when provision is indirect through purchasing, it requires a minimum degree of government capacity to do effectively, and this is more likely to be lacking in the poorest countries

Strengthening policies for health financing is critical for partner developing countries. Failure to do so continues to be the main constraint, preventing the realization of better outcomes from current investments. Where developing countries have put effective policies in place, they have been able to achieve universal coverage, effective risk protection, and sustained improvement in health outcomes, and they often do so at below-average levels of expenditure.[35]