HEALTH WORKFORCE SHORTAGES: TURNING CRISIS INTO OPPORTUNITY

Investing in the health workforce to create employment for women and youth

CREATING UNIVERSAL HEALTH COVERAGE AND JOBS

Human beings share a number of basic and universal values: we want to live in a stable, safe society where we can live healthy, useful lives, receive good education, find a decent job with a fair income, and become independent, contributing members of our society. Most of us also value equity, fairness and justice: we believe everybody should have the same opportunities to lead a healthy, happy life, irrespective of gender, age, socio-economic background, ethnicity, place of residence and other characteristics.

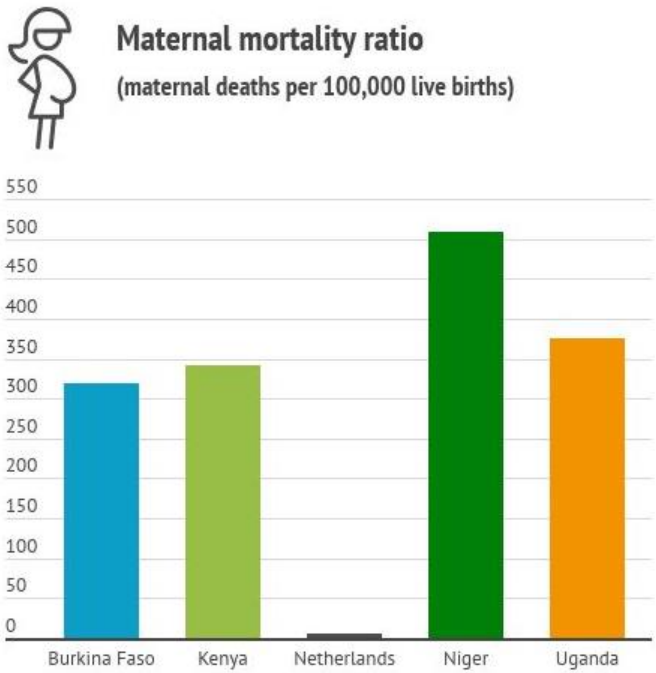
At Wemos, we work to help achieve this by advocating the right to health for all: everyone, everywhere, should have access to health services and be protected from health threats, on the basis of their need, not the ability to pay. However, there is a major challenge in the way of such Universal Health Coverage: the health workforce crisis.

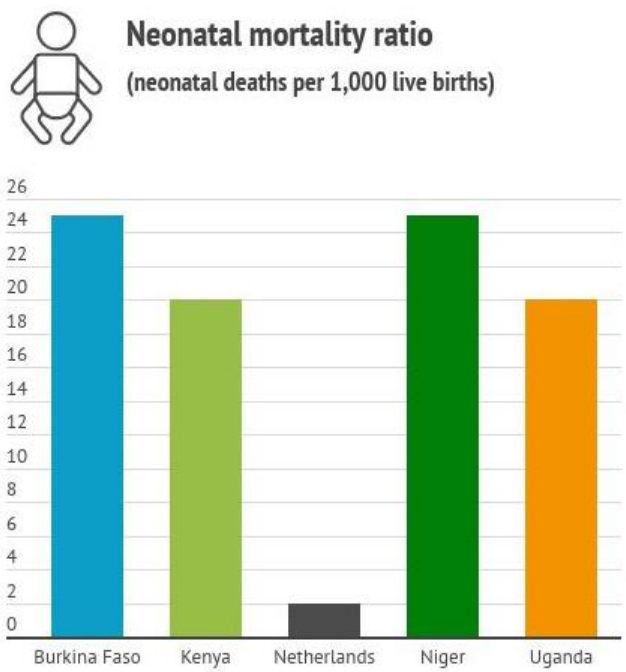
In this paper we describe this challenge in more detail. And we will share with you how we believe we can turn this crisis into an opportunity, achieving Universal Health Coverage (UHC) *and* creating brighter futures for youth and women at the same time.

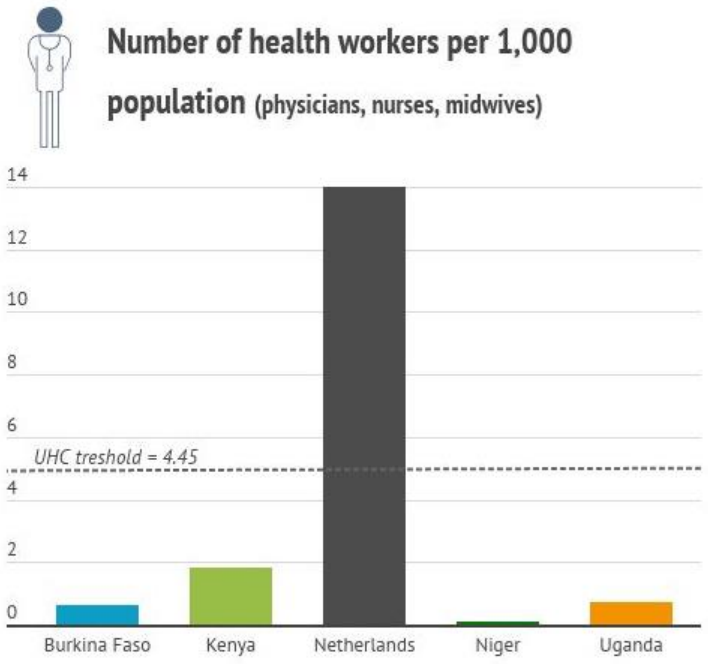
THE GLOBAL HEALTH WORKFORCE CRISIS

The world is facing a global health workforce crisis and an unequal distribution of and unequal access to skilled health workers. It is expected that by 2030, there will be 40 million more health sector jobs, mostly in middle- and high-income countries, while in low-income countries the shortage of health workers is expected to increase to 18 million. This will have a damaging impact on access to health for these countries' populations.

Many low- and (lower-)middle income countries have sub-optimal health care systems, with considerable shortages in the health workforce across all cadres. Compared with the UHC threshold density of 4,45 health workers per 1,000 population to achieve the absolute minimum of health coverage, many countries are far behind: Uganda has 0,7 health workers, Kenya 1,8, Burkina Faso 0,6 and Niger only 0,1[i].







The scarcity of health workers directly correlates with alarming health statistics such as maternal mortality and new-born mortality, as the example on the previous page shows us. It is clear that the gap between reality and the agreed ambitions in the Sustainable Development Goals (SDGs) for low- and middle-income countries is staggering.

1. EMPLOYMENT AND DECENT WORK FOR YOUTH

At the same time, many low- and middle-income countries face high, and rising, unemployment rates, especially among women and youth. The health sector is known to harbour a relatively high number of volunteers and informal care workers in a vulnerable occupational situation. Unemployment, lack of education and income insecurity all exacerbate already existing inequalities.

Of the Ebola-stricken countries Sierra Leone and Liberia, it is well known that half of their (qualified) health workers perform their activities as a volunteer, because they cannot be paid properly due to public wage bill and budget restrictions. After the Ebola disaster, there were promises that these volunteers would be absorbed into the health workforce and offered a regular job with regular salaries. This promise was never fulfilled, increasing the likelihood that these health workers quit their work and leave the health sector.

WHAT ARE THE OPPORTUNITIES?

The good news is that we can reverse this situation by making the right investments. Sufficient investments in education, vocational training and jobs creation will build a brighter future, especially for youth, male and female. In the context of Universal Health Coverage, investments in a fit-for-purpose, educated, motivated and supported health workforce is a two-edged sword: it contributes to a strong health system *and* provides jobs for many.

In the more industrialised countries, after prolonged and intensive investments, we see that a large proportion of the working population can now count on relatively stable employment in health and social care: 1 in 10 jobs on average in OECD countries, up to 1 in 5 or 6 in Nordic countries[ii]. Thereby they substantially contribute to income security and economic stability, as well as to the country's Gross Domestic Product.

Given the fact that 40% of the world's population is under 25 years of age[iii], the expected benefits of investing in health sector jobs is enormous – in terms of secure employment and increased prospects for a brighter future for many, as well as in terms of stronger health

systems. This also goes for regions such as MENA, the Middle East and the Horn of Africa, where approximately 25% of all youth is currently unemployed, and for sub-Saharan Africa, with youth unemployment rates around 12%.

HOW TO MAKE THIS HAPPEN?

If we want to make this work in low- and middle-income countries, serious investments are needed. It will require a context-specific health labour market analysis to determine the number of positions required to provide health for all, quality training institutes, the creation of jobs and continued efforts to improve working conditions, including salaries.

Also, sufficient numbers of students have to be motivated to pursue a career in health care. They should be facilitated in starting and finishing their studies and they have to be able to rely on a responsible government that provides sustained investments in decent, stable and secure jobs with living wages. Only when young people truly believe in their possibilities to have a good future, they will be motivated to work for it.

"During our time, the government used to employ workers directly from college. During my final year in college we were asked about areas we want to work in. Some people were posted in the areas they wanted, and other in areas where there is need, according to government priorities."

Foster, clinical technician at Balaka District Hospital, Malawi

2. THE POTENTIAL OF DEMOGRAPHIC DIVIDEND

Unfortunately, many African countries are struggling to create sufficient jobs for the increasing numbers of workers entering the job market: of the long-term unemployed in sub-Saharan Africa, 48.1 percent is between the ages of 15-29 years. For the Middle East and North Africa, this percentage is as high as 60.6 percent[iv].

Among the (many) factors challenging the employment of these youths are the mismatch between the skills on offer and the requirements of employers, the drain on skilled talent suited for the needs across Africa, and lack of investments in public sector employment.

WHAT ARE THE OPPORTUNITIES?

Africa is home to the world's youngest and fastest-growing population. Over 40 percent of people are under the age of 15, and 20 percent are between the ages of 15 and 24. Overall, Africa's population is predicted to have increased from 1,2 billion in 2016, to 1,3 billion in 2017[v]. This means that as many as 20 million young people are poised to join the workforce every year for the next three decades[vi].

Given sufficient jobs of good quality, these youngsters have the potential to achieve the magical demographic transition and dividend where the dependency ratio (i.e. the ratio of the younger population not in labour versus the active population) falls far enough for incomes and savings to begin to rise, thus accelerating economic growth and well-being. This crucial demographic transition is known as the 'demographic dividend' and can only be achieved if employment figures rise substantially[vii].

HOW TO MAKE THIS HAPPEN?

The demographic dividend has been acknowledged by African leaders and decision-makers as a strategic basis for focusing and prioritising investments. For African countries to capitalise on this demographic dividend, the future workforce must be educated, trained, and have adequate employment opportunities[viii]. This starts with a solid health labour market analysis that needs to be future-proof. Not only is the proportion of youth on the African continent growing; the African health systems are facing increasing challenges of an ageing society and a rise in non-communicable diseases, adding to their – already substantial - disease burden. Recent increases in the number of health workers have not been able to keep pace with such demographic and epidemiological developments. Investments need to be stepped up.

3. WOMEN'S EMPOWERMENT

Women make up 70% of the health workforce. However, gender inequity remains a challenge. Only 25% of senior roles are held by women. This means that in reality, women deliver global health and men lead it. These gaps in gender leadership are driven by stereotypes, discrimination, and power imbalances. Some women are further disadvantaged on the basis of their race or class. Moreover, women workers often face bias, de-skilling, discrimination in salary, and sexual harassment by colleagues, patients and superiors.

In addition, a significant proportion of female health workers globally earn their livelihood in non-skilled cadres, e.g. as lay counsellors or community workers. They are often either unpaid

or underpaid, especially with respect to their male counterparts, which puts them in a position of dependence and income insecurity[ix].

WHAT ARE THE OPPORTUNITIES?

Investing in decent health sector jobs, in a safe and secure environment, means investing in women's economic empowerment. If women are enabled to work to their full potential, they will be more motivated to stay in their jobs and in the health sector where they are so needed. At the same time, solving these problems leads to a great empowerment of women and a more equitable society. If all those women who are currently working in informal settings, would transit to the formal economy, this would greatly improve their independence. Moreover, literature has shown that the earnings of married women contribute substantially to their households' and extended family's health and well-being.

At the same time, for health care seekers, the availability of (more) women delivering delicate health services - including those related to sexual and reproductive health - might lower barriers to access these services. So, they might seek help sooner and prevent more severe health problems.

"For me, becoming a nurse was just a childhood dream. My mom used to say that I liked to help others. She said: "my daughter wants to be a nurse". And then I thought, yes, let me become a nurse and help others. […] The best thing is to be able to assist people who are seeking help and seeing them become better."

Deborah, midwife at Matawale Health Centre, Malawi

HOW TO MAKE THIS HAPPEN?

Gender-transformative policies are needed to tap into female health workers' potential. Adding jobs to the health workforce is one thing; creating decent jobs for women and closing gender gaps in leadership and pay, is quite another. This requires plans to increase the number of women being educated and employed globally, on the basis of country-specific investment plans addressing context-specific health worker shortages and gender issues. In addition, we need to develop female leaders and leadership in health, enabling them to engage more effectively in policy-making and decision-making.

WHAT WE CAN DO?

We see clear ways to create a brighter future for many young people, including women, and to build stronger health systems while doing so. The key is to increase investments in education and skills, and in the creation of decent and secure jobs in the health sector, where the (mostly female) employees are free from all forms of discrimination, bias and harassment.

The primary responsibility for such investments lies with the national governments, who ideally spend a substantial proportion of their budget on health, including health worker salaries. But where domestic resources are insufficient, development partners could step in to provide additional resources. In this SDG era, with countries' commitments to global solidarity and shared responsibilities, this would be the right thing to do. However, many donors are reluctant to commit to long-term and recurrent expenditures, such as health workers' salaries. And recipient governments are reluctant to accept foreign aid for salary payments, because of this lack of long-term commitments and the volatility of funding. Fortunately, spending on health and health worker salaries is increasingly being recognised as an investment with an excellent return. We hope this will convince donors to help create decent health jobs and to build stable, more equitable and healthy societies in which our shared values can thrive.

GOVERNMENT'S OPTIONS FOR SUSTAINABLE FUNDING FOR HRH

A fundamental question is of course how governments will be able to create more fiscal space for investments in the health sector, including salaries for health workers.

In simple terms, fiscal space is understood to be the availability of funds and the flexibility and freedom of a government in its spending choices. In our factsheet '[Fiscal space for health and four ways to increase]', we elaborate four options to increase the fiscal space and funds for health, together with their benefits and risks. These options are: 1). raising domestic revenue; 2). improving efficiency and reducing waste; 3). domestic or external borrowing; and 4). foreign grants.

ROLE OF DONORS

Large multi-lateral global health actors such as the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), the Global Vaccine Alliance (Gavi) and the Global Financing Facility (GFF) are heavily invested in strengthening the health systems of their recipient countries. So are large international financing institutions, such as the World Bank and the International Monetary Fund. They have been able to transform and improve many health services in terms

of coverage and quality, and train and deploy many additional health workers in the context of their interventions.

Many of the recipient countries have a costed action plan to develop their health workforce for the long run. What many of them lack are funding sources. Global health actors such as the Global Fund, Gavi, GFF and the World Bank could contribute their health systems by strengthening funds to such national plans.

WHAT DO WE DO AT WEMOS?

As a civil society organisation advocating for global health, we work on the following:

Evidence building

- We have undertaken fiscal space analyses in Malawi and Uganda. The findings of these country case studies have yielded relevant information that can be (and is currently being) used for in-country advocacy to increase investments in health.
- We have made an analysis of how the GFF works in Kenya, Malawi, Uganda, and Tanzania. This informs donors, and feeds both our lobby towards the World Bank / GFF, and the in-country advocacy by our collaborating partners who aim to improve the effectiveness and efficiency of GFF investments.

Networks and collaborative efforts

- We are a member of the GFF Community of Practice in Share-Net, the Netherlands Network on Sexual and Reproductive Health and Rights, where we share information, data and experiences on the GFF.
- We always conduct our country studies together with locally grounded civil society organisations, thereby ensuring that the findings represent relevant issues.

Lobby and advocacy

- We currently host the Secretariat of the Health Workers for All Coalition, a network of civil society organisations involved in global and national policy-making on human resources for health. Increased investments in education of health workers, the creation of decent jobs, and the implementation of existing commitments are the Coalition's core focus areas.
- We participate in global discussion fora to defend and promote the right to a health worker for everyone, everywhere, and we provide input to public consultations on matters ranging from the Global Action Plan for Health and Well-being to the Dutch draft strategy on Youth, Women and Employment.

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