Strategic US Initiatives for Health Workforce Self Sufficiency in Developing Nations[1]

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Policymakers striving to meet a number of important US and international health targets such as PEPFAR's "2-7-10" or WHO's 3x5 over the last two years have witnessed programmatic logjams due to shortages of trained healthcare workers and weak health systems. In order to meet important goals for disease treatment and prevention, actors at every level are finding it necessary to engage in health system strengthening, particularly to train and retain an adequate density and mix of healthcare workers and the support systems they need. In a globe facing the gravest health disaster in history, this political moment presents a new hope for countries reeling from the impact of AIDS.

A number of new bilateral and multilateral initiatives are underway or soon to be launched to support health systems strengthening, including several pieces of legislation before Congress to bring US volunteers and staff to developing countries to address health worker shortages, as well as other bills that promote utilization, training and retention of indigenous health workers in US HIV/AIDS programs.

Further, the Office of the Global AIDS Coordinator will necessarily be in the process of drafting new areas of work as PEPFAR reaches 2008 deadlines. US bilateral AIDS initiatives have been hindered by shortages of healthcare workers and crumbling health system infrastructure in focus countries. Already, PEPFAR makes use of "work-arounds" on US limitations on salary and public sector support, while also attempting to launch new community health worker programs. Future incarnations of PEPFAR will offer greater opportunities for effective health systems strengthening on a scale more commensurate with the crisis.

Additional forces are lined up in support. 2006 is WHO's designated year for Human Resources for Health. The Global Fund to fight AIDS, Tuberculosis and Malaria has made explicit request for new applications that focus on health systems strengthening. Other bilateral funders such as DfID are providing substantial support for training, retention and support of healthcare workers in the developing world.

A US working group is forming to win new initiatives in support of healthcare workers. This memo describes some of the key initiatives necessary to address the health worker crisis in developing countries.

Summary:

A. The US should lead a global initiative to reach minimum health workforce density. The US contribution to such a global initiative could be to achievement of 2.5 workers per thousand residents in sub Saharan PEPFAR focus countries – *cost estimates included*;

B. A health workforce initiative should include an emergency drive to quickly unleash existing underutilized health capacity by accrediting and deploying large numbers of community health workers, while ensuring adequate supervision and integration with primary health systems;

C. US programs should adopt policies of health worker "additionality" that support training and retention measures for the number of indigenous health staffers necessary to meet program goals, while taking specific actions to avoid draining health staff from the primary system;

D. US assistance programs should adopt new models for country-level, country-driven technical assistance to generate national ownership and establish rational coordination of donor resources, as well as coordination of health planning by public and private providers;

E. Expatriates and volunteers can be used to build towards self-sufficiency if used explicitly as emergency response teams to provide care concurrent with training of sufficient permanent local replacements integrated into primary health systems;

F. The Global Fund to fight AIDS, Tuberculosis and Malaria is already engaged in health systems

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[1] In addition to assistance from Health GAP staff and steering committee members, thanks are due to workg group member Eric Friedman from Physicians for Human Rights for valuable contributions to this text.

strengthening and should be supported more reliably and include a new additional reserve-fund that protects against fiscal shortfalls and enables bolder applications;
G. Internal and external policy barriers to health system scale-up must be removed in Congress, US government agencies, and at the International Monetary Fund;
H. Measures to address brain drain should be adopted that increase health professional training opportunities in the United States and discourage active recruitment from poor countries.

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To address the crisis of human resources for health in countries ravaged by HIV/AIDS, The US Administration and Congress is urged to implement the following recommendations:

A. Lead a global initiative to achieve minimum healthcare worker densities, with a US focus in sub-Saharan PEPFAR countries:

According to Ambassador Randall Tobias, the head of the Office of the Global AIDS Coordinator (OGAC), the biggest obstacle faced by the US is a shortage of healthcare workers. Similarly, the WHO's 3x5 initiative and many Global AIDS Fund grants have been stymied by health workforce shortages and weak overall health systems. New investments will be needed to meet US global health targets such as those sought by PEPFAR as well as international commitments like the Millennium Development Goals or the G8 commitment to provide universal treatment coverage by 2010.

To share these additional costs while achieving established targets, the US should call for and support a global health workforce self-sufficiency initiative, urging donor nations to provide assistance to developing countries to achieve minimum health workforce density[2]. The US could lead the way by taking responsibility for supporting adequate health workforce density in PEPFAR focus countries, working with "Country Action Teams" of public and private actors on the ground to develop and implement plans. New money will be necessary to train and retain workers, but estimates indicate first year expenses of $650 million, scaling to $2 billion over five years time will be sufficient to double the healthcare workforce in target countries.

A private analysis was prepared in spring of 2005 year for US officials en route to the G7 Summit by WHO Special Envoy on Human Resources for Health Lincoln C. Chen, Chair of the JLI and Director of the Global Equity Center at Harvard Kennedy School of Government (with support from Health GAP, Physicians for Human Rights and Global Health Council). *This* memo includes all of Dr. Chen's findings, and his methodology is available as an appendix.

- **A global initiative for self-sufficiency in sub-Saharan Africa is urgently needed, and would consist of donor countries working with public and private actors in specific impoverished nations to establish and sustain *minimum health worker densities* – the number of trained health workers needed to achieve quality health coverage.**
- The term "minimum health worker densities" should mean the minimum ratio of health workers (of a nationally-determined skills mix) to population size required in a particular country needed to achieve and sustain local health priorities, US HIV/AIDS treatment and prevention targets and international health goals. A starting source to determine minimum health worker densities is the WHO's Joint Learning Initiative. The JLI establishes 2.5 trained health workers per thousand residents as the minimum number necessary to achieve minimum health standards in sub-Saharan Africa.
- Logical choices for the US-specific focus of a global initiative may begin with LDC PEPFAR countries, where country-level planning and experience may be strongest.

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[2] The Joint Learning Initiative on Human Resources for Health and Development determined that Africa has approximately 1.0 health workers/1,000 population, whereas a minimum health worker density of 2.5/1,000 population is required to achieve global health goals. Doubling the health workforce in five years would make significant progress towards this goal.

- Other donor nations should be challenged to provide assistance to other countries.
- An initiative to attain health workforce self-sufficiency would convene teams of relevant public and private actors to rapidly develop and implement plans to achieve minimum healthcare worker density. The US should then facilitate access to all available sources of internal and external financing for appropriate components of the overall plan. Specific program components and an packages of health improvements should be developed by teams at the country level. *(see "New models for technical assistance" below)*
- **New US money will be necessary, but rough estimates indicate that even relatively modest new investments can *double* the healthcare workforce in target countries.** This investment in health workforce strengthening is a necessary complement to ensure the success and sustainability of the historic U.S. investments to fight AIDS.
- **$2 billion would be needed in the first year from African governments and the collective donor community to at least double sub-Saharan Africa's health workforce. Over five years, the total global cost will gradually rise to $7.7 billion annually.**
- **The U.S. share of this total cost would be approximately $650 million for the first year, rising to $2.6 billion over five years.** This 1/3rd percentage is commensurate with the U.S. percentage of the world's economy and similar to the US contributions to food aid programs and the Global Fund to fight AIDS, Tuberculosis and Malaria.
- This investment will need to be accompanied by donor and country-level policies that increase the size, skill, motivation and support for health workforce, and the rapid launch of community health worker initiatives. The majority of the funds required will necessarily have to come from the donor community.

The approximate breakdown of the $2.0 billion required worldwide in year 1:

- 35% for health worker compensation, including stipends for community health workers and raising health workers out of poverty wages[3]
- 10% for incentives to health workers to serve in rural areas
- 25% for health worker pre-service education and continuous learning[4]
- 30% for human resource management and planning; health workplace safety; training, supervision, and support for community health workers and caregivers; human resources support to the not-for-profit NGO and faith-based sectors; global and regional support and learning

The approximate breakdown of the $7.7 billion required in year 5:

- 45% for health worker compensation, including stipends for community health workers and raising health workers out of poverty wages
- 15% for incentives to health workers to serve in rural areas
- 15% for health worker pre-service education and continuous learning
- 25% for human resource management and planning; health workplace safety; training, supervision, and support for community health workers and caregivers; human resources support for not-for-profit NGO and faith-based sectors; global and regional support and learning

These are the categories of investments required to educate, recruit, and retain the numbers of health workers necessary to at least double the health workforce and progress towards minimum coverage densities; to enhance health worker coverage in rural and other under-served areas, and; to increase the effectiveness of the workforce by improving health worker motivation and making the best use of health workers' skills.

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[3] The estimated needs for health worker compensation as well as incentives to serve in rural areas are based on WHO figures on public health expenditure in Africa. South Africa has been excluded from these estimates because of its uniquely large health budget compared to the rest of sub-Saharan Africa, as well as its having already surpassed the 2.5 health worker density target. Some investments in South Africa's health workforce will still be required.

[4] Pre-service education costs are derived from preliminary World Health Organization estimates.

Contributions levels should be sustained over time, but may be assumed to be "bell-shaped." Decreasing contribution levels over time should be accompanied by predictable measures to facilitate local continuation.

B. Launch a new emergency drive to rapidly train and deploy substantial numbers of "community health workers" through existing and new programs:

It takes a long time to train the numbers of doctors and nurses necessary to meet US policy goals such as those established by PEPFAR or other US-endorsed targets such as the Millennium Development Goals. However, the "low hanging fruit" of the healthcare worker shortage can be found in every village and community where people with AIDS live, or have families and care givers. Untrained community members–women and people with HIV–are already providing the bulk of care in many areas. A tremendous labor force is already "in the field" and can be quickly harnessed with modest investments in training and compensation for currently untrained, unpaid community caregivers at the village level.

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Community health workers can be deployed very quickly (versus the time it takes to train and graduate a professional) and at modest expense. Village-level health workers can quickly be trained to provide basic care, treatment and prevention services while serving as the first line of referral to health professionals. Community health workers can operate as "satellites" of clinics to extend coverage to remote areas.

Community health workers are less susceptible to be lost to wealthier nations. Moreover, robust community health worker initiatives that substantially recognize, accredit, compensate and deploy this largely female and HIV+ workforce will reduce women's vulnerability to infection while contributing visibility that destigmatizes individuals living HIV.

- Simple and accelerated training criteria have already been developed by WHO and OGAC. Expanded US support for such training programs could quickly certify and equip tens of thousand of peer educators to provide voluntary counseling and testing, prevention education, treatment literacy, adherence counseling, symptoms monitoring, and basic care and prevention services.
- Community health workers can quickly extend basic health services to underserved rural areas, linking remote locations to regional clinics in a decentralized referral and supervision system that sends complex or severe cases to regional teaching hubs.
- Economic empowerment of women through paid healthcare labor is important in breaking the cycle of vulnerability that women face. Increased social status and economic resources, and increased knowledge about health will reduce women's personal and collective vulnerability to infection. Openly HIV-positive community-based health workers enhance the efficacy of AIDS programs as peer educators teaching treatment literacy and prevention skills while serving to destigmatize living with AIDS.
- Key elements in the success of community-level health workers include compensation, proper and ongoing training, continued supervision, and close linkages to health professionals within the broader health system. New health workforce initiatives should supply funding to train and support community health workers while working with governments, professional associations and PWA groups to ensure rapid deployment and coherent integration of community care workers into local health systems.
- Support for training and funding community health workers should be included as core components of programs such as the Global Health Corps, as well as PEPFAR and other initiatives.

→ The political moment to seize this opportunity is unprecedented. New initiatives that capture and formalize the huge workforce of community caregivers are the best hope for dramatic short-term improvements in health outcomes. Community caregivers help address the shortage of health workers, brain drain, and the high cost and length of time necessary to graduate new healthcare professionals.

C. US assistance programs should seek "health workforce additionality," adopting measures to train and retain new indigenous workers in sufficient numbers to meet program needs:

Affirmative measures must be adopted by donors–especially by disease-specific initiatives–to avoid draining existing workers from primary health systems. While it may be relatively easy (in some locations) to attract needed local workers by paying 50 cents an hour more than the public clinic, doing so leaves the overall health system less able to address general health needs and subsequently inadvertently erects *new* barriers to reaching US health targets.

US aid programs could be required to "cover their own costs"; in countries facing a healthcare workforce shortages. That is, if PEPFAR needs 100 physicians and 450 nurses in a country to meet its goals, then PEPFAR should support the production and retention of that number of physicians and nurses, utilizing imported staff only as necessary to train replacements and fill gaps while taking steps to train new health workers. Programs in the health field in developing countries–especially disease-specific initiatives such as PEPFAR–should adopt new policies that support training and retention for *at least* the number of indigenous healthcare workers necessary to meet program goals, while taking proactive measures to avoid drawing from other health programs. Healthcare workforce "additionality" should become a core priority of PEPFAR.

- **A groundbreaking target could be established requiring, over time, *indigenous* health workers to provide *all* prevention, care and treatment services supported by PEPFAR–*without eroding the capacity of the health system to provide other essential health services*.** Utilization of local healthcare workers is already established as "best practice" for foreign assistance programs and agencies. By working toward "100% local," OGAC will enhance local ownership and the capacity of focus countries.
- **However, adopting specific safeguards to protect existing health systems and programs is absolutely central.** From a health workforce perspective, one serious problem of PEPFAR at present is that the program adds significant new tasks on an already overburdened health workforce. Absent a scaled-up effort to improve the size and efficiency of the health workforce, this creates two possibilities. Either PEPFAR is unable to achieve its goals, or it does achieve its goals but at the cost of reducing the capacity of the primary health system to provide other essential health services. This could happen by some combination of drawing health workers away from other jobs, and by asking strapped health workers to perform additional tasks, which will reduce the time during which they can provide other health services and contribute to burnout.
- Setting a new indigenous health workforce target for PEPFAR is not merely an important moral principle regarding sustainable development. With a stronger overall health system, important disease-specific initiatives such as PEPFAR are able to fully and sustainably succeed. By expanding the number of healthcare workers by a number sufficient to meet program needs, programs like PEPFAR can address the unintended harm and distortions that can be caused by donor-driven disease-specific initiatives that employ large percentages of a too-small health workforce, while avoiding the cost-and unsustainability of over-reliance on flown-in expatriates.
- OGAC progress reports state that almost 80% of the staff hired are local workers in their country of origin. As PEPFAR heads towards renewal and revision, striving for 100% indigenous workers (with flexible deadlines) will use the platform of this already historic initiative to set an important new standard for local ownership and sustainability, while measures ensuring additionality will takr an important new step to address weak health systems that have stymied efforts to truly reach program goals.
- PEPFAR country teams, or new Country Action Teams (below) should include specialists with bottom-line responsibility for human resources for health issues.
- This could take the form of an *amendment to PEPFAR* that could happen immediately either through US legislation or by adopting new policies administratively.

D. Adopt new models of technical assistance that promotes country ownership and ground-level coordination of multiple donor inputs into disjointed public and private health services:
For years, wealthy nations and multilateral institutions have proclaimed the importance of donor cooperation. In reality, the task has been extremely difficult. Multiple funding streams, government actors and differing

program goals often lead to inefficient health programming at the country level, poaching of public sector health workers by well intentioned disease-specific initiatives, and incoherent use of donor resources. The United States could break new ground by convening country level teams to develop and implement comprehensive health programs to achieve nationally established goals in keeping with US policy targets such as PEPFAR's treatment and care goals or universal access to treatment by 2010. Convening entities (such as PEPFAR) should facilitate access to all internal and external financing resources available worldwide to support discreet components of the comprehensive health system plans. By facilitating planning and implementation at the country-level to develop comprehensive health strategies, *then* seeking support for discreet components from multiple international sources, the US can provide coherence and coordination from the ground-up while promoting country ownership and expanding country expertise.

Multiple bi- and multilateral assistance programs generate administrative burdens while contributing to waste and inefficiency at the country level. The bulk of health services in some African nations are provided by mission hospitals. Religious health associations are facing the same crisis shortage of trained health workers as programs like PEPFAR, and are often in direct competition for the same workers. New steps should be taken to better integrate public and private health providers and disease-specific programming like PEPFAR or Stop TB into a nation's primary health system. Effective strategies to achieve health workforce self-sufficiency will necessarily be developed in consort with local authorities and in a manner coherent with national priorities.

- **The United States should convene "Country Action Teams" of public and private health actors on the ground to develop and implement comprehensive health plans and facilitate access to financing.**
- Similar to the GFATM's Country Coordinating Mechanisms, such teams should consist of representatives of relevant health implementers including national governments, mission hospitals, workplace treatment programs, NGOs delivering care, treatment and prevention *as well as* representatives of the national health and finance ministry and other development partners.
- US technical staff can convene and assist these teams to develop new or improve existing comprehensive national health plans, create technically sound applications and then facilitate access to all sources of financing in support of discreet components of the plan –including the GFATM, bilateral donors and foundations. For instance, a Country Action Team might determine that health worker salary increases, new medical schools and malaria control are among national priorities. The Country Team determines that the optimal agency to provide financing for salary support for heath workers is a European bilateral aid agency, that a private sector bed net manufacturer will provide bulk discounts, a multilateral lender will fund technical support for managers to strengthen health workforce management, and that a private foundation will build a new medical training facility.
- The US should convene the teams, help establish goals, helps craft the comprehensive plan, assists submission of high quality applications and facilitate access to financing, then works with the teams to troubleshoot monitoring and implementation.
- Country Action Teams that bring all public and private health actors and development partners together to design and implement integrated plans to reach health workforce outcomes will halt the damage that can be caused with unintentional 'poaching' of health workers by uncoordinated bilateral programs, while supporting new local ownership and desperately needed ground-level coordination of public, private, NGO/religious mission and disease specific healthcare initiatives.
- Country Action Teams should include specialists who bottom-line human resources for health issues.
- This is an *amendment to PEPFAR authorizing legislation* that can be launched immediately. It could also occur administratively within OGAC.

E. Use volunteers and imported health workers as emergency steps to temporarily alleviate health workforce challenges:

This paper seeks to describe initiatives to sustainably achieve health worker self-sufficiency in the developing world, and therefore looks to reform open-ended aid programs that rely on imported health providers. However, given the crisis shortage of indigenous health workers, these expatriates are often necessary for the time being. For a consideration of volunteer and programs, this paper uses as a frame of reference the Global Health Corps bills proposed by Senator Frist and Representative Lee. The Global Health Corps provides a potential vehicle to experiment with new measures to train new local replacements and implement service-learning measures, while launching and temporarily overseeing community-health worker efforts.

Relieving health worker shortages with imported expatriates can serve as temporary catalysts for building new healthcare capacity:
The Global Health Corps is a volunteer and staffed-based program that, if passed by Congress, will provide an opportunity for US citizens to provide healthcare services and emergency relief to people in impoverished nations. The use of volunteers and expatriates is an expensive and difficult-to-sustain way to improve the health conditions of the developing world. To contribute towards longer-term solutions, the Global Health Corps should provide health service *concurrent with and primarily as a means* to train and activate local replacements, strengthen health systems, and reach underserved areas and populations. Integration of GHC personnel into the mix of public and private providers that make a nation's health system is vital, and, except in cases of urgent disaster relief, any deployment of GHC should be in consultation with in-country providers. GHC should provide important pre-service as well as on-the-job training and support for growing an in-country workforce.

- The functions of *"education and training to local persons to improve healthcare outcomes, and to assist in the development of local and indigenous healthcare delivery capacity and self-sufficiency"* and *"healthcare training, health systems development, and technical support"* are extremely valuable and to be applauded.
- Imported health workers should be used primarily to train replacements. This component of the legislation is very valuable, and could benefit from more definition and target setti7ng. (more below)
- One of the most effective and quick ways to utilize volunteers to substantially increase local health capacity is to train and deploy community health workers, and legislation authorizing GHC should include this as a central "purpose" of the Corps. Utilizing existing OGAC or WHO training modules, Global Health Corps could greatly extend program reach and benefit by rapidly accrediting village-level workers to provide basic care, treatment and prevention services while serving as the first line of referral to health professionals. Community health workers should operate as "satellites" of the clinics where Health Corps teams will be based. The Corps members could supervise and train community members while integrating them into the local health system.
- The cross-agency and multiple volunteer recruitment strategies in the bill are creative ways to increase the size of the pool, and utilization of existing programs will enhance efficiency. *An additional means to substantially increase the number of program volunteers* is to expand eligibility to Diaspora health professionals who are in the process of establishing US citizenship but can't return to their country of origin without "resetting the clock". This contributes to the self-sufficiency concept while taking at least one step against brain drain. It would also be of great value to the US and to recipient countries to open eligibility to certain kinds of south-south volunteers, and involving skilled volunteers from accredited institutions in other countries, such as doctors or nurses from Egypt.
- The pool and skill mix of participants will be greatly enhanced with the inclusion of college loan forgiveness for volunteers in needed professions. Differing versions of the GHC legislation have included student loan forgiveness provisions, and the Senate version of the bill will be stronger and much more widely supported with the restoration of student loan measures.
- The GHC authors have recognized that trained healthcare workers in isolation are insufficient to address health crises. One useful addendum to the technical assistance capacity and value of the Global Health

Corps that addresses some of the weaknesses of sporadic volunteer programs would be to include a permanent staff of 100-200 "systems builders" posted in-country to solve implementation problems and provide sustained support for health system strengthening. Technicians and managers could work with ministries of health and finance to address the lack of capacity in newly coordinated public and private sector health programs by developing and implementing strategic plans to train and sustain adequate numbers and mixes of healthcare workers, lab technicians, IT managers and supply chain managers. These permanent GHC postings can help train-up or provide TA for fledgling in-country health administrators, and make use of existing or underway needs assessments performed by WHO, USAID, PEPFAR, national planning bodies and other actors. These health systems czars are needed by OGAG or by Country Action Teams, and are valuable with or without a Global Health Corps.

Defining Outcomes:

- ***The bill requires the Director to establish performance measures.*** The bill could benefit from specific clinical and indigenous personnel targets and outcomes, in particular with regard to building sustainable health workforce self-sufficiency. It could be valuable to explicitly articulate targets and deliverables in the text of the bill. ***Minimum healthcare worker density*** will be a valuable and simple measure of efficacy to establish in legislation.
- It will be useful to explicitly establish a goal of training local GHC replacements, and measure progress towards 100% local health workers.
- As trainers, the Global Health Corps could play a role in supporting health workforce "additionality" for other US assistance programs seeking to "cover their own costs" by producing the number of health workers needed to meet program goals without draining workers from the public health sector or other programs.
- Strengthening the concept of "training for self sufficiency" already in the bill by establishing report language to measure this effort will be a valuable addition to US policy and intelligence.
- The Global Health Corps should contribute towards preventing HIV among resident healthcare workers by implementing universal precautions and administering post-exposure prophylaxis, as is standard healthcare practice in industrialized countries. Additionally, Health Corps could launch antiretroviral treatment for local healthcare professionals living with HIV, thus increasing their lifespan and length of professional productivity, while improving work conditions.
- Instead of open ended-commitments, it may be easier to program on a scale commensurate with need if GHC has a specific end-point. A 10-year bell curve of staff postings may be assumed, thereafter tapering away from emergency status and becoming a smaller service program. "Training towards self-sufficiency" has an end point.

F. Secure and stabilize the Global Fund to fight AIDS, Tuberculosis and Malaria in a manner that enables bolder applications:

The GFATM has been engaged increasingly in health systems strengthening since its first round of grants. Yet, year after year, advocates must scrabble to secure adequate funding for the Global Fund. This year, due to a shortfall in US funding, important grants in Southeast Asia addressing disease surveillance and health workforce issues were awarded but were left to sit on the shelf. Even if the Global fund *was* fully funded at the end of each cycle, the Secretariats' very tight fiscal need projections *disincentivize* nations from submitting applications on the scale truly necessary to fight the three diseases for fear of rejection simply for having taken too large a slice of the too-small pie. The United States should more consistently fund the Fund, and establish a new emergency reserve over several years that protects against fiscal shortfalls and enables bolder applications.;

- A The US should make commit to making regular contributions equal to 1/3rd of the projected need for the coming year.
- Additionally, to safeguard against the Fund's fiscal shortfalls and to enable the potential of more ambitious applications, the US should establish a reserve buffer that, after gradually building for three years, is equivalent to 1/3rd of an *additional* year's estimated GFATM budget.

- The Global Fund could only draw upon the reserve buffer if technically sound applications exceed projections.
- Disbursements from the reserve fund should be matched 2-to-1 by other donors over a two-year period.

G. Remove internal and external policy barriers to health system scale-up:
IMF macroeconomic policies intended to safeguard against inflation have literally prohibited expenditures and halted implementation of desperately needed PEPFAR and GFATM programs, and make it extraordinarily difficult to implement measures to retain sufficient health workers necessary to provide quality health coverage and meet program targets. While new health spending *could* theoretically contribute to inflation in desperately poor countries, the *certain* economic impact of 20-30% infection rates greatly outweighs potential harm. The US Treasury Secretary should move strongly to abolish IMF public spending ceilings on health and education in countries heavily affected by the AIDS pandemic.

Likewise, limits placed by Congress or US agencies on public sector and recurrent salary support cause undue burdens to US global health initiatives, requiring burdensome waivers, work-arounds and regular rule-bending. Congress should provide every flexibility to US agencies working to support strengthen health systems adequate to scale-up access to care, treatment and prevention on a scale to meet US program targets. Agencies should roll back antiquated internal policies limiting public sector investments and salary support.

External: Macroeconomic policy changes at the IMF are necessary to create fiscal space for health sector capacity building and human resources for health.

- IMF policies greatly hinder the ability of the US and other donor governments to support public health systems at the scale necessary to succeed. IMF policies render it impossible for national governments or donors to provide salaries adequate to retain needed health workers or managers. Public sector wage spending limits directly impact health and education, and imposed and enforced directly and, increasingly, implicitly by the International Monetary Fund and the World Bank, are barriers to US diplomatic and global health goals and must be explicitly replaced.
- **The US Treasury Department should urge the IMF to adopt new policies that exempt health and education budgets from spending ceilings, and place inflationary concerns more appropriately in the context of the human health disaster of HIV/AIDS. Policies that limit public sector wages must be replaced with proactive policies in support of increases in public wage spending.**

Internal: US policies that limit public sector and recurrent support hamper US aid efforts. Congress should take steps to allow OGAC and GHC Directors maximum flexibility to take actions deemed necessary without burdensome waiver processes, and US agencies should repeal 'in-house' limitations.

- Momentum behind addressing health worker crises presents an opportunity to rectify sometimes-arbitrary congressional limits on public sector investment and recurrent salary support. These policies have hindered the capacity of the U.S. to achieve health improvements such as scale-up of AIDS treatment.
- US agencies doing country-level work are forced to routinely bend rules or laboriously work around prohibitions against salary or public sector support in order to retain personnel necessary to fulfill program requirements. Policy makers should grant US aid programs the flexibility needed to strengthen overall health development so that US treatment and prevention targets may be realized.
- Investments directly in a country's public health infrastructure bolster the health system; extend the reach of United States public diplomacy; and supports country ownership of plans to address healthcare worker shortages and health systems development.

H. Measures to address brain drain should be adopted that increase health professional training opportunities in the United States and discourage active recruitment from poor countries.
Self-sufficiency should also start at home. The US does not produce a sufficient number of medical school graduates to fill residency spaces, and is on track to be as many as 800,000 nurses and 200,000 doctors short

by 2020. 20% of physicians in the United States are international medical graduates, and after India, the largest number of these are *from* the United States; Americans who trained abroad because of too few training slots. The shortage of health professional training in the United States greatly increases the drain of health professionals out of developing countries so that impoverished nations are subsidizing the training of doctors and nurses in rich countries while still being left without capacity. Increasing US medical school slots will be an important contribution towards slowing brain drain, and will serve as an important companion to a global initiative focusing on the supply side. Additionally, countries such as Canada and South Africa have established bilateral agreements to limit and compensate for health worker migration, which may present promising models.

- In addition to new measures to increase compensation and training in the developing world, the US should take steps to increase medical training slots available.
- The United States should promote international and bilateral agreements to financially compensate developing countries for losses incurred due to inadequate training capacity of industrialized nations.

Urgent action is needed to overcome the health worker crisis. None of the US or international global health goals, especially tackling HIV/AIDS, will make headway without significant mobilization of an adequately motivated, skilled, and supported workforce. For sub-Saharan Africa, with relatively modest investments, it is within our reach to achieve health workforce self-sufficiency by expanding training, deploying community-based workers, providing adequate compensation to health professionals, extending coverage in under-served communities, and strengthening of management, planning, safety, and support systems. An immediate infusion of resources could jump-start the workforce to reverse the spiral of avoidable death, sickness, and human suffering.

The challenge is large but the road ahead is clear. The need is beyond dispute and the costs are manageable. All that is necessary is sufficient commitment.

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