Health workforce benchmarks for universal health coverage and sustainable development

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Universal health coverage (UHC) includes the guarantee that everyone will be protected over the entire life-cycle by a defined set of essential health services fulfilling four interrelated criteria, as set out in Social Protection Floors Recommendation, 2012 (202) of the International Labour Organization (ILO): availability, accessibility, acceptability and quality.[1] Insofar as it furthers health, which is essential to human productivity and economic progress, UHC – and the health workforce needed to attain it – serves as a foundation to sustainable development.

Gaps in the health workforce – in number, distribution and skills – undermine service availability, acceptability, accessibility and quality. Such gaps can also create financial barriers and impoverish people when they have to seek care without being covered by a social health protection system or scheme. Access to quality services is vitally dependent on the existence of a health workforce that is able to meet needs and enjoys decent working conditions, characterized by training opportunities, attractive employment, good career prospects, fair remuneration, adequate social protection, a safe work environment and access to dispute settlement mechanisms, as described in the ILO Nursing Personnel Convention No. 149.[2]

Service accessibility is further compromised by factors external to the health sector that influence the financing of health and of the health workforce. Of particular relevance are the socioeconomic contexts in which people live and work. Poverty, unemployment and low wages affect a household's ability to pay for needed health care, be it through taxes, employee contributions, premiums or out-of-pocket expenditure. At the national level, high poverty rates and the existence of large informal economies often result in tax revenues that are insufficient for adequate funding of health care and that challenge governments' technical capacity to supply services in areas where unregistered workers and their families live. In highly vulnerable countries, defined by the ILO[3] as those where most people work in the informal economy and most of the population is poor, health care is accessible to much fewer people than in countries with low poverty rates and small informal economies.[4] Furthermore, in such countries most health care is financed by out-of-pocket payments that can reach catastrophic levels and plunge families into dire poverty or bar their access to needed care. According to the ILO, over 1.5 billion people in the world are living and working in socioeconomic contexts that challenge adequate financing of UHC and the attainment of sustainable development, so critically dependent on the presence of a healthy population.

Any health workforce benchmark for measuring sustainable progress towards UHC must reflect the above-mentioned aspects, including the basic socioeconomic causes of UHC gaps beyond the health sector.[5] One such benchmark is the ILO's staff-related access deficit indicator (SAD).[3,6] The SAD measures the relative difference between a particular country's health workforce density and the population-weighted median health workforce density in a group of countries defined by the ILO as having low vulnerability (and hence used as the global standard). These are countries with low poverty levels and small informal economies and therefore with the potential to successfully tackle the root causes of health workforce gaps and access-related deficits in UHC and, ultimately, to achieve sustainable development.

The SAD – currently 34.5 health workers per 10 000 population[7] – suggests that one third of the world's population lacks access to health care because of gaps in the health workforce. Globally, more than 90 countries are challenged by health workforce deficits. Burundi, for example, has a deficit of 33 health workers per 10 000 population, which leaves 95% of the population without access to health care. These and other countries with high levels of poverty and large informal economies should strive towards the achievement of the SAD benchmark by adopting coherent socioeconomic and health policies that foster sustainable development by prioritizing adequate labour market policies, poverty alleviation and decent working conditions. This relative benchmark has the flexibility to respond to health developments such as the growing burden of noncommunicable diseases and the demographic transition. It is useful for planning and investment purposes at the national level. Countries must, however, make internal decisions to achieve an equitable health workforce distribution and adopt socioeconomic policies embedded in national development strategies to create synergy between increased wealth and improved health. ■

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