The global significance of healthcare for the economy and labour market

In most countries, healthcare represents a considerable growth factor for the economy. In 2009, USD 5.97 trillion (USD 900 per person) were spent on healthcare throughout the world. On average, African countries spent 6.5% of their gross domestic product (GDP) on health, which corresponds to USD 83 per person. The South-East Asian countries spent an average of 3.7% of GDP or USD 48 per person (World Health Organization/WHO, Global Health Expenditure Atlas, 2012). According to WHO estimates from 2006, 60 million full-time paid employees work in healthcare, two thirds of who are direct healthcare providers (doctors, nurses, midwives, pharmacists etc.). The remaining one third works in support roles (managers, administrative personnel, ambulance drivers etc.). If we include workers who are indirectly employed in healthcare (e.g. in the insurance sector and associations), estimates rise to 100 million employees worldwide.

Typically, 70% of all doctors are male and 70% of all nurses and carers are female. This is an extreme imbalance which, as a rule, is more prominent in developing countries than in industrialised nations. Globally, around two thirds of all service providers work in public healthcare and one third in the private sector (WHO, World Health Report “Working together for health”, 2006).

A stabilising factor in times of crisis

As a labour market, the field of healthcare is not particularly sensitive to the economy. Instead, it is a stabilising element. This has been apparent during the latest financial crisis, when global employment figures have dropped drastically in many sectors whilst demand for healthcare personnel has increased constantly. The rise in employment in the health industry is surpassed in most developing countries only by the real estate sector and the building industry (ILO, Key indicators of the Labour Market -KLM, 7th Edition, 2011).

Main problem: the lack of qualified workers

For years, global unemployment figures in the healthcare industry have been low. However, numerous countries are suffering from a lack of qualified medical workers. In developing countries, this is usually due to insufficient financial resources for the education and training of nurses, doctors, midwives and other medical specialists. Now that an acute shortage of healthcare personnel has become evident in industrialised nations, too, developing countries are also faced with the increasing migration of qualified workers who are attracted or actively recruited by industrialised nations with better earning opportunities and working conditions.

In many countries, this brain drain has catastrophic consequences. In Africa, for example, the ratio of qualified medical staff to inhabitants is 2.3 to 1,000 compared to 18.9 to 1,000 in Europe. Whilst Africa has to bear 24% of the global burden of disease, just 3% of the world’s healthcare personnel work there. It is estimated that by 2015 the continent will have a shortage of 420,000 doctors (see Table 1 for figures on overall numbers of medical personnel).

The shortage of qualified workers is particularly serious in rural areas. Accommodation and transport problems resulting in the migration of personnel are often added to the poor working conditions. In many regions, specialist workers with little training (known as community health workers, fieldshers or promotores de salud depending on the region) and traditional midwives play an important role in providing medical services for the rural population.

Precarious working conditions

In most developing countries, public healthcare is characterised by a heavy workload, poor working conditions, low job security and proportionally low pay (especially for nurses and auxiliary personnel). The sector has one of the highest risks of illness in the workplace and absence from work. In many developing countries, healthcare workers are more af-

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<th>WHO-Region</th>
<th>Number of Countries</th>
<th>Deficit of Qualified Workers within States</th>
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<td></td>
<td>Total</td>
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Source: WHO, 2006
affected than normal by violence and sex attacks at work. Added to this, the risk of infection—above all in Sub-Saharan Africa—is considerable due to poor hygiene standards and a high proportion of HIV/AIDS patients in healthcare facilities. It is first and foremost women, who constitute the majority of people employed in healthcare (in some countries up to 80% of the total sector workforce), who are affected by these difficult working conditions.

The role of the private sector

In many developing countries, the private sector plays an increasingly important role as a provider of healthcare services and thus also as an employer. It generally offers better working conditions and better pay than public healthcare but in many countries it is subject to worse regulation. 30% of all doctors and more than 50% of all other health service providers in medium- and low-income countries are employed in the private sector (WHO, 2006). Also, the number of doctors who work in public healthcare and supplement their income with second, private jobs should not be underestimated.

More money for health – a curse or a blessing?

The issue of whether increasing funds for healthcare projects in developing countries has a positive impact on the employment situation in those countries is controversial. Proponents cite the great unmet need for qualified workers, which can only be satisfied through more expenditure on education and training and better working conditions and earning opportunities. They say that as long as international Development Cooperation (DC) work takes this into account, it has an important key to improving the employment situation.

Sceptics, on the other hand, remind us that prioritising the social sectors in the course of focussing on the Millennium Development Goals (MDG) will lead to a disproportionate amount of budget funds being allocated to the health and education sectors in many developing countries—at the expense of the manufacturing sectors and infrastructure projects. Whole professional branches would die out and qualified specialists from other sectors would emigrate. The result would be a service-based economy which—especially in countries with low population figures and low tax revenues—would not be in a position to generate sufficient state revenues or finance the import of required manufactured goods.

This argument, however, suppresses a second important aspect of employment promotion in the social sectors. Instead of regarding expenditure on personnel in the health and education sectors solely as a burden on the state budget as finance ministers in developing countries tend to do, an increase in numbers in employment in healthcare should also be seen as an important investment in the promotion of the health of the workforce in general (cf. the position paper on health and qualitative growth).

The impact of FC support on employment in the health sector

The division of labour between the German Financial Cooperation (FC) and Technical Cooperation (TC) is such that the TC is generally responsible for programmes directly relevant to employment in the health sector (e.g. education and training). Yet FC involvement in the health sector has a series of direct and indirect effects on employment.

Strengthening health systems

As part of its involvement in strengthening healthcare systems, the FC also includes the topic of the employment situation in sector dialogue with partner countries. Due to the high significance of good human resources management for the efficiency and effectiveness of healthcare investments, quantitative availability, training levels, pay levels and the motivation of qualified medical personnel play an important role in the assessment of a partner country’s sector policy. For example, solutions to the following issues are sought during dialogue with the partner country, in cooperation with the TC: What proportion of the budget should be spent on wages, salaries and allowances? How can the education and training of qualified workers be improved? What professional standards must be put into place and how can they be monitored? What incentives can increase the motivation of service providers and counteract the migration of doctors from rural areas?

Competition creates incentives for more and better employment

The topic of the qualification of specialist workers has long played an important role in approaches to projects and programmes. The majority of FC-financed infrastructure measures include a personnel training component. The financed projects only demonstrate their worth through the expert use of laboratory equipment and operating theatres, qualified administration of medicines and skilled provision of appropriate advice and information to patients.

The case study from Kenya (see box below) shows that the application of the principle of competition to the development of service providers can have a positive effect on employment figures, professional standards, working conditions and wage levels in both the private and public sectors. Attractive working conditions, job security and appropriate pay levels can make a decisive contribution to preventing the migration of qualified workers and counteracting the lack of personnel in developing countries.

In the Project “Support to Aga Khan University’s Health Programmes” in coordination with the East African Community, the training of midwives and nurses is even the central programme goal of the FC’s support via the development of the education infrastructure and the financing of education and training.

Promoting good working conditions

An important direct effect of FC involvement in the health sector is the improvement of working conditions in the sector. In the government-provided health service in particular, ramshackle wards and a lack of laboratory equipment and essential medicines often make the work of health service providers practically impossible. An improvement in the infrastructure and supply of medicines has tangible, positive effects on the motivation and ability to act of employees.

Efficient use of skilled workers

In the health sector, the FC is heavily engaged in the promotion of sexual and reproductive health and rights (SRHR). Here, it abides by the principle of promoting family
planning and mother-and-child health services and the prevention of sexually transmitted diseases as part of a single concept rather than as separate, specialist services. In view of the lack of qualified workers in many developing countries, these integrated services are an effective approach to efficiently deploying medical personnel, improving their levels of training, increasing their motivation and making them into a flexible resource.

**Positive effects for the employment situation in other sectors**

Health promotion also results in important, indirect positive effects for employees in other sectors and for the advancement of employment in rural areas and amongst women.

In addition to benefits enjoyed by the local and regional construction sector, health investment in developing countries gives rise to significant positive effects for important employers such as numerous suppliers, producers of technical medical equipment and the global pharmaceutical industry.

Good health provision – above all in rural areas – is an important prerequisite for the locating of trade in a specific region and the counteraction of migration to the cities.

In the field of HIV/AIDS in particular, health information and services are frequently directed at occupational groups which, due to their jobs (long-distance drivers, soldiers, sex-workers and migratory workers), are at especially high risk of being infected with a sexually transmitted disease. Workplace programmes which provide the workforce with information and destigmatise the subject of HIV/AIDS as well as the availability of condoms and voluntary HIV tests improve the working environment and reduce the risk of behaviour- and job-related disease.

Sex education and improved access to family planning services lead to women in developing countries having fewer children, thus giving them the opportunity to engage in productive employment. Together with the improvement of educational opportunities for women, the promotion of mother-child health is therefore a basic prerequisite for the better integration of women into the official labour market.

Furthermore, it has been proven that a reduction in childhood illnesses stabilises children's school attendance and improves their chances of access to employment.

**Prospects for the increased promotion of employment in the health sector**

The appropriate consideration of the promotion of employment is an important factor for the success of international cooperation in the health sector in view of the grave lack of qualified workers in the sector. Another aim is to increase awareness in Germany of the fact that poaching specialists trained abroad further heightens the crisis in the health sector of the country of origin. If these trends are not counteracted by means of a suitable agreement on the exchange of specialists or via compensation arrangements, the Development Cooperation will not be able to effectively combat the problem of the lack of specialist workers in the sector. Instead, the migration of health personnel could become an increasing risk to the success of FC and TC projects.

The FC can address this problem and provide positive impetuses for employment in the sector through a range of approaches.

1. As part of its contribution to the **promotion of the health system**, the FC must pay due attention to the different dimensions of effective healthcare provision. Fair access, quality assurance, the supply of qualified workers and health financing are four important topics to which the FC must devote its attention in both its approaches to programmes and sector financing. The fighting of individual diseases carries a risk of tying up scarce personnel resources, which are lacking in another area, i.e. in the provision of basic medical care. The fight against HIV/AIDS in Southern Africa is an example of poor management here.

2. The FC must **actively address human resources policies** in both sector dialogue and project-related cooperation with partners. Here, topics such as education and further training, the removal of inequalities in the regional distribution of specialist personnel and incentive systems for employees in rural areas are of central importance. In the case of the promotion of private healthcare providers, there is a risk that in many countries the lack of specialists in the already badly equipped public healthcare system will increase.

3. The integration and development of **community health workers** should be more heavily promoted through programmes in rural regions. They are less likely to migrate to the cities or abroad than fully trained qualified workers and their knowledge of the needs and health problems of communities make them important mediators in health systems.

4. In addition to improving the physical working environment (through the renovation of the infrastructure, laboratory equipment and similar), the FC should also aim to **improve working conditions**, especially for women. Abuses in this regard must be detected and remedied by means of sensible countermeasures (codes of conduct, more female managers and the establishment of interest groups).

5. If the FC also succeeds in **mobilising private capital** in partner countries in order to strengthen individual medical specialisms, invest in research and development and develop local medicine production, for example, new long-term jobs could be created in the health industry.

**Further information**

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The financing of infrastructure, contraceptives and consumables via the state healthcare system proved to be inefficient and not particularly demand-oriented, especially since healthcare providers were not offered incentives for providing their patients with the best possible care.

In 2004, the Kenyan government therefore agreed to a pilot programme intended to avoid many of the structural weaknesses of supply-oriented health financing. As part of this output-based aid (OBA) programme, it has been possible since 2006 for disadvantaged women in particular to obtain heavily subsidised healthcare vouchers, which give them access to certain SRHR services in accredited institutions. The doctor who treats them is paid by the voucher agency (a kind of clearing centre for doctors working for the service) upon proof of services rendered. The provider can decide upon the usage of income earned in this way. As the patient can freely choose the provider, competition for patients develops amongst the accredited public and private health institutions. This leads to investment where patients want to see it. Numerous examples show that these investments also benefit medical personnel.

The Provide International Centre in Nairobi’s poor quarter, Korogocho, has appointed five new employees since it joined the voucher scheme in 2008. Public institutions, too, have for the first time been able to independently appoint new employees as required for the duration of the scheme. In addition to a series of investments in medical equipment and the equipping of the labour ward, the Lumumba Health Clinic in Kisumu has also installed a kitchenette for employees – a small investment which might have a major impact on the morale of workers faced with long shifts without a break. As well as more nurses, the manager of a private clinic in Korogocho has recruited two locums who regularly help out in the clinic. A computer with Internet access has also been purchased so that employees have access to the latest information and trends in their medical specialism.

These examples show that the right incentives and a certain amount of financial leeway are required to enable healthcare providers to create jobs and improve the working conditions of employees. Through education and training measures and by monitoring work standards, the programme contributes to an improvement in the employment situation in the participating institutions.