

Paper Presented By Rotimi Sankore
on Resolving the Health Worker / Human
Resource Crisis in Africa
to 37th World Union Conference on Lung
Health

(Organised by the International Union Against
Tuberculosis and Lung Disease)

- Paris October 31st to November 4th 2006.

- **This year's Union conference theme of "*Strengthening Human Resources for better lung health*"** is indisputably one of the most important themes in healthcare. For Africa, it is probably the most important theme and I salute the union for choosing it.
- **Introduction:**
- We must make no mistake about this. The future of Africa hinges on whether or not its human resource crisis and in particular its health worker crisis is resolved within the next 5 to 6 years. If it is not then I have no doubt that we are facing the strong possibility that sometime in the near future the extinction of African's living in Africa will force itself onto the world agenda.

- This is no exaggeration. Africa is the only continent on which an estimated six million people die annually from a combination of diseases of which HIV, TB and malaria top the premier league of death. Not six thousand, not sixty thousand or six hundred thousand, but six million. Significantly, Africa tops virtually every other mortality league table from water borne diseases, maternal mortality, to child mortality to cervical, breast, prostate and every cancer known to humanity.

- To place this in context, we sometimes know things but need to see it from other angles to see its real impact. The annual number of deaths in Africa from disease is the equivalent of either of Libya (5.8m people), Eritrea (4.4m people) Sierra Leone (5.5m people), or Togo (6.1 people) disappearing every year. Or, any combination of Botswana, Swaziland, Lesotho, Namibia, Gambia and Gabon, Mauritius, Mauritania and Namibia all with populations of 2 million or less dying en mass every year.^[i] Other countries like Somalia, Tunisia and Chad are at the 10m people or less mark and could vanish in a year and half. If one were in the business of making money, the business to go into based on current projections would undoubtedly be the coffin making business.

- In any other context death on such a scale would be called genocide. The Nazis murdered an estimated 6 million Jews in 7 years from 1938 to 1945. In 1994, about 1 million Tutsis and other citizens were murdered in the Rwandan genocide in 100 days. Upwards of 2 million died at the hands of the Khmer rouge in Cambodia between 1975 and 79. In Darfur in we have not yet seen the final figure but the deaths are rapidly approaching half a million.

- Today, United Nations population researchers conclude that unless the spread of HIV alone is halted or reversed, Africa will top the global AIDS death league with about 100 million deaths by 2025. This is more than double the projections for India and China of 31 million and 18 million respectively, both of which have larger populations than Africa. People aged between 16 and 45 affected.
- If Africa has not recovered from the loss an estimated 100 million to slavery and slave trade induced death over a 400year period leading up to about 1850, clearly the chances of recovering from the same number of deaths within a 45 year period are impossible.

- It can therefore not be overstated that the numbers currently being lost to disease in Africa are untenable and unsustainable in the long run. On a continent of an estimated 900 million people^[iii] the implications of such deaths on such a large scale are clear for the stagnation of development, the collapse of economies and the possible disappearance of entire countries.
- But this need not happen. Almost all the diseases are preventable and curable with the notable of HIV, which is in any case containable given the right resources and policies.

- **Why is this happening and what does the health worker crisis have to do with it?**
- The astronomical number of people being lost to a multitude of preventable diseases in Africa points to one fact. Africa is suffering a public health care crisis. Not a HIV crisis, not a TB crisis or a malaria crisis but a public health crisis. In other words, these three diseases claiming lives in the millions and others claiming lesser, but no less significant numbers of African lives are but symptoms of a bigger problem.

- So we ask the crucial question. Is it in anyway possible to resolve Africa's public health care crisis without resolving the human resource crisis? Or to put it in a way most of our leaders will understand given the militarization of many of our countries over the past few decades. Is it possible to fight a war without an army? Is it possible for the war on disease to be fought and won without a well-equipped army of doctors, nurses, radiologists, laboratory technicians, community health workers and others? The obvious and resounding answer is NO!

- **Brain drain, pull {and linked push} factors deepening the Africa's human resource / health worker crisis**
- The WHO 2006 report paints a stark picture of the world's health worker crisis. It also reveals a little recognised fact outside healthcare circles i.e. that Africa is the only continent on which the total number of shortages (817,992) exceeds the existing number of health care workers 590,198. It also hints at an even more horrendous fact that is underlined by several studies over the last 5 years i.e. that Africa is also the only continent that has a greater percentage of its health care workers working outside Africa than those working in it. For instance studies indicate that there are more Malawian doctors working in the UK alone than in

- To quote Dr Peter Ngatia of AMREF “According to the International Organisation for Migration (IOM), Africa has already lost one third of its human capital and is continuing to lose its skilled personnel at an increasing rate, with an estimated 20,000 doctors, university lecturers, engineers and other professionals leaving the continent annually since 1990. This same source estimates that there are currently 300,000 highly qualified Africans in the Diaspora, 30,000 of whom have PhDs.”

- Overall [1] According to the 2005 World Migration Report a new generation of “Sub-Saharan African Diaspora has been mainly concentrated in the US (881,300), France (274,538), Britain (249,720), Germany (156,564) and Italy (137,780)”. Tens of thousands more are dispersed in lesser concentrations throughout Canada, Belgium, Holland, Ireland, Spain, and as far away as Australia, Russia, Eastern Europe and Asia. {Rotimi Sankore writing in the special cover report of New African, November 2005}

- So we know that the problem is not entirely caused by not training enough health care workers, but that it is also exacerbated by the fact that existing ones are leaving at a rate faster than they can be replenished. The crucial question then is why?
- **Push Factors**

- Many people have identified poor pay, lack of infrastructure, equipment, medicines, unstable societies and so forth as causes of this health worker exodus that exceeds biblical proportions – and they are right. In addition, many people have also cited the rights of individuals to seek better training, remuneration and overall job satisfaction and they are also right. These “push factors” are important and need to be remedied, but they are only one side of the coin.

- **Pull Factors**

- The other question many people have not asked nor answered is why are there so many health worker vacancies in the more developed parts of the world that it needs an exodus of tens of thousands of African and other developing world health workers to fill them? In one sentence, what are the real “pull factors”?

- One key answer not dis-similar from a crucial “push factor” is that beginning in the early 1980’s the level of investment in education dropped in many western countries in proportion to what was needed sustain the production of prerequisite numbers of health care workers and other professionals. This was the Reganite and Thatcherite era of vicious slashes in public expenditure including in education, which then had a spill over effect to other sectors of the economy and society.

- In the UK for instance, the end of grants to university students and the promotion of student loans meant that students and especially those studying longer courses like medicine, dentistry could graduate with debts of anything from £20,000 to £30,000. Not surprisingly student intakes dropped off and health care authorities with the active support of their governments turned to Africa and Asia to recruit health care workers knowing fully well that the health care worker shortages and millions of deaths they sought to avoid for their citizens (by robbing other countries) would befall those countries whose health care workers were poached.

- Even where health care workers were not comprehensively poached, the Reganite and Thatcherite driven imposition of IMF public expenditure cuts and ceilings amongst others resulted in the sickening contradiction of hospitals needing to employ staff but not being able to do so because of IMF and other IFI inspired budget policies. This has resulted a paradox in countries like Kenya, where simultaneously, there are thousands of nursing vacancies to be filled, but alongside this travesty there are thousands of unemployed nurses (whom of course will leave the country at the first opportunity they get)

- Generally speaking, the falling birth rates in the west but in Europe especially also means that many western countries have encouraged immigration of skilled workers and professionals from the developing world to make up their population deficits.

- These countries have created skilful ways to encourage active participation of African's and so we have a variety of schemes such as the Highly skilled Immigrant program in the UK and the Green card lottery in the US. In 2005, six African countries were in the top 10 countries with the greatest number of 'winners' of the US Green Card Diversity Lottery. These are Nigeria (6,725), Egypt (6,070), Ethiopia (6,060), Morocco (5,298), Ghana (3974), and Kenya (3,168). The total African figures for the top ten are 31,295 and the total non-African figures are 23,044. The figures are similar for the previous 10 years.

- In a paper for the Population Reference Bureau “ US Diversity Visa Are Attracting Africa’s Best and Brightest” Arun Peter Lobo an American population expert wrote that because “they provided a swift path to immigrate to the United States... the diversity visa program became the primary vehicle for the increased flow of skilled Africans to the United States”. He further stated that because “African immigrants are disproportionately [higher] in professional, managerial and technical (PMT) occupations” 44% compared to 34% of all immigrants – “their departure could further undermine social and economic conditions on the African Continent.”

- The situation could still get worse for Africa. In a research paper Europe: A new Immigration Era Professor Philip Martin and Jonas Widgreen experts on labour, economic development and migration point out that with Europe's fertility rates in decline, if Europe's big four France, Germany, Italy and the UK want to maintain their 1995 labour force populations at the same level by 2050, immigration would have to rise to 1.1 million a year from 237,000.

- In a special chapter devoted to Africa, the 2005 World Migration Report states that “Africa is now the only continent that still faces all of the classical obstacles to successful development”. One of these five obstacles the report emphasises is “brain drain, which has continued steadily since the period of independence [and] is depriving Africa of a very significant part of their skilled human resources, which they have trained at considerable cost”.

- Research by the IDRC indicates that “the United States, with its 130, 000 foreign physicians, saved an estimated US\$26 billion in training costs for nationals... while estimates suggest that Africa spends approximately US\$4 billion annually on salaries of 100 000 foreign experts (all sectors, not only health) to ‘build capacity’ and/or provide technical assistance, and incurs a loss of US\$184 000 per migrating African professional”.

- Quoting WHO and OECD figures amongst others, IDRC further illustrates the problem using the cases of Nigeria and South Africa Africa's two powerhouses. "One-third to a half of all graduating doctors in South Africa migrate to the US, UK and Canada, at a huge annual cost to South Africa (lost investment in education/training). Including all health personnel, the losses for South Africa reach US\$37 million annually. This exceeds the combined (multilateral and bilateral) estimated education assistance for all purposes, not just health professional training, received by South Africa in 2000." Alongside this "over 21 000 Nigerian doctors are practising in the US, while there is an acute shortage of physicians in Nigeria."

- Not surprisingly, [while noting that Italy is the only G8 country that produces a surplus of physicians and nurses] IDRC concludes that “another reason for the deterioration of health-care systems in developing countries is the ‘brain drain’ of health professionals... which primarily benefits wealthier nations, such as the UK, the US and Canada, [and] calls into question G8 commitments to support developing countries in reaching health targets of the International and Millennium Development Goals”.

- **What is to be done?**
- As always, the question as asked by a historically famous revolutionary politician is the most crucial one – what is to be done?

- For some of us that have joined the struggle to resolve Africa's public health care crisis from a human rights point of view there is absolutely no doubt in our minds that the right to health and health care is the most vital right of all. This is not just because every single human being on the planet will suffer sickness at some point in their lives, and therefore potentially suffer a violation of the right to health, its also because as we have concluded in CREDO - Africa, *“you have to be alive and well to be able to enjoy or exercise any other right in any meaningful way”*.

- If we agree that healthcare is a right in its own right and also an access right to the right to life then we must seek to ensure that that right is enforceable, not least because failure to enforce it could potentially lead to the death of any single person or any society as whole in a way that the failure to uphold any other right does not affect people.

- Africa's public health crisis and in particular the human resource component of this crisis can therefore not be resolved outside of the context of upholding the right to health. In turn, the right to health cannot be upheld in any sustainable way unless African governments commit and are allowed to commit adequate resources to health care
- CREDO-Africa has therefore concluded that in practical terms the following constitute the core of what is to be done and accordingly seeks the support of all African's and friends of Africa (including the International Union Against Tuberculosis and Lung Disease) for our campaign to achieve the following campaign objectives-

- **In Africa: 15% Now! Train and Retain Africa's Health Care Workers**
- That African governments make resolving the health worker shortage their number one public health care priority and in consultation with health care workers and other civil society, set measurable targets for training, retention, and resolution of all push factors that facilitate exodus of health care workers including reviewing remuneration and working conditions for health care workers.

- That towards this goal, African governments immediately implement their pledge to dedicate 15% or more of their annual budgets to health care (and ensure that a commensurate percentage of this is dedicated to resolving the human resource crisis).
- That the allocation and expenditure of this 15% or more be monitored by health care professionals and other civil society.

- **Internationally: 15% Now! End the Health Worker Brain Drain**
- That western and international public pressure is placed on International Finance Institutions, donor countries and the IMF in particular to ensure those conditionalities such as expenditure ceilings and other policies that hinder healthcare development and ancillary pillars such as education are immediately ended. In particular any such policies that stands in the way of 15% or more of budgetary expenditure being dedicated to healthcare is ended.

- That western governments that benefit, promote and depend on brain drain to prop up their health care systems immediately cease any domestic policies that promotes such and in particular ensure that they increase domestic public expenditure for education in general and health care worker training in particular.

- That governments of countries that have benefited most from the “brain drain” cease such policies and together with African governments and African civil society examine ways to compensate Africa’s health care system for the damage their recruitment policies have done.
- That the next 2007 International Aids Conference to be held in Mexico places commensurate emphasis and focus on the scaling up human resources and health care infrastructure, especially in Africa.

- That all intergovernmental organisations such as UNAIDS and its sponsoring agencies focus on and take practical steps towards supporting the resolution of Africa's human resource and infrastructure shortages within the next 5 to 6 years.

- ***Sankore is Coordinator of Centre for Research Education & Development of Rights in Africa [CREDO-Africa]. He can be contacted at: info@credonet.org**
- [\[i\]](#) UN Population division, world population chart for 2004
- [\[ii\]](#) UN Population projections for 2005 (in 2004)