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How the Global North is solving its health worker shortage while exacerbating the Global South's

Nago Humbert • Observatoire Éthique et Santé humanitaire

It is an issue spanning ethics, professional conduct and social justice that Nago Humbert, a specialist in medical psychology and paediatric palliative care and head of the humanitarian think tank Observatoire Éthique et Santé humanitaire, presents here. Observing an imbalance between the numbers of health workers in the Global North and those in the Global South, he stresses the need for the former – and its humanitarian organisations – to stop keeping this fatal imbalance in place.

Each year, almost five million children die before reaching the age of 5. Most of them live in sub-Saharan Africa and Southeast Asia, and most die from an illness that could be treated with simple resources that our so-called developed countries have access to, for instance antibiotics to treat pneumonia or rehydration to treat diarrhoea. Yet for at least half of these tragically untimely deaths, the main cause is malnutrition, particularly fatal when a child suffers from another condition like sickle cell anaemia or AIDS. So we cannot consider these deaths inevitable, as we tend to do too easily when a natural disaster claims lives.

When you compare government investment in healthcare systems – especially in Africa – you see a correlation between investment and a fall in infant mortality rates. And infant mortality is intrinsically linked to poverty as the survival rates of children aged under 1 are lowest in the world's poorest countries. Incidentally, we can suppose there is a similar trend in the poorest classes of Western societies.

As regards maternal mortality, reducing cases is one of the toughest aims to achieve through the United Nations' Sustainable Development Goals (SDGs). By 2030, in sub-Saharan Africa, 390 women will die in childbirth for every 100,000 live births.[1] According to the World Health Organization (WHO), roughly 830 women worldwide die each day due to complications from pregnancy or childbirth: "In 2015, 303,000 women died during or after pregnancy or childbirth. Most of these deaths were in low-income countries and the majority could have been avoided."[2]

[1] ReliefWeb, *Atlas of African Health Statistics 2022: Health situation analysis of the WHO African Region*, 1 December 2022, https://reliefweb.int/report/world/atlas-african-health-statistics-2022-health-situation-analysis-who-african-region
[2] Organisation mondiale de la Santé, *Mortalité maternelle*, 19 septembre 2019, https://www.who.int/fr/news-room/fact-sheets/detail/maternal-mortality

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This woeful observation shows we are a long way from achieving the SDGs and that there is still much work to be done to reduce infant mortality by two-thirds and maternal mortality by three-quarters, to stop the spread of AIDS and to control malaria and other major diseases like tuberculosis, cases of which are constantly on the rise.

Access to care and a shortage of health workers

If the global rate of maternal mortality is so high, we can look to the shortage of qualified health workers for a reason why. In Africa, only 65% of births are supported with the presence of qualified health workers – that is the lowest level in the world, and one that is far below the target set at 90% for 2030.[3]

On a global scale, an extra four million health workers are needed to meet the SDGs. Developing countries and Western countries largely share responsibility for this shortage. The former are responsible because of their negligence and lack of determination to set up a health system that gives everyone access to care. The latter are responsible because they can only conceive of one model of health system – their own – while often taking advantage of a workforce that comes from developing countries to make up for a shortage in the Global North. For example, in Switzerland there are 4.5 doctors for every 1,000 inhabitants; in France 3.26; in the United Kingdom 2.3, and in Malawi 0.02. Yet there are more Malawian doctors in Manchester than in Malawi!

When you look at the percentage of doctors for every 1,000 inhabitants, you realise that the whole of sub-Saharan Africa – with the exception of South Africa – is below the threshold of 0.5%.[4] A 2022 WHO survey of 47 African countries found that the region "has a ratio of 1.55 health workers (physicians, nurses and midwives) per 1,000 people, below the WHO threshold density of 4.45 health workers per 1,000 people needed to deliver essential health services and achieve universal health coverage."[5]

According to the International Organization for Migration, Africa has already lost one-third of its health workers.[6] It is estimated that over the past thirty years, an average of 20,000 qualified workers have left Africa each year. And everything suggests that this uptick of migration towards the Global North is set to continue. We will not go into the consequences of the disastrous policies in structural adjustment that were imposed in the 1990s by institutions like the International Monetary Fund (IMF), whose restrictive

[3] ReliefWeb, *Atlas of African Health Statistics 2022…, op. cit.*
[4] L'Atlas sociologique mondial, *Classement des États du monde par nombre de médecins pour 1000 habitants*, 4 mars 2020, https://atlasocio.com/classements/sante/professionnels/classement-etats-par-nombre-de-medecins-pour-1000-habitants-monde.php
[5] World Health Organization, "Africa's advances in maternal, infant mortality face setbacks: WHO report", 1 December 2022, https://www.afro.who.int/news/africas-advances-maternal-infant-mortality-face-setbacks-who-report
[6] International Organization for Migration (IOM), www.iom.int See also Medicus mundi Suisse, *L'émigration des personnels de santé : une pénurie mortelle ?*, 3 septembre 2008, https://www.medicusmundi.ch/de/advocacy/publikationen/news/2008/09/03/l%E2%80%99emigration-des-personnels-de-sante-une-penurie-mortelle ; et Organisation mondiale de la santé, *Migrations internationales des personnels de santé : un défi pour les systèmes de santé des pays en développement*, 16 janvier 2008, https://apps.who.int/gb/archive/pdf_files/EB122/B122_16Rev1-fr.pdf

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measures have stopped some governments from recruiting health workers. Their effects still being felt today: suffice to say that a few years ago, Kenya's health minister was unable to recruit unemployed nurses because of conditions put in place by the IMF.

Double jeopardy: the ethical responsibility of governments and NGOs

Switzerland's role in draining health workers from the Global South is doubtless more limited than that of countries that once wielded colonial power. But through a domino effect, Switzerland still contributes to the drain on Africa's health workforce, as well as that in neighbouring countries like France and Germany. Around fifteen years ago, we took part in a Swiss Confederation committee meeting on the issue of the health worker shortage alongside the president of the *Fédération des médecins suisses* and the president of the *Association suisse des infirmières et infirmiers*.[7] Our conclusions were very clear, and they sadly still apply today: it is unacceptable that a country as wealthy as Switzerland is not training enough health workers – especially doctors and nurses – to care for its own people while taking advantage of health workers trained abroad without contributing to their training costs and impoverishing the health systems of these workers' native countries – which, as we called out, are in a situation of double jeopardy.

In German-speaking Switzerland, there was a shortage of doctors to run hospitals effectively. However. this was offset by an influx of several thousand doctors from Germany. So, Germany's health system lost this number of doctors and had to look to Poland, Ukraine and the Czech Republic to recruit new ones. In turn, these countries recruited doctors from countries further east. And then these nations had to look to Africa to find doctors – and so we come full circle. A few years ago, a German health minister jokingly threatened the Swiss government on this precise matter. He quipped that he would be sending them an invoice for their doctors' training costs. He did have another ace up his sleeve that he clearly didn't use: increasing the salaries of junior doctors in Germany, putting their pay at the same level as that of Swiss junior doctors; Switzerland's hospitals would have struggled.

However, the motivations behind this medical emigration from the Global South to the Global North are not purely financial. Other factors weighing heavily include prospects for professional development in training and research as well as political and social instability (caused by armed conflict, insecurity and corruption). If no serious reflection on how to reverse this trend is undertaken, this fatal dearth of health workers in the developing world will have more dire consequences in the coming years, not least because of population growth in the Global South.

We need to start by reviewing the policies of the World Bank[8] and the IMF, which impose drastic budgetary measures that result in less leeway for public health budgets. Drafting

[7] Fédération des médecins suisses (FMH), www.fmh.ch ; and Association suisse des infirmières et infirmiers, https://sbk-asi.ch
[8] World Bank, https://data.worldbank.org

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international treaties on brain drains is another solution. As regards careers in health, partnerships should be rapidly fostered between the Global North and the Global South, especially between university hospitals in order to provide additional training tailored to medical needs specific to developing countries and, in conjunction with them, make jobs more attractive for returning trainees (through research projects, infrastructure, etc.). The ground should be prepared for this return of health workers well before they leave for the Global North and their return should be incorporated into training schemes – with guarantees from partners in the Global South. At the same time, we need to openly discuss a widespread trend in development aid: what we could call a symptomatic funding of health. In the 1990s and 2000s, priority was given to the fight against AIDS. That was clearly vital and appropriate. But an automatic effect of this was an ever-greater lack of funding in other fields of health: tuberculosis, malaria and malnutrition still cause more harm in Africa than AIDS does. It could be said that Western countries experienced a similar trend with Covid-19, albeit on a different scale. Policies in the funding of health systems crucially need to adopt a comprehensive, systemic vision.

The responsibility of humanitarian NGOs

How can humanitarian organisations help reduce this fatal shortage of health workers in the Global South? First, as a bare minimum, by not participating in the massive brain drain, but this is often not the case. Indeed, the arrival of substitute health workers from the Global North in certain part of the world that do not have a health system can have a paradoxical effect: it can prompt a departure of the small number of local health workers who are already there. Several years ago, at Doctors of the World – Switzerland, we decided not to send doctors to a provincial hospital in Haiti. This was simply because the handful of local doctors who were already there would have used this influx of new doctors as an opportunity to leave their provincial hospital, settle in the capital and start a medical practice there. We need to urgently consider the impact that our actions have on national health systems before we undertake projects in the field, however generous and charitable those projects might be.

When we try to improve access to care among the most vulnerable, we should never let our presence undermine a national public health system. Yet medical NGOs do undermine public health systems through an approach that is, in itself, laudable: a desire to recruit local health workers. Many doctors devote themselves to NGOs to the detriment of their own health system – and not only for financial reasons, as we have already mentioned.

When a natural disaster hits a country, the mass recruitment of local workers for just a limited time often causes an imbalance in that country's health system. Following the Gaza Strip bombings in 2008, most NGOs decided to focus efforts on mental health to treat post-traumatic stress disorder among the local population. Consequently, they widely recruited – at wages much higher than usually paid in the Gaza Strip – Palestinian psychologists who had been trained through the Gaza Community Mental Health Programme and worked for this institution. A few months later, when these NGOs' emergency projects ended, they let go of all these local professionals. It was Dr Eyad al-Sarraj, the founding director of this

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remarkable institution – which we worked with in the early 1990s – who alerted us to this kind of collateral damage that humanitarian NGOs can cause through their projects.

We need to stress that the burden of responsibility for shortages of health workers – and for solutions to cover any shortfall – is clearly shared between both Western governments and those of developing countries. The former are responsible because they do not train adequate numbers of health workers to care for their own populations. They make up for their lack of action and vision by relying on health workers from less developed countries. The latter are responsible too because, although they admittedly lack resources, they also lack the political will to invest in health budgets and therefore develop health services their populations can access. They would doubtless achieve this if they finally introduced universal health coverage and guaranteed decent pay and working conditions for their health workers. This would prevent health workers there from all too often holding on to a single ambition after completing their training: emigrating to the West.

Translated from the French by Thomas Young

Biography

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