Austerity and mobility of health workers in Eastern & Southern Africa

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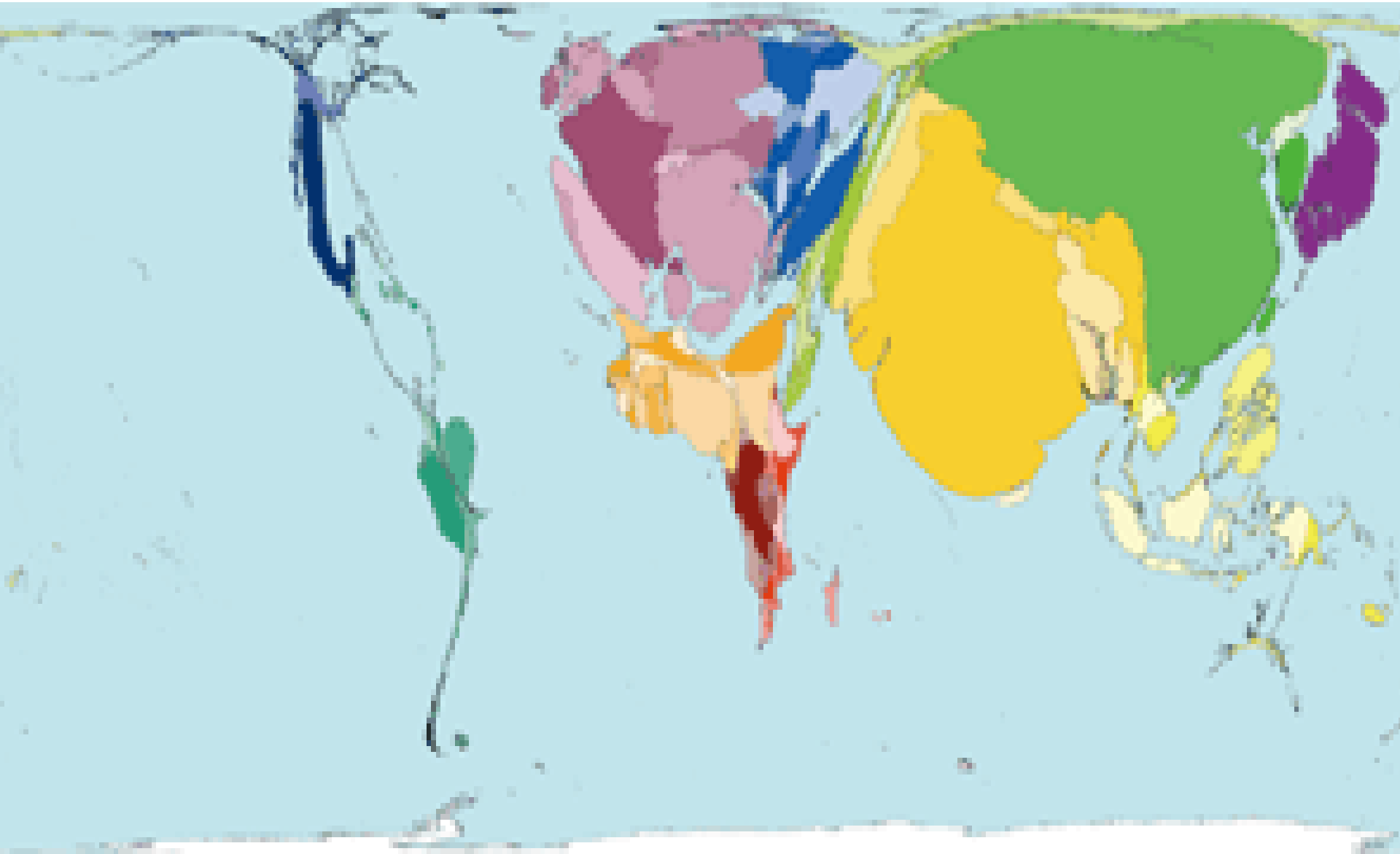
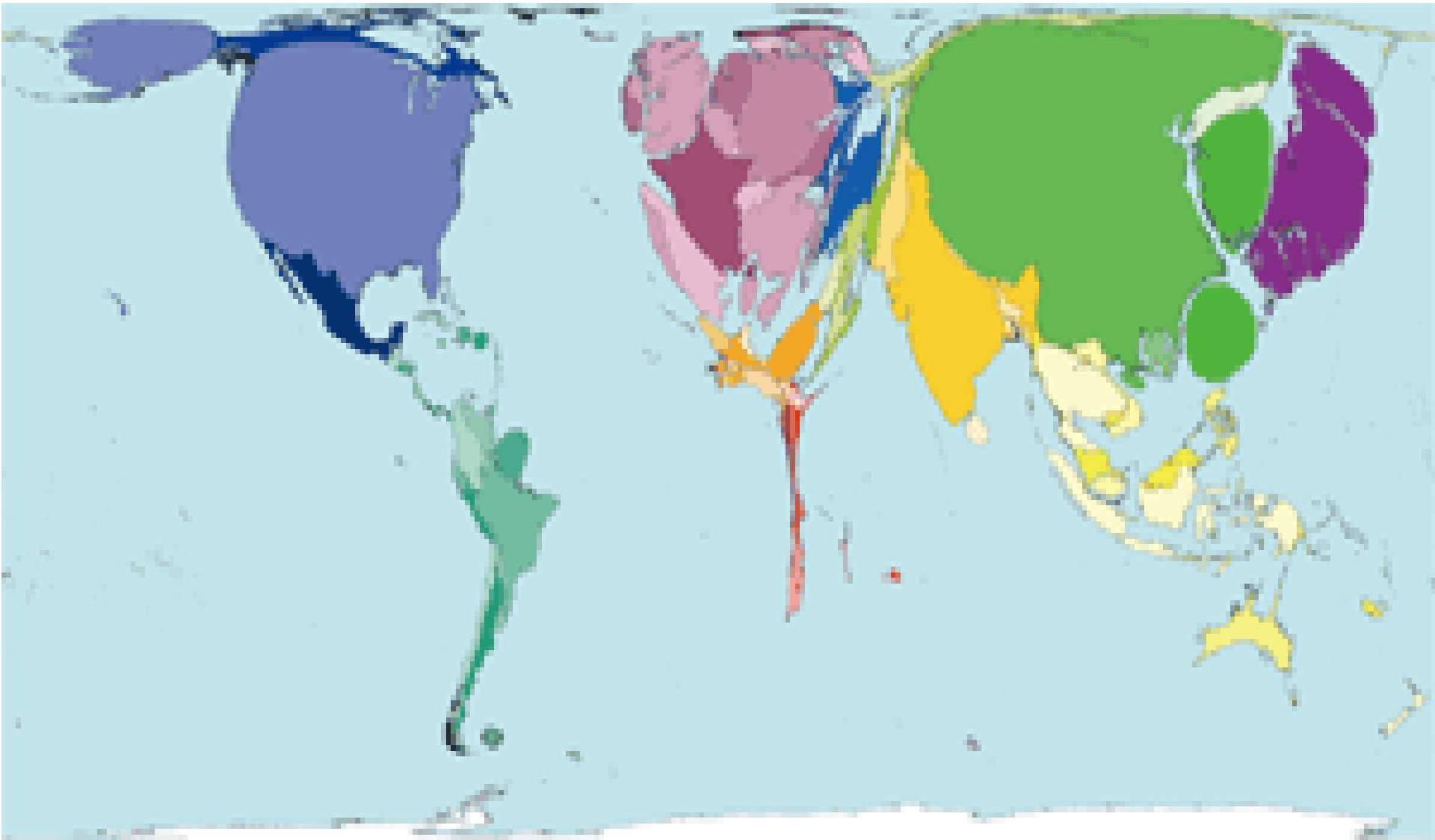
The African Challenge

- High disease burden; low density of health professionals (associated with relatively high mobility)
- Under-development; many "hard-to-reach" areas (rural/remote) → unattractive to health professionals
- High % of rural populations
- Chronic under-investment in health; generally low salaries, poorly resourced facilities
- Rural communities often have greatest health needs → inequitable access

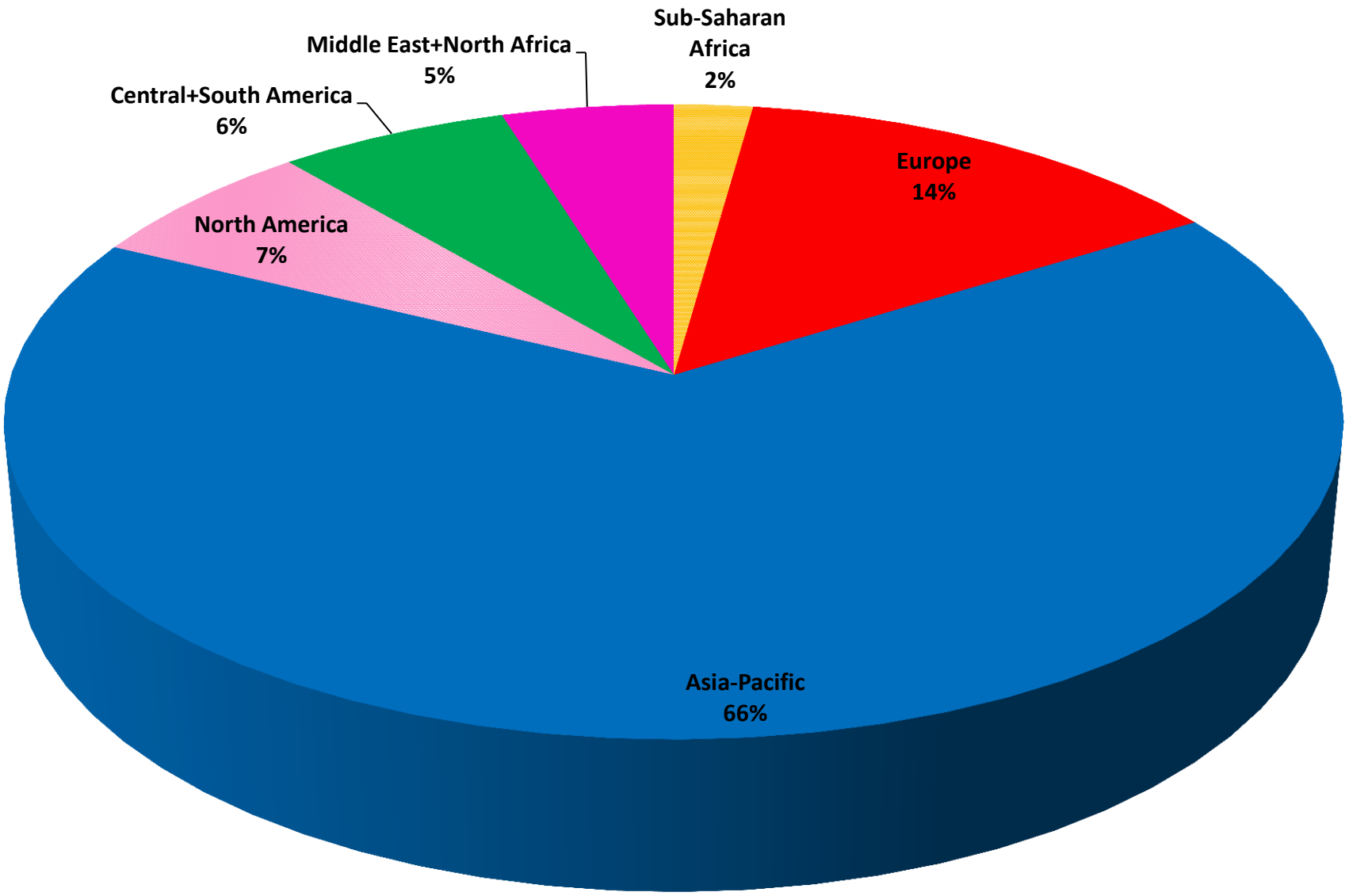
World Wealth Distribution: 1500



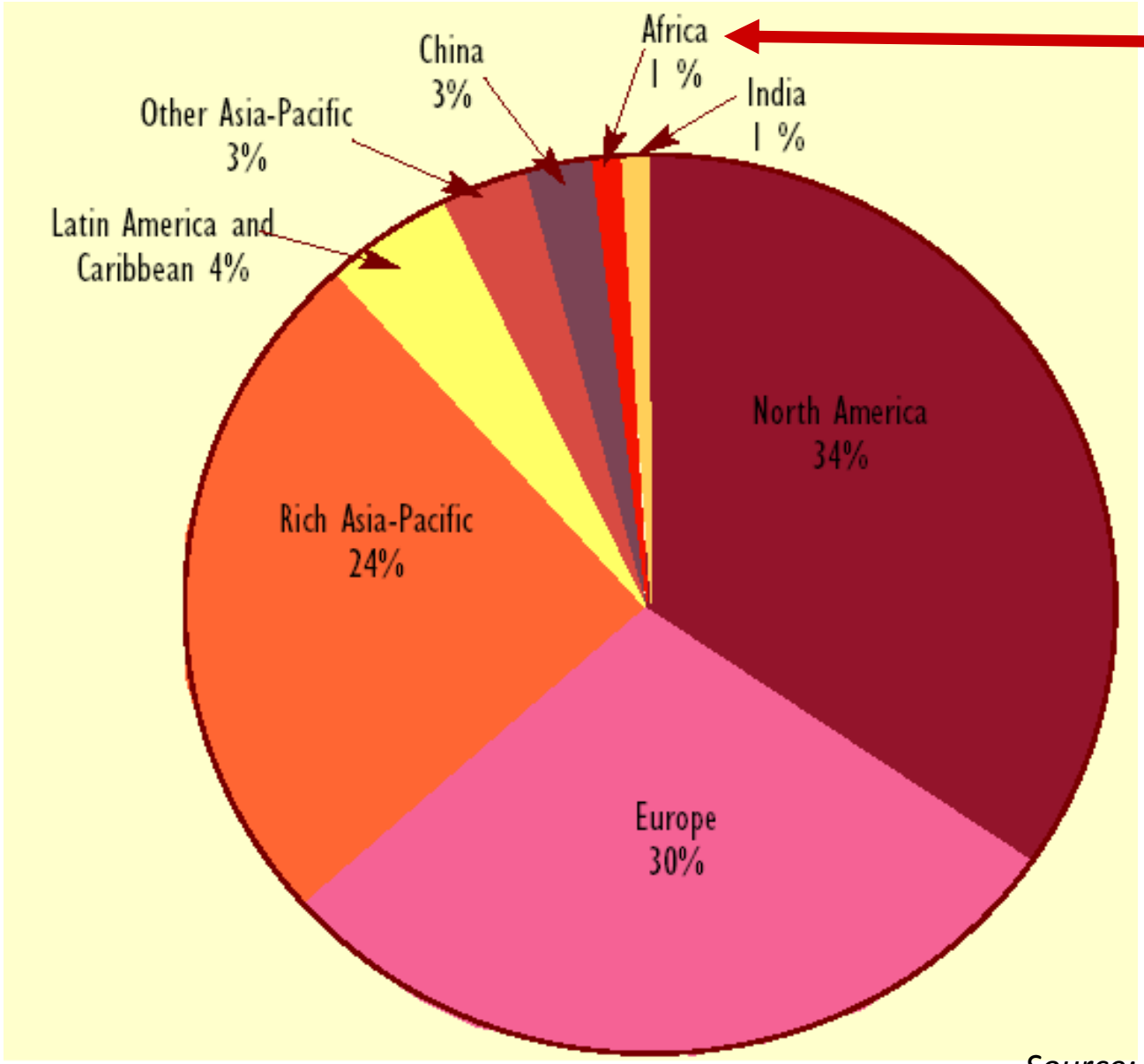
World Wealth Distribution: 2015



World Middle Class by 2030



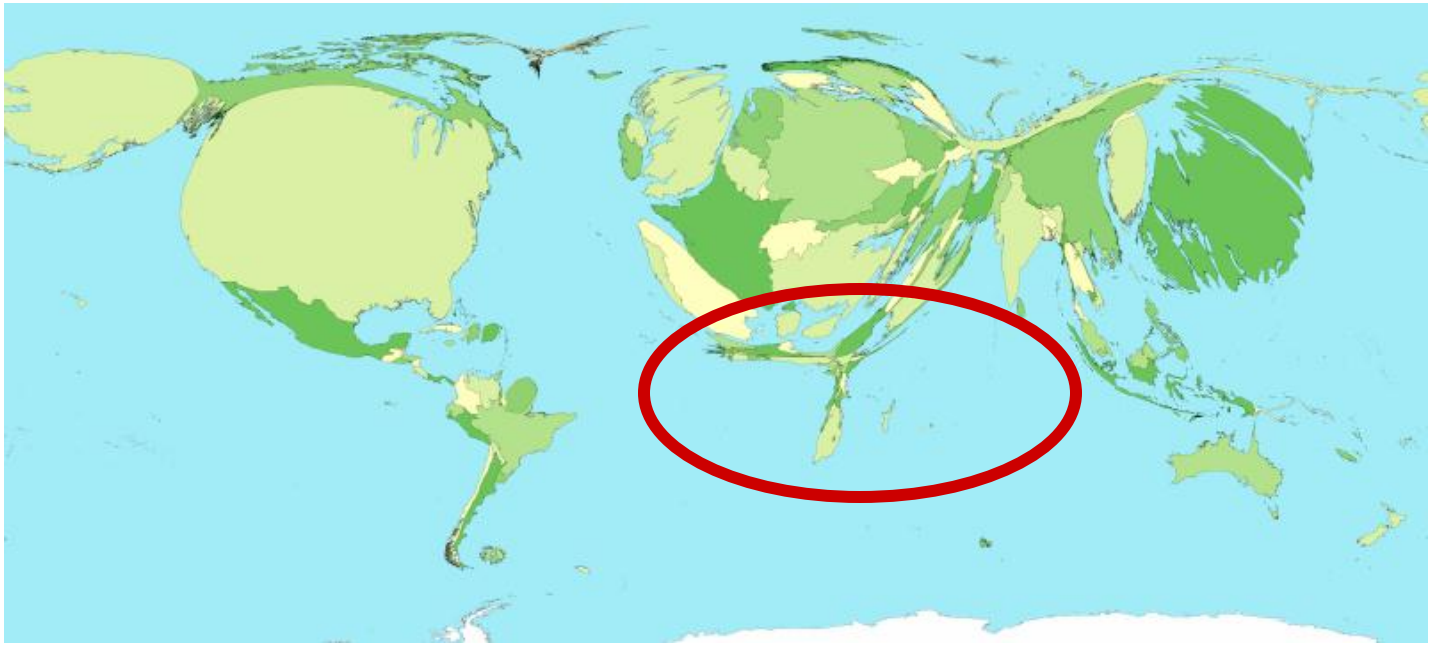
Global inequalities: African disadvantage and global PHC?



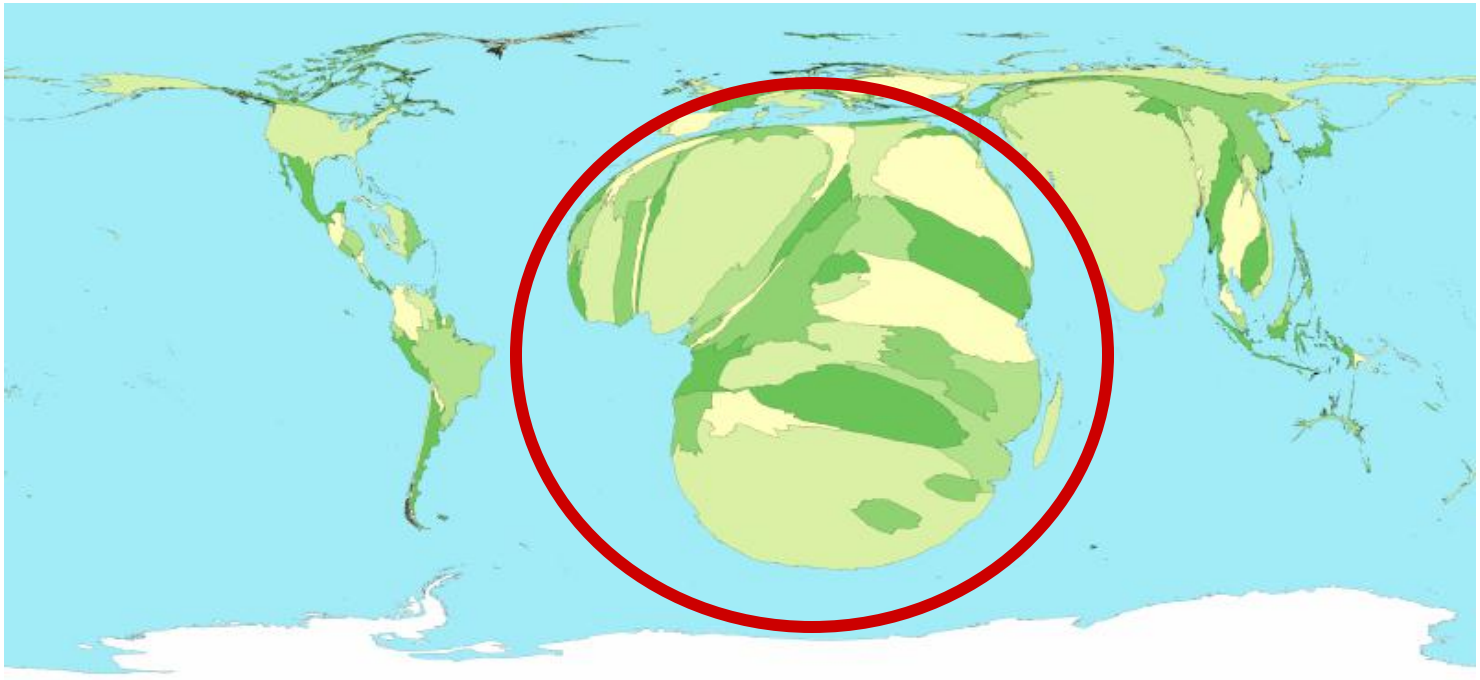
AFRICA:
10% population
25% disease burden
60% people living with HIV
1% global health spending
2% global health workforce

Source: Davies et al 2006; Atim 2006

GDP



People living with HIV and AIDS



Source: Newman 2006, www-personal.umich.edu/~mejn/cartograms/

Impact of Structural Adjustment Programmes

'By the end of the 1990s, the health systems in most sub-Saharan countries had virtually collapsed. Few people could afford annual check-ups, medicines or user fees at hospitals. One result was the resurgence of infectious diseases such as malaria, tuberculosis and cholera. A WHO study revealed that in some developing countries, malaria deaths tripled in the first four years of the reform, partially due to the collapse of curative health services and the soaring prices of antimalarial drugs. Such was the impact of structural adjustment programmes on the health systems of most African countries.'

E Samba, WHO Regional director for Africa, December 2004

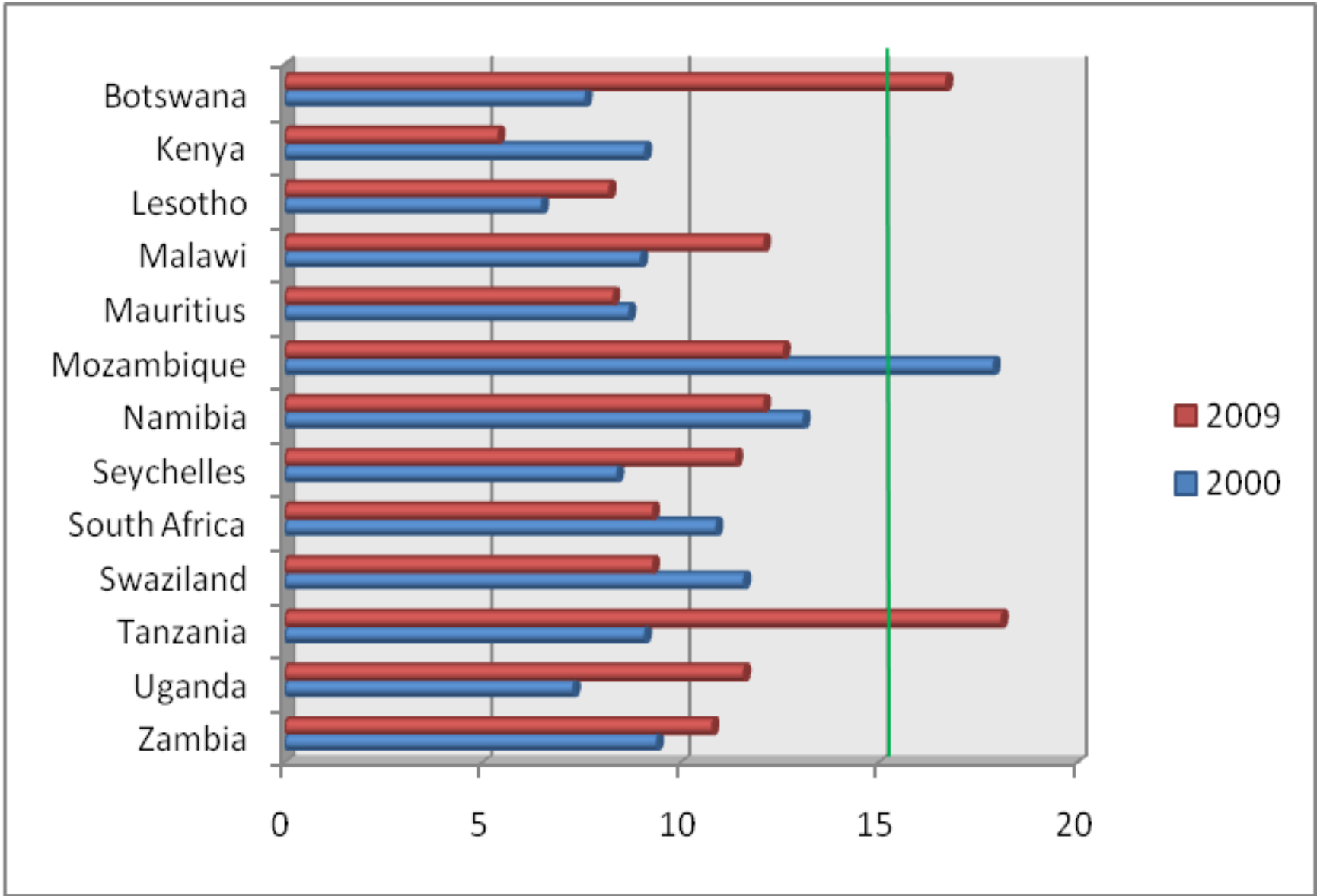
Health Financing in ESA Region

Per Capita Expenditure on Health in US$

Country	Year 2000	Year 2009
Botswana	155	612
Kenya	17	33
Lesotho	28	70
Malawi	9	19
Mauritius	145	383
Mozambique	14	25
Namibia	131	258
Seychelles	402	366
South Africa	251	485
Swaziland	78	156
Tanzania	10	25
Uganda	15	43
Zambia	18	47

Towards Abuja Declaration Targets

Government Health Expenditure as a Percentage of General Government Expenditure



Towards Abuja Declaration Targets

- In 2009, two countries were spending at least 15% of Government funds on health.

- Most countries were making progress towards the Abuja Target.

- A few countries were spending less in 2009 that they did in 2000.

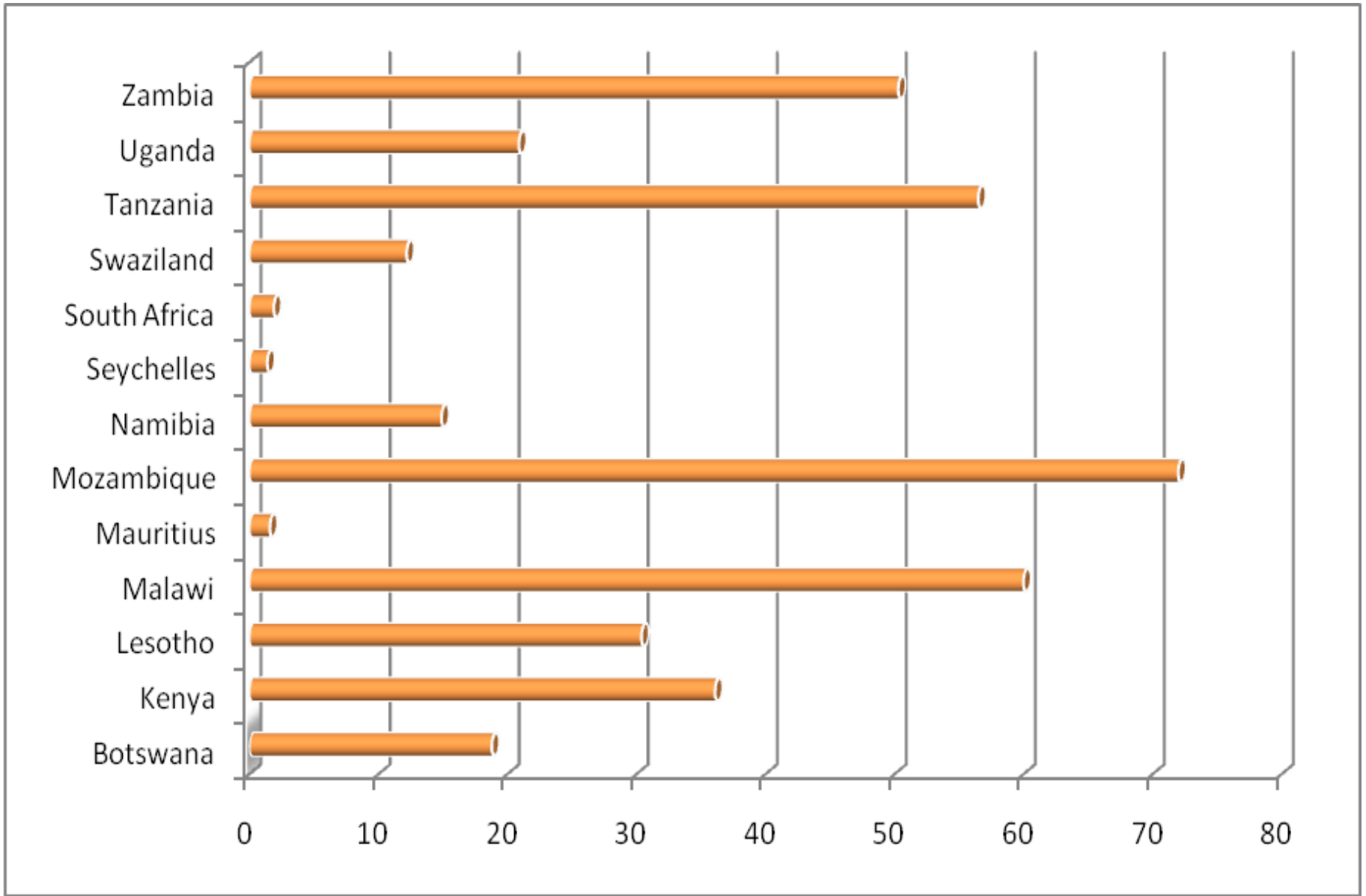
- Achievement of the Abuja Declaration target may not always result in a significant increase in resources. However, given the benefits of tax funding, this may be viewed as a proxy of Government commitment to improve health financing

Reliance on External (Donor)Funds

- Most ECSA countries are unable to raise sufficient domestic funds for health and as such, complement domestic funds with donor aid.
- The flow of external development aid is dependent on a multiplicity of factors, some beyond the control of the health sector.
- Financing of health services from external sources is unpredictable & unsustainable in the long term.
- Dependence on external donor funds also raises issues of alignment of the funds to country priorities, but also predictability in funds flow.

Donor Dependence in ECSA

External Funds as a Percentage of THE (2009)



Donor Dependence in ECSA

- The extent of donor dependence in health varies between countries. Some countries heavily depend on donor funds, while others are not.

- Reliance on external funds brings about the following challenges:
  - Financial sustainability of programmes in the medium/long term
  - Predictability in the flow of funds
  - Alignment of expenditures to country priorities
  - When the donor sneezes……

Under-investment in Health & HP Migration

- "Doctors continuously rotate to countries offering a better standard of training, more attractive salaries and working conditions, and a higher standard of living" (Eastwood et al, 2005).
- Such was evident in the early 2000s in Tanzania, DR Congo, Kenya, where doctors moved to South Africa, with South African doctors going to the UK, British doctors going to Canada and the USA, and Canadian doctors to the USA, the "conveyor belt around the globe" (Bundred and Levitt, 2000, Mullan, 2005).
- The loss of a sizeable number of highly skilled health professionals from African countries affects the functioning of the already weak health systems (Hyder, 2003; Buchan, 2003; Liese Dussault, 2004).

Scope of HCW Mobility

- Internal
  - rural – urban
  - Public – private
  - Poor – wealthy
- International
  - Managed (bilateral agreements)
  - Within the region
  - Beyond Africa (UK, USA, Canada, Australia, NZ)
  - Temporary/long term/permanent
- Which professionals?

Consequences…..

- Migration of skilled health professionals from Africa may adversely affect the quality, effectiveness and equity of health care offered in health institutions,

- Movement of health professionals to the private sector may seriously disadvantage the poor, most of whom cannot afford the fees charged at private health institutions.

- In countries such as Zimbabwe and Cameroon, the extent of migration of health professionals had made it necessary for non-qualified personnel to perform duties that are normally beyond their scope of practice (Awases *et al*, 2004; Chimbari et al, 2008).

- Countries that lose scarce skilled staff suffer a negative impact on the effectiveness of their health care systems (Ojo, 1990; Moses et al, 2006; Stilwell et al, 2004; Serour, 2009).

‘Knock-on’ Costs of HCW mobility

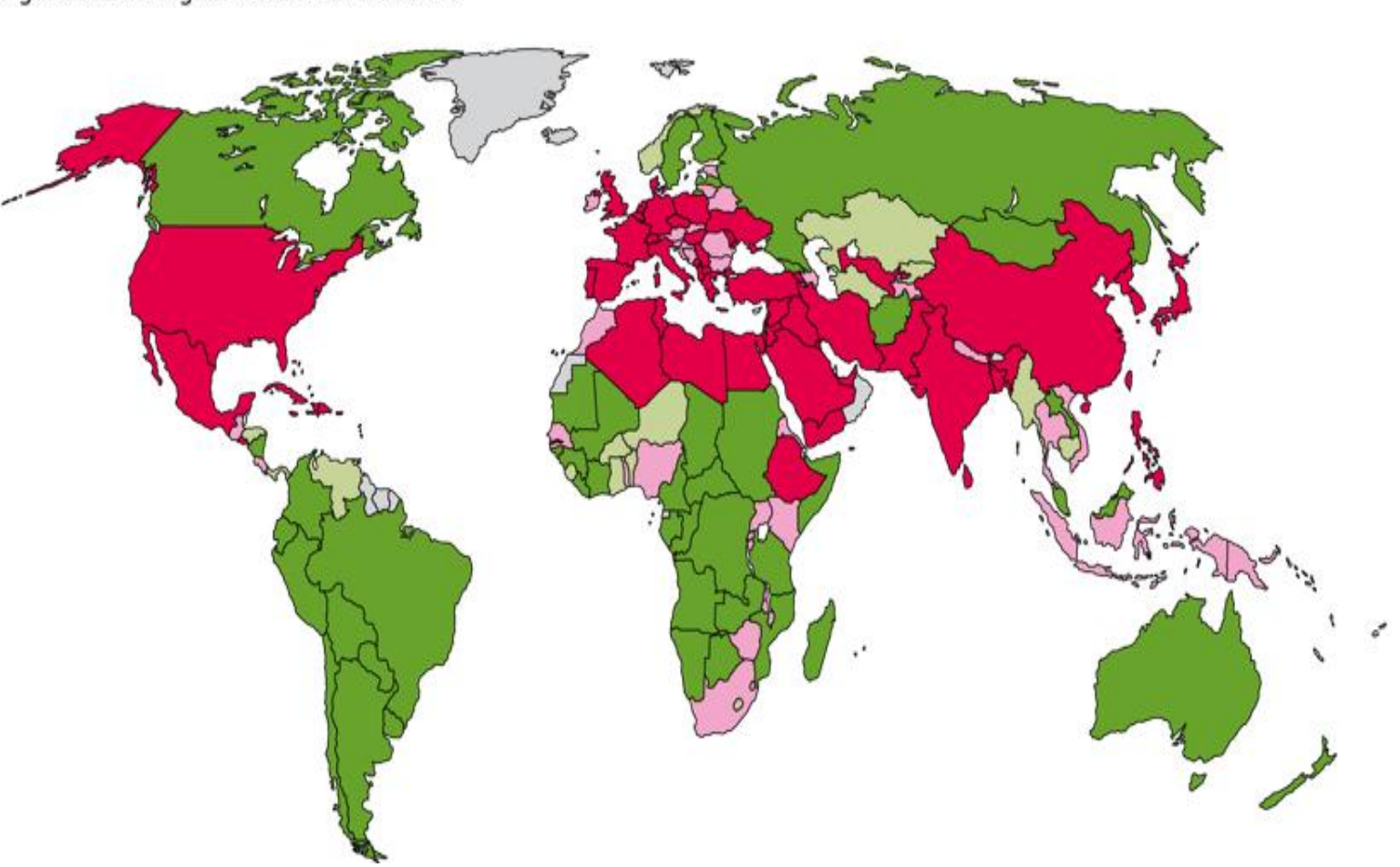
- Negative effect on overall functioning of health systems
- Loss of institutional memory and experience
- Unmanaged disease burdens
- Costs to households of seeking care at higher levels
- Costs to families and communities of lost members and skills

Outflows of wealth from Africa

- Debt payments
- Transfer pricing
- Falling terms of trade, unequal tariff regimes
- Loss of capital due to privatization
- Patent, copyright, management and consultancy fees
- Outflows of profits
- Increased interest rates in industrialized countries (debt more expensive)
- Uncompensated skills outflows
- Depletion of natural resources
- Biopiracy

Ecological Creditors and Ecological debtors

Figure 6.59 Ecological creditors and debtors



Source: WWF 2006a

EQUINET Suggested Interventions….

- Increased recognition of unfair trade regimes
- Debt cancellation
- South-south dialogue and trade flows growing
- Resistance to privatisation of essential services
- Investments in domestic producers, e.g. smallholder food production, especially women
- Stimulation of local food markets
- Recognition of rights to universal access to treatment
- Trade flexibilities to protect public health, e.g. in TRIPS
- Regional co-operation to procure and produce drugs
- Improved aid responsiveness to poverty levels, country planning
- Increased global transfers

A framework of universal coverage to guide responses (EQUINET 2009)

- **ABUJA PLUS:** Meeting the commitment of 15% government spending on health (in 2005 only being met in one ESA country) PLUS debt cancellation, debt resources to health and international support to health systems
- **FAIR FINANCING:** User fees, threatening equity, to be replaced by progressive tax and social insurance
- **EQUITABLE RESOURCE ALLOCATION:** Effective use of government resources to offset disparities by resource allocation formulae integrating equity
- Increased allocations to primary care levels

A Word About the Code

- Was strongly advocated for by African countries and other players
- Response from African countries has so far been lukewarm at best
- Reasons not yet clear, but seem to be related to sense of unfulfilled expectations, lack of capacity to implement/report, failure to disseminate the Code
- Work under way to sensitise the stakeholders and mobilise a critical mass of advocates to change the fortunes of the Code in African countries.

Acknowledgements

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- Health Workers for All.....