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Online Textbook Chapter

African Health Care Worker Shortage

The dire need for health care services that many African countries are currently experiencing is one that has begun to receive much more attention from developed nations, as well as international organizations. As a corollary, recent trends have shown a surge in official development assistance to African nations, ending a swift and steady decline since the end of the Cold War (5). Given the fact that Africa shoulders the largest disease burden of any continent and has the least amount of resources with which to combat it, a policy reversal of this type has become an imperative. To this point, the majority of this aid has been focused on supplies and medications. The current emphasis of the international community is on supplying already existing clinics with tools to prevent and treat prevalent disease entities. There is, of course, a need for this type of relief, as a lack of access to medications and proper disease prevention tools plays a major role in the disproportionately large burden of disease seen in Africa. The problem, however, is that there are no complimentary investments being made in health care infrastructure. The most acute of these infrastructural shortfalls is the lack of health care workers. In fact, if current trends continue, there will be far too few workers to properly distribute the supplies and medications that donor countries intend to contribute. This has the potential to create a severe bottleneck for the increasing amounts of aid being offered by donor countries. With insufficient manpower to provide health education, implement prevention efforts, and properly dispense medications, levels of foreign aid will essentially become irrelevant.

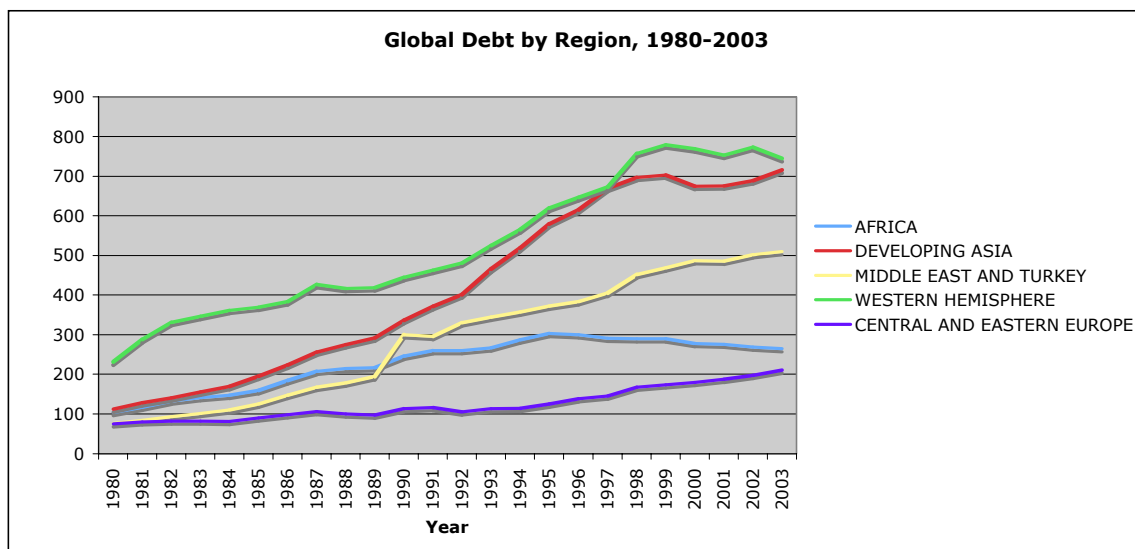
The current shortage of health care workers in Africa has a variety of etiologies. The situation may be caused, in part, by several years of reduced education and health care spending. Structural adjustment programs, implemented by the International Monetary Fund and the World Bank over the course of the last 25 years, have required developing nations to drastically reduce public spending in order to qualify for further financial assistance. Reductions in spending have included publicly funded education and health care programs. The largest contributor to the shortage, however, is the mass exodus of trained health care workers from their native countries to industrialized nations around the world. There are several factors, including poor working and living conditions, that cause this migration of health professionals, which results in a huge loss in human capital for their countries of origin. The situation is exacerbated even further by health care worker shortages in developed nations. These shortages result in the active recruitment of foreign health care workers by institutions in countries like the United States, in an attempt to supplement a domestically trained workforce that is insufficient to meet the nation's health care demand. Therefore, it is clear that policy changes are needed at many levels in order to ameliorate the growing African health care worker crisis.

Structural Adjustment Lending and Reductions in Public Spending

In the midst of the world financial crisis of the late 1970's, World Bank president Robert Macnemara put forth a radical new financial plan to help normalize the growing account deficits of African nations. The cornerstone of this new plan was the introduction of Structural Adjustment Lending. Structural Adjustment Lending consisted of new, large-scale lending programs to African nations that carried with them

stipulations that individual governments were required to follow in order to qualify for additional development loans. The notable conditions to be met included fiscal adjustment, trade liberalization and, in general, a movement towards free markets and away from state intervention (3). According to the 1980 World Bank annual report, the goal was to “reduce current account deficits to more manageable proportions by supporting programs of adjustment . . . to strengthen the balance of payments, while maintaining their growth and developmental momentum” (2). The line of thinking that predominated at this point, and continued to predominate over the course of the next 25 years, was that the African state had become oversized and that a reduction in spending was necessary to achieve fiscal balance (1).

Therefore, in order to meet the criteria for adjustment lending, governments began reducing expenditures. This relatively dramatic policy shift did eventually result in a reversal of the trend of increasing fiscal imbalance. By 1995, the indebtedness of African nations was on the decline (4).



Source: International Monetary Fund, World Economic Outlook Database, 2003

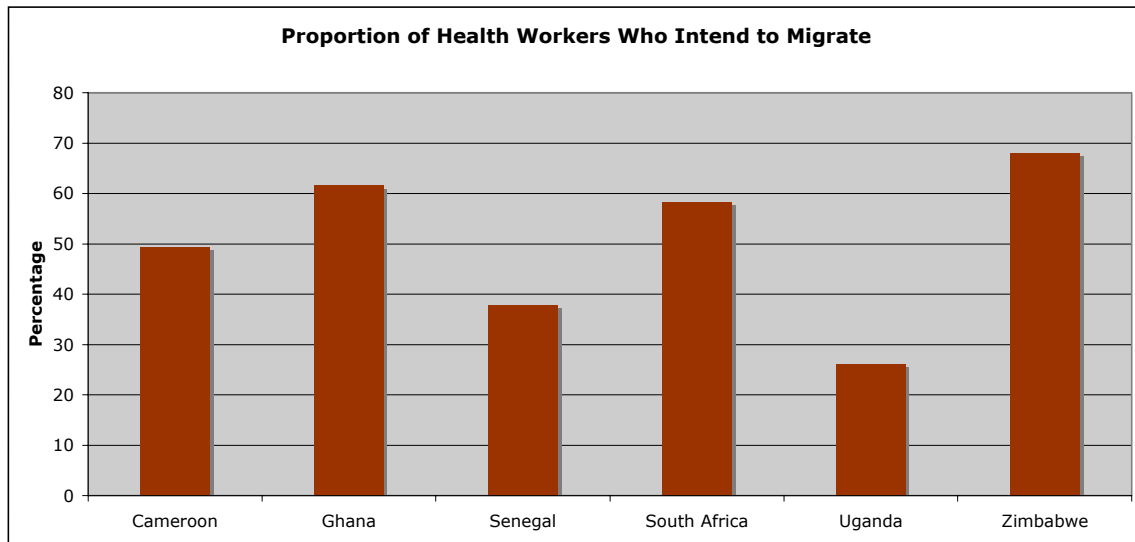
There was a price to pay for this reduction in fiscal imbalance, however. Throughout this 23-year period, the decline in education and health care spending was severe, immediate and prolonged. As one study points out, “the average annual growth rate of public expenditure on education between 1970 and 1980 was 4.4%, but between 1980 and 1983 the annual growth rate was -9.2%” (6). Africa’s share of world education expenditures continued to fall across the entirety of the adjustment era, with consistent declines during the 1980’s and 1990’s (1). The trend in health care spending was similar. During the 1990’s, the African continent demonstrated an average per capita health care expenditure between \$25 and \$35 and “never approached even 1.5 percent of the level spent by rich states in the North” (1).

These strict economic policies have limited the growth of African health care infrastructure. Reduced investment in education has contributed to reduced quality of tertiary and professional education and has left many nations unable to cope with a disproportionately large burden of disease. Inadequate health care spending has further exacerbated this issue, limiting the number of qualified health care workers governments are able to employ. In this way, structural adjustment lending has contributed to shortcomings in both the ability to educate and retain a sufficient number of health care workers. Increased privatization of these services has done little to increase health care access and has succeeded in driving workers away from the areas with the most need. Market forces alone provide little incentive for physicians to remain in areas where supplies and reimbursements are at a minimum. As a result, rural villages with high rates of disease and scant resources are the areas that have felt these forces most acutely. Increased pressure by the World Bank and IMF to limit public welfare spending,

however, has only played a part in the African health care worker shortage. The loss of trained workers to first-world nations is the more immediate and alarming problem.

“Brain Drain” – Exodus of African Health Care Workers

The divestment in higher-level education seen throughout the structural adjustment era in Africa has been of secondary importance to the large-scale migration of health care workers out of their countries of origin. In recent history, investment in the education of health care workers has been of questionable value. This is because a large percentage of health care workers trained in African nations leave in order to pursue career opportunities in foreign, developed nations. In a World Health Organization Study of health care workers in six African countries, at least 25% of workers in each country expressed a desire to migrate. In Zimbabwe, this figure reached an astounding 68% (8).



Source: Migration of Health Professionals in Six Countries WHO Regional Office for Africa, 2004

The massive loss of human capital in the form of trained professionals, experienced by almost all African states, has numerous economic ramifications. Not only does the state essentially lose the money that was invested in educating these workers, but they also lose out on the economic gains from their lifetime participation in the national economy.

This phenomenon costs African economies billions of dollars per year and is one of the key reasons why studies have shown some of these nations to be net world creditors (1).

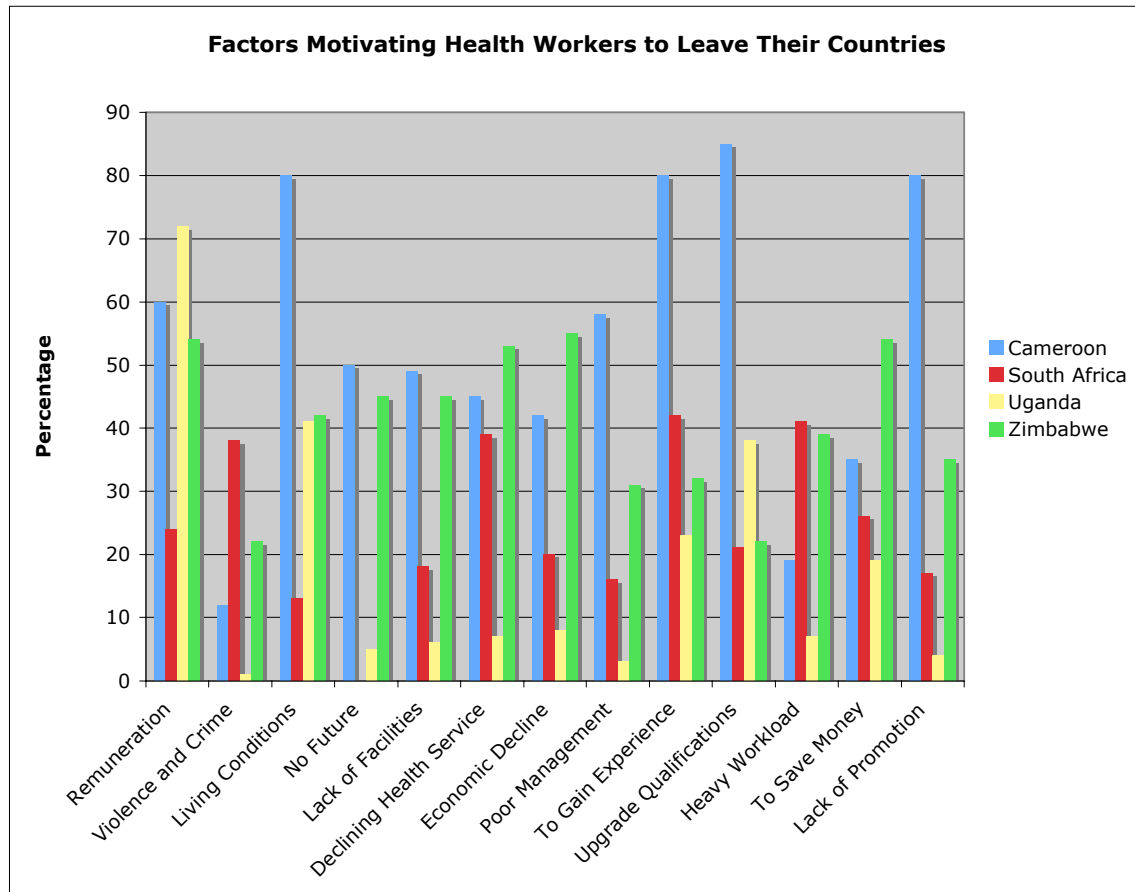
The etiologies of the flight of human capital are many, but one of the most prominent is the low level of remuneration found in African health care systems. A 1994 World Bank report stated that the salaries of lower level health care workers had fallen so low that it was becoming difficult for people in such positions to provide for even a small family (7). With such low levels of compensation, it is hardly a surprise that health workers look to other options to provide for their families. As one health worker from Zimbabwe stated, “We are paid so little that all of us in the medical profession think about going overseas... I don’t want to go, but I want to work in modern conditions. I want to be paid enough to support my family” (7). In many countries, an insufficient income is even a problem for physicians. The average physician salary varies greatly from country to country, ranging from \$50 per month in Sierra Leone to \$1242 per month in South Africa (7). The president of the Ghana Medical Association, Dr. Jacob Plange-Rhule states, “The current situation does not allow (physicians) to make adequate savings and really it does not assure any future security” (7). Insufficient salaries are particularly troublesome when the same professionals in other countries are earning significantly higher salaries for the same amount of work. For example, a nurse in Australia and Canada earns 25 times more than a nurse in Zambia and 14 times more than a nurse in Ghana (7). Even when taking into account the cost of living, these differences are dramatic.

Differences in wages can be large within countries as well, which has led to internal migrations of health workers, from rural areas, which tend to be poorly staffed,

poorly supplied, and serviced with public funds, to urban centers, where the private sector is strong. Here the link to reduced state spending on health care is strong, as salary differences between public and private sector health care workers are often dramatic. In Kenya, for example, a nurse that goes from the public to the private sector receives an immediate 40% pay increase (7). The maldistribution of health care workers that results can often be striking, as is the case in Ghana. The Greater Accra Region is home to 30 physicians per 100,000 in population. This is a stark contrast to eight out of the other nine regions in the country, none of which have more than 5 physicians per 100,000 in population (9). Therefore, not only are health worker numbers dwindling, those that are staying in country are concentrating in urban areas, away from the rural, underserved locations that are most in need of medical care.

However, financial well-being is not the only factor pushing African health workers to look overseas for viable employment opportunities. As can be seen in the figure below, increased levels of remuneration is just one of several reasons cited by practicing physicians for wanting to leave their country of origin. In four countries sampled by a 2002 WHO study, factors such as poor living conditions, a lack of adequate facilities, and declining health services were cited almost as frequently (8). These figures indicate that simply raising the salaries of health care workers would be an incomplete solution. Whatever the approach, it must be holistic and take into consideration that improving health systems, facilities, and professional mobility are equally as important as raising salaries. As shown in the table below, increases in opportunities for continuing education and better management of health services would be motivation enough for most health care workers to stay in their home countries.

Attempting to implement health care programs without sufficient levels of health care and economic infrastructure is a situation that drives migration to the same degree as inadequate levels of compensation.



Source: Migration of Health Professionals in Six Countries WHO Regional Office for Africa, 2004

Factors that would motivate health care workers to remain in or return to their countries

Country	Better/Realistic Remuneration	Conducive Working Environment	Continuing Education and Training	Better Management of Health Services
Cameroon	67.8%	64.2%	66.6%	54.9%
Ghana	84.8%	80.7%	66.9%	70.1%
Senegal	90%	*	*	*
South Africa	77.5%	67.8%	51.9%	57.8%
Uganda	83.5%	36%	29%	29%
Zimbabwe	76.6%	69.3%	50.6%	63.3%

*For Senegal, all of these categories may be applicable, but the data is not available

Source: Migration of Health Professionals in Six Countries WHO Regional Office for Africa, 2004

Recruitment of African Health Workers by Developed Nations

Health care worker shortages in wealthy countries are intimately related to those in resource poor settings. The set of structures that drive African health care workers out of their home countries and into developed nations around the world would not be complete if these workers were not responding to a demand for their services. This demand is coming from shortfalls in the number of health care workers throughout the developed world. The long-term solution to this problem requires recruiting new teachers, training a larger health care workforce, and a general investment in health care education. The solution up until this point, however, has rested upon the recruitment of health care workers from developing nations in order to fill the void. The former solution demands coordination, planning and investment, while the latter has none of these requirements. It is no surprise then that it is the second strategy that has been implemented in first-world countries around the globe as a temporary solution. Health care workers in Africa continue to be recruited by institutions in countries like the United States, United Kingdom, and many others in order to make up for shortages of nurses and primary care physicians.

No global health care worker has experienced a greater demand in recent history than that of the nurse. Massive nursing shortfalls are occurring in many first world nations and trends indicate that this problem will only worsen (10).

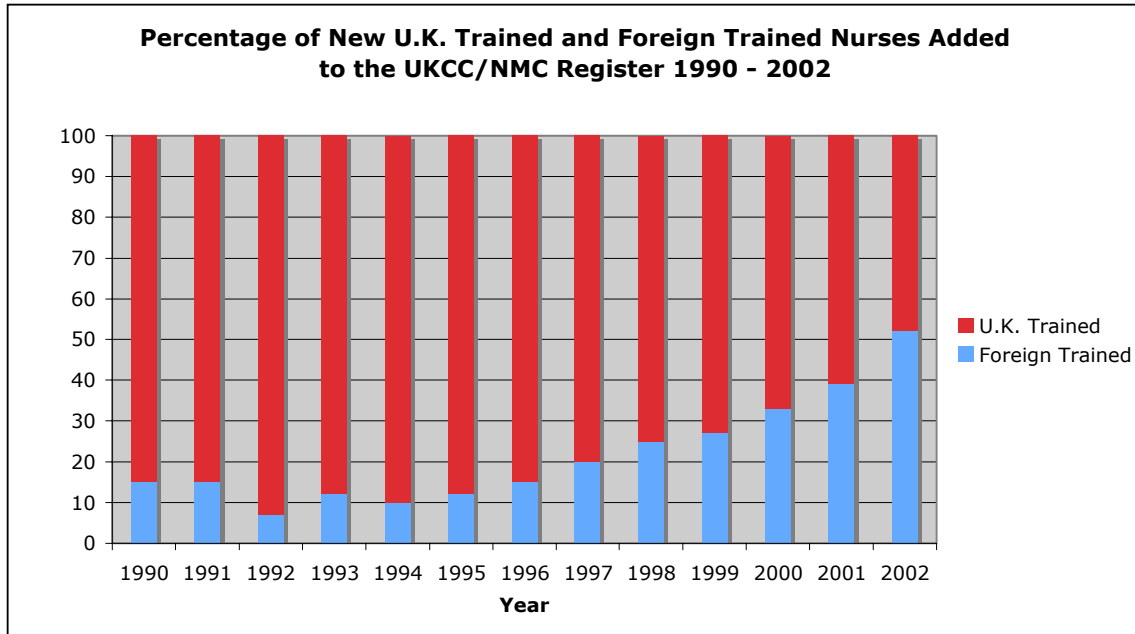
Host Country Registered Nurse Workforce and Foreign Nurse Contributions

Host Country	Number of RNs in workforce	Predicted shortfall (shortfall year)	Foreign Nurses as percent of workforce
US	2,202,000	275,000 (2010)	4
UK	500,000	53,000 (2010)	8
Ireland	49,400	10,000 (2008)	8
Canada	230,300	78,000 (2011)	6

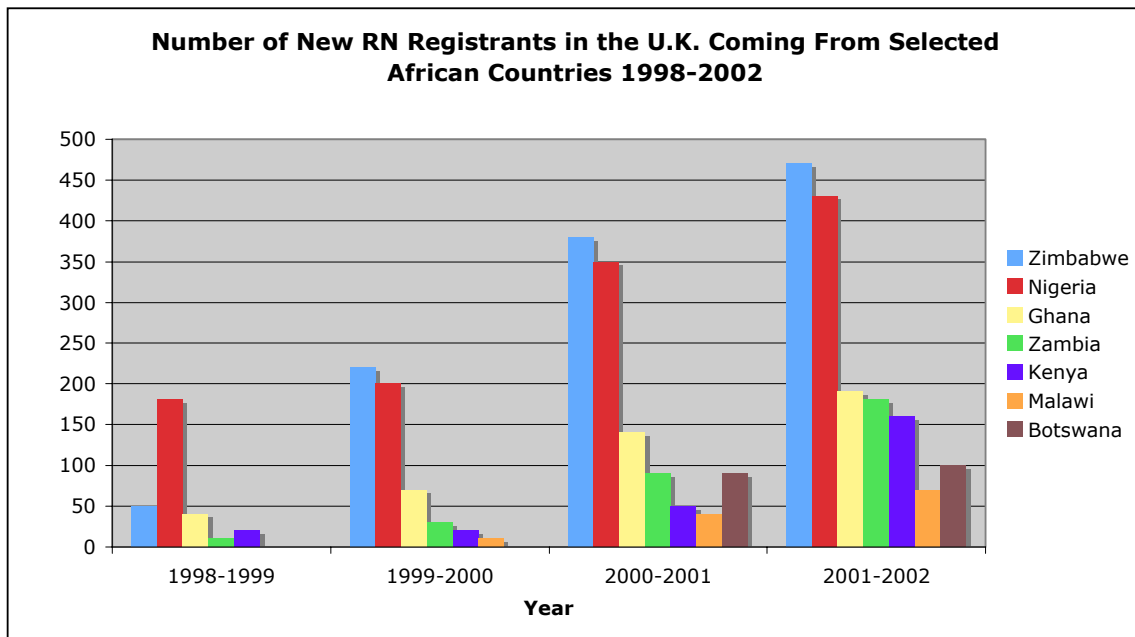
Source: Trends in International Nurse Migration. Health Affairs. Volume 23, No. 3, May 2004

To fill this gap, wealthy countries have turned to nurses in resource-poor settings. Nurses in low-income countries are often struggling financially, facing meager salaries and poor living conditions. First world institutions have capitalized on this disparity and used lucrative salaries and benefits in order to lure nurses from the developing world. What is perhaps most perverse about this relationship is that the number of nurses per population in countries where nurses are being recruited from is about half of the number in countries doing the recruiting (10). This is a very poignant example of capital flight from Africa to the developed world in the form of human capital. Often public institutions in Africa have paid for the training of these nurses. Bringing them to industrialized nations becomes a form of taxation of countries with scant resources.

It seems logical that the United States would be the world's largest importer of nurses due to the size of its health care industry and the severity of the nursing shortage it faces. However, strict educational requirements have greatly limited the number of nurses eligible to practice. A much larger recruiter of foreign nurses has been the British National Health Service, which has engaged in an active recruitment campaign over the course of the last 15 years. As one study sites, "In 2002, for the first time, more nurses joined the U.K. register from overseas than from educational sources within Britain" (10). As can be seen from the first figure below, foreign nurses are beginning to make up a huge part of the nursing workforce in the U.K. As the second figure indicates, this increase is, in part, due to a steady increase in the number of nurses arriving to the U.K. that have been trained in African nations. Not only is Britain increasing the recruitment of foreign nurses, it is doing so in the countries that can least afford to lose them.



Source: Trends in International Nurse Migration. Health Affairs. Volume 23, No. 3, May 2004



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Thus, it is clearly necessary for developed nations to invest in the training of their own nursing workforce if these recruitment trends are to decline. In the late 1990s,

enrollment in US nursing schools was on the decline and it appeared as if waning interest was the major culprit of the impending nursing shortage (13). However, this trend has reversed in recent years and applications to nursing programs have increased dramatically. The most important contributor to the shortage now appears to be a body of teaching faculty that is in the midst of a steady decline. Although interest in a career in nursing is growing, a limited number of faculty members is restricting the number of domestic nursing professionals that can be trained. In 2005, over 145,000 qualified applicants were rejected from nursing programs around the country because there were not enough qualified faculty to properly educate them (11). The current nursing faculty vacancy rate has increased to 7.9%, representing nearly 1400 vacant teaching positions (11). This is an increase of 32% since 2000, indicating that the problem is likely to worsen in the coming years (11). If the United States is not willing to invest in the recruitment of additional nursing faculty members, its institutions are left little choice but to look to foreign health care workers to meet their needs.

In the United Kingdom, the nursing shortage has other origins. One contributor has been the cuts made to the number of nurses trained by the British government in recent years. As one study indicates, “Training places were significantly cut during the late 1980s and early ‘90s” (12). This resulted in a significant drop in registered nurses during this period. The NHS is still feeling the effects of this drop, and recent increases in the number of nurses being trained may only serve to offset these cutbacks. In addition, an estimated one third of nurses that graduate from the training programs offered by the NHS do not register to practice (12). There are a variety of suspected explanations for this phenomenon, including remuneration, the changing nature of the

job, and perceptions of being valued (12). This can be more difficult to control from a policy point of view. However, it is much easier for the British government to impact African health care worker recruitment policies, as it is the National Health Service itself that is responsible for nearly all of the recruiting. Whatever the solution, policy changes in both the United Kingdom and the United States are necessary in order to curb the growing migration of African health care workers to these two regions.

Conclusion

The solution to the African health care worker crisis must come at multiple levels. Within Africa, steps must be taken to increase the capacity of existing educational institutions. More public spending on health care is necessary in order to ensure that graduates from domestic institutions are compensated enough to support a family and provide schooling for their children. Essential medicines and medical supplies are necessary to maintain the morale of the medical personnel staffing clinics. It is also crucial that developed nations put an end to the recruitment of health care workers from resource-poor nations that already have far fewer workers.

The most difficult aspect of this issue is that if all of these areas are not addressed simultaneously, the problem is likely to worsen. If wealthy nations do not address health worker shortages within their own borders, recruitment will continue. If African health care workers are not given reasonable benefits, they will continue to leave. If African nations are not able to invest more in their health and education systems, they will lack the infrastructure necessary to properly train an adequate health care workforce.

The bottleneck created by the lack of health care workers in Africa must be resolved if this continent is to have any hope of dealing with the disproportionately large

burden of disease it faces. Continually growing aid monies gathered and sent by donor countries will have a much smaller impact on this burden of disease if the recipient countries lack the facilities and personnel necessary to utilize it. The economic future of Africa may well depend on its ability to overcome the current disease burden that inhibits its growth. The shortage of health care workers constitutes an emergency for the entire continent.

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