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6 human resources for health

Abstract

This chapter reviews human resources for health in South Africa from an international perspective. It highlights the vast inequities in global and regional distribution of health workers and briefly examines those factors affecting human resource development.

International migration of health workers is affected by both push factors, such as the impact of HIV and AIDS on health workers and poor working conditions and pull factors, such as underproduction of health workers in developed countries coupled with aggressive recruitment.

The liberalisation of trade, including in health services, influences the brain drain from public to private and from developing to developed countries. The General Agreement on Trade in Services (GATS) with its four modes of supply for trade in services threatens to aggravate this problem. The chapter further examines the impact of migration and highlights possible responses to address the impact.

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resources: **international context**

Introduction

"Many classify human resources as recurring expenditure, not as an investment. Amazingly, buildings are considered capital assets, while human capital is considered a recurring burden."[a,1]

The recent increase in interest in human resources for health (HRH) is a result of convergence of a number of factors. These include:

- The international commitment to the Millennium Development Goals (MDGs), several of which are health-related.
- The urgent need to address the HIV crisis and the fact that increased donor resources are now available for treatment of AIDS related diseases and cannot be properly utilised due often to personnel shortages, partly because of external migration.

It is the latter phenomenon that is drawing attention to the international factors affecting HRH. These factors are clearly becoming increasingly influential at a global level, and at the individual country level, especially in the southern African region.

This chapter focuses on health professionals, such as doctors and nurses, since they are involved in migration as a result of comparable scopes of practice in different countries in the North and the South.

a Quoting Chen, 2004 in reference to donors and agencies being part of the problem.

Place of HR in health systems

Percentage expenditure

Human resources account for the largest expenditure of any health system. For example, the Dominican Republic spends 67% of its health budget on personnel and Ecuador 72%.[2] Health worker salaries usually exceed two thirds of the public health budget in the lowest income countries, and in some countries can exceed 75%.[3]

Distribution and density

There is an estimated 100 million health workers globally, 75 million of whom are 'uncounted' (e.g. traditional healers, community health workers). The World Health Organization (WHO) estimated that in 2000 there were 9 million doctors and 15 million nurses and midwives.[3]

There is one health worker per 1 000 population in sub Saharan Africa (SSA) with more than 10 per 1 000 in Europe and North America.[3] The specific health worker to population ratio for SSA is 32 physicians per 100 000 population and 135 nurses per 100 000 population. These nurse and doctor population ratios are the worst in the world.[4] In a number of SSA countries there are fewer health workers than 30 years ago, despite larger populations and increased health needs.[3]

Table 1 shows estimates on health workers in selected SSA countries. SA has more professional health workers than any other country in SSA, with the exception of Mauritius.

However, even more than in other SSA countries, SA exhibits marked differences in health worker density between the public and private sectors, and between rural and urban areas in the public sector.[5,6]

Table 1: Estimates of health personnel per 100 000 population

Country	Year	Physicians	Nurses (including midwives)	Pharmacists
Angola	1997	7.7	114.5	0.2
Botswana	1999	28.8	241.0	8.4
Democratic Republic of Congo	1996	6.9	44.2	2.0
Mauritius	1995	85.0	232.9	20.0
Mozambique	1990	1.2	32.1	2.6
South Africa	2001	69.2	388.0	24.2

Source: WHO Global Atlas of the Health Workforce

Table 2: Public and private distribution of health workers 1998-99

	Estimated dependent population	GPs	Medical specialists	Psychologists	Nurses
Public	82%	27.4%	24.8%	5.8%	58.9%
Private	18%	72.6%	75.2%	94.2%	41.1%

Source: The Public-Private Mix South African Health Review 1999

International health system factors affecting human resource development

Planning

There are differing opinions as to whether the continued demand and migration of health professionals is an indication of poor workforce planning, or whether developed countries are deliberately factoring in foreign recruitment of health professionals for economic reasons.[4]

A study of five industrialised countries revealed that workforce planning often includes the assumption that the current system of health care delivery is adequate. The researchers described medical workforce planning as determined by 'mechanistic estimates of demand for medical care, from demographic forecasting, resource constraints, and estimates of likely retirement and other loss of existing medical staff.'[7]

As such, the process of forecasting these countries' future staff needs is flawed and inadequate because it assumes that the historical supply of personnel, particularly doctors, reflects demand.[7]

Since the forecasting method is flawed, medical nursing and ancillary health care worker students intake has been inadequate. In four of the five countries, the government directly controlled medical school intake by limiting university funding to a certain number of places.[7] This has contributed to the current global crisis in health care worker supply.

For example, health workforce planning in developed countries has not taken adequate account of the increase in the numbers of people over 65 years of age. The resultant increase in chronic diseases has increased the demand for health services.[4,5,8] In addition, the 'greying' of the current workforce will result in a need to recruit more skilled personnel from developing countries.[9]

Fewer young people in developed countries are entering the health worker profession, resulting in less health workers available to care for the elderly.[4] Inadequate production of health workers in developed countries continues. This occurs despite countries (e.g. USA) predicting that over the next 20 years there will be a shortfall of around a million nurses.[5] At the Southern African Development Community (SADC) Health Ministers meeting held in 2001, the Ministers noted with concern the developed countries' unwillingness to plan their human resource needs adequately.[10]

Recently, emigration to developed countries has increased. Due to continuing shortages of health professionals in developed countries, it is anticipated that migration will increase significantly in years to come.[5,11]

The impact of GATS will also affect the availability, distribution and migration of health care workers. Therefore, it must be factored into all future HRH planning strategies.

Production

The assumption that developing countries are facing a crisis in HRH solely due to inadequate production of skilled health care workers is incorrect. The production of adequate skilled health personnel would not stop the current human resource crisis in developing countries. This is due to push factors, within and outside the health system, that contribute to migration.

Curriculum emphasis and teaching methods in developing countries, including SA, have mirrored training of health professionals in the North. Some countries have tended to focus on training specialists, doctors and nurses, whose training is of long duration and not always relevant to the needs of the country, rather than training auxiliaries such as medical assistants, community health nurses and community based workers.[5]

However, recently in SA there have been attempts to ensure that curricula have more focus on primary health care to better equip health professionals to work where they are needed. There have also been attempts to include rural and community health attachmentments.[5]

However, the focus on clinical medicine has continued.[5] This has often meant that especially doctors, but also other health workers, have been prepared for practice in highly resourced, technologically sophisticated environments present in the private sector and academic health centres in the South, and for most settings in industrialised countries.[4,5,12] This has facilitated the emigration of health professionals from SA to developed countries (e.g. UK) and their smooth transition into those countries' health services.

There have been situations when emigration has involved experienced academic staff. This, linked with decreased budgets allocated for training, has affected many southern African countries' ability to maintain production of health workers, both in terms of numbers and quality.[5,13]

Management

Poor management of health services in developing and developed countries has resulted in geographical and skills imbalances of health workers.[3] Maldistribution has resulted in urban concentration of health workers in all countries, as well as maldistribution between private and public health sectors in some countries. This has been worsened, especially in poorer countries, by unplanned migration.[3]

An understanding of factors affecting motivation and performance has not sufficiently informed planning and management.[3] In a recent survey done in Cape Town, nurses expressed frustration with a number of management-related issues, including inadequate training to deal with HIV and AIDS, lack of moral and practical support, and insufficient supervision. They expressed feeling demotivated as a result of the increasing focus on therapy at the expense of health promotion and preventive services.[14]

International migration of human resources for health

History of migration

There is a long history of global movement of labour even before the notorious slave trade. In the 1950s and 1960s there were large movements of unskilled labour from the Caribbean, Africa and Asia to Europe. Accompanying the growth of the service sector and the 'knowledge economy' and the consequent need for a larger pool of skilled labour, there has been active recruitment of professionals, including health personnel, from Southern countries.[1] We argue below

that this process is likely to be accelerated by some of the new conventions governing global trade.

Extent of Migration of HRH

There are few accurate data available on international migration of HRH. Where available the data primarily focus on doctors. There are some data on nurses with little information available on other health professionals (e.g. dentists).[4]

The global migration movement of personnel is generally from developing to more developed areas. Historically, within SADC, SA, gained health professionals from its poorer neighbouring countries as well as other developing countries. For example, 22% of the doctors in SA and 78% of doctors working in rural areas are foreign trained.[15] However, this situation has changed and the national Department of Health's (DoH) policy on the recruitment of foreign health professionals states that the recruitment of individual applicants from any developing country will not be supported. In addition DoH guidelines regarding the recruitment of foreign health personnel recommend that employers should refrain from recruiting in developing countries, especially the SADC region.[16]

Some analysts have questioned whether this strategy has assisted South Africa's neighbours to retain these personnel, or whether it has merely resulted in emigration from Africa to the North.[1]

At the same time that SA was restricting entry of doctors from African and several European countries, it concluded an agreement with the government of Cuba to admit Cuban doctors. They have been deployed in most provinces and have significantly increased the number of doctors working in under-served areas, particularly in District and Regional hospitals.[b] While it is generally accepted that the Cuban doctors have played an invaluable role in servicing remote areas of SA, there have been some concerns regarding language difficulties and the appropriateness of the specialised Cuban training in the South African context.[17] In 2004, the South African DoH finalised an agreement with Iran, similar to the agreement with Cuba, where Iranian doctors will work in rural areas. Currently there are also approximately 80 doctors from the United Kingdom working in under-serviced areas.[18]

In turn, SA loses health professionals to wealthier countries.[5] A significant number of South African nurses and doctors migrate to the USA, Canada, the UK, Australia and New Zealand.[4] But it appears from the UK registry that nurses are less likely to migrate permanently with 85% leaving the UK within 4 years after entering.[8]

Thirty one percent of doctors and 13% of nurses in the UK National Health Service (NHS) are foreign nationals, mostly from outside the European Union.[5,8,16] Twelve percent of foreign nurses in the United Kingdom are South African.[8]

The following figures reflect the numbers of South African medical doctors employed in developed countries:

- There are 600 South African doctors registered to practise in New Zealand. The estimated cost of this fact to the South African taxpayer is in the region of R600 million.[19]
- Of the 5 334 non-federal physicians, trained in African medical schools, and licensed to practice in the United States of America in 2002, 1 943 were South African.[20]
- The South African Medical Association has estimated that at least 5,000 doctors have left South Africa for the US, Canada, Australia and the UK.[20]
- According to the OECD, six percent of the UK's health workers and 10% of Canadian hospital based physicians are South African.[5]

While the majority of health professionals leaving SADC countries appear to be from SA, the impact may be greater for some other countries, which lose fewer in absolute terms but proportionally a large share of their trained professionals; and may not have capacity to replace them through training.

Factors influencing migration

Push factors

It is widely thought that remuneration is the largest factor influencing people's decision to migrate, from public to private sector or migration abroad.[5] Remuneration differs greatly between countries. For example, in SA an experienced intensive care or theatre nurse earns around R90 000 a year, whilst a nurse in Saudi Arabia would earn between R228 000 and R360 000 per annum tax-free and a UK nurse between R256 000 to R448 000.[5] The wages for health workers within Africa differ greatly with nurses in Australia and Canada earning about twice as much as those in SA, but about 25 times as much as nurses in Zambia.[21]

b Personal communication: Dr Carmen Baez.

There is a triple burden of HIV and AIDS on health care personnel: as workers; carers and patients. Nurses for example, are facing increased psychosocial stress because of increased pressures, low morale and burnout. This is especially the case where no antiretrovirals are offered.[3] In SA, nurses have expressed feelings of hopelessness because of the magnitude of the HIV problem, and frustration at not being able to do enough because of the emphasis on curative activities at the expense of education and health promotion, and an increased focus on quantity rather than quality.[22]

Nurses also have non-health related burdens placed on them because of the HIV and AIDS pandemic. There are expectations to assist with funerals of impoverished clients and to assist clients and their families to obtain food and money. In SA, a number of poor occupational health and safety conditions have resulted in a high risk of occupational exposure to HIV and other diseases.[22] Nurses at risk of occupational exposure to HIV have spoken of the extra strain this places on their family life as family members react negatively due to stigma and fears. A recent survey of South African nurses showed a national HIV prevalence of 15.7%.[23] There is evidence that, particularly amongst nurses, fear of contracting HIV through inadequate protection at work is acting as an additional pressure to migrate abroad and deterring individuals from taking up nursing as a profession.[3]

Work overload, staff shortages and inadequate medicine supplies are contributing to burnout, high absenteeism, stress, depression, low morale and de-motivation and are responsible for 'driving health workers out of the public health sector'.[22]

The loss of health professionals can result in a negative downward spiral. As health professionals leave, facilities become more understaffed and the remaining health workers become overworked. This in turn can become a push factor for the remaining nurses who are unable to cope with the additional burdens.[5]

Fears regarding crime, personal safety and security, political insecurity, war, civil conflict and political oppression and lack of educational opportunities for children, may influence decisions to migrate.[1,4,5] The majority of emigrants from SA (98%) cite high crime as the reason for leaving the country. Other primary reasons quoted by South Africans were the decline in standards of living, affirmative action policies, high cost of living, taxation levels and poor standards of public services.[24]

Pull factors

"The impact of international macro economic policies and the GATS will almost certainly increase shortages of health professionals in developing countries at a critical juncture."[4]

Aggressive recruitment strategies by rich countries feature as a powerful pull factor in health worker migration.[5] In the UK, Canada, and the USA, underproduction of health workers and greater requirements for health personnel imposed by ageing populations are key drivers of aggressive recruitment policies. As a result of the high demand for professionals in developed countries, the United States and some European countries have eased immigration restrictions for health professionals.[4]

The proliferation of private health services, and the resultant movement of health workers from the public to private health sector, has aggravated the demand for foreign nationals to work in public health facilities and has contributed to increased migration.[4]

Common pull factors cited are often the inverse of push factors. For example better pay and benefits, better working conditions, safer work environment, professional development and career opportunities, better living conditions, freedom from political oppression, and better educational opportunities for children are some of these factors.[5,25] In addition, professionals in developing countries wishing to specialise face limited options due to few opportunities for specialisation within the public sector. For that reason, many leave their countries to continue their studies in developed countries where there are a larger number of specialist facilities.[5]

It has been observed that there is greater likelihood of people emigrating to a country where fellow citizens, relatives and friends are already based.[5] This is because easier access to information on emigration processes, work opportunities, educational and accommodation details and a ready-made support structure in a host country all contribute to the choice of country.[5]

The General Agreement on Trade in Services (GATS) which is administered by the World Trade Organization (WTO), was adopted in 1995 and aims to liberalise trade in services, including health services.[4,26,27] This clearly influences the brain drain internally from public to private sectors, and from developing countries to developed countries. There are four GATS modes of supply for trade in health services.

GATS essentially reduces or facilitates the erosion of restrictions placed on immigration, entry visas, works permits,

insurance reimbursement and other key factors that impact on international trade. It has also been mooted that GATS will also reinforce the trend towards 'the international harmonisation of qualifications', which will in return facilitate migration of health personnel.[1]

Mode 1: Cross-border supply (CB) This mode includes telemedicine, tele-education, teleconferencing and subscription to journals and data bases on the Internet. From a health perspective, the use of the internet or telemedicine can be used to improve the provision of health services. While the demand and potential for telemedicine is not yet clear, it is likely that telemedicine will predominantly link specialist facilities and practitioners. This may affect worker morale and job satisfaction and ultimately impact on a decision to migrate. However, the information transmitted to those practising in the periphery may not be appropriate to those settings and may aggravate a tendency towards inappropriate, sub-specialist practice at the expense of a generalist and comprehensive approach.[4,26,27] This mode of trade has limited impact on human resources for health in an international context.[27]

Mode 2: Consumption abroad (CA) This mode includes travelling abroad in the form of health tours to access cheaper health services and seek high-technology treatments. There are significant implications for a number of countries, including SA, that provide such services. These cater for foreigners from developed countries, in the form of medical tourism, and developing countries that lack the capacity to provide highly specialised care.

Medical tourism invariably results in an increased demand for private health facilities. This subsequently increases the demands for health professionals in the private sector, thus exacerbating the inequity in service provision between the public and private sectors.[4,27,28]

There has been a growth in medical tourism in SA contributing to an increase in the 'internal' public to private sector brain drain.[4] It is thought that to provide services to foreign private patients requires 4 to 5 times the resources to provide similar services to the local population.[29] While countries like Cuba benefit financially from medical tourism, most countries will experience a negative impact as health professionals are drawn to the expanding private sector.[27]

In SA, both Afrox and Netcare SA advertise programmes to support foreign patients on their web sites. Afrox has a foreign patient assistance centre which assists with visas, flights and transport, accommodation and setting up appointments for the patients and their family. They also employ translators to assist French and Portuguese speaking patients.[29] Netcare has an International Central Referral Office, which coordinates travel and treatment for international patients.[30]

Mode 3: Commercial presence (CP) This allows foreign companies to deliver services locally and includes setting up privately owned and / or managed hospitals, clinics and health insurance.[4,28] By 2001, twenty-one African countries had signed the GATS agreement allowing private providers to compete to provide health care.[4,27] Most countries allow foreign health insurance and a number allow foreign companies to provide professional services such as hospital services.[4] There is consensus that this exacerbates the 'internal' brain drain as staff move from public to private facilities, resulting in a shortage of staff within the public facilities.[4,27] It is often the most skilled who move first, with a resultant decrease in quality of care within the public sector.[27] This mode can also result in 'cream skimming', where healthier patients utilise the private health services and those with greater health needs and unable to pay for services utilise the public health services.[3,27] While the presence of foreign patients (under mode two) and foreign investors (in the form of mode 3) may result in an improvement of health care especially in the form of increased availability of highly sophisticated medical technology, it is also likely to 'distort the health care market by enhancing tiered health care systems and internal brain drain.'[27]

While not directly linked to mode 3, there is increasing evidence that private South African health care companies are carving out a presence in neighbouring countries. African Life Health, a subsidiary of African Life Assurance has set up operations in Kenya, Botswana and recently into Lesotho with the purpose of setting up Lesotho's first medical scheme for over 30 000 government employees, facilitating the establishment of "regional Medi Centres" and primary care networks.[32] Afrox Healthcare Ltd., a large South African private hospital group registered on the Johannesburg Stock Exchange, in 1994 expanded its services into Botswana, where it runs a private hospital with 132 beds and a range of health services including running three theatres. According to the Afrox website, this is the only private hospital in Botswana.[33]

Mode 4: refers to the **Temporary movement of natural persons (NP)**. This refers to the cross-border movement of health professionals either for study purposes or to temporarily provide health services outside their country of origin / fill vacancies abroad.[4,28] This mode is commonly understood to facilitate 'the *export* of human resources'.[5] This mode enables the removal of many barriers to movement of

health professionals such as work permits, visas and licences to practise.

In some instances, this provision of health services outside the country of origin is beneficial for both host and exporting country e.g. the Cuban doctors in SA.[5,11] However, it can lead to the shortages of skilled health professionals and directly contribute to the brain drain.[4]

Health professionals moving abroad for work or study purposes may be influenced to stay because of a variety of reasons such as their new lifestyle, not wishing to break social bonds formed or disrupt children's education or they simply may not be aware of job opportunities in their home country.[5] There are conflicting ideas as to whether exporting countries benefit from skills acquired by migrants when and if they return home. Some suggest there is a benefit while others argue that the skills are often inappropriate for the home situation.[4]

Impact of migration

Apart from the direct benefit of meeting the health needs of their citizens, migration helps developed countries gain through saving the cost of training health professionals. Estimates as to what this saving amounts to vary. In the early 1970s it was estimated that for every skilled worker emigrating, the US gained US$20 000.[4] The United Nations Conference on Trade and Development (UNCTAD) has estimated that developed countries save US$184 000 in training costs for each professional aged 25 to 35 years.[4] These savings for the developed countries are significant and in effect amount to poorer countries donating to richer countries and therefore contribute to widening the gap between rich and poor countries.[4]

A longer-term effect of the brain drain is that source countries not only lose their present supply of workers but also a pool of future workers. The loss of academic health professionals in Ghana, for example, has led to the ranks of academia being severely depleted and has affected the country's ability to train new health care workers.[5]

The 'loss of institutional memory' from large-scale resignations and other turnover factors result in a duplication of work and wastage of resources. This is especially relevant in the face of disease management strategies and programmes such as AIDS, reproductive health, malaria, and tuberculosis where strategies are reinvented repeatedly due to the loss of key health personnel and the resulting gap in institutional continuity.[5]

Exporting countries, often already inadequately staffed, especially in remote or rural areas are not only losing knowledge, skills and institutional memory, but also carry the economic burden of training health professionals for the developed countries.[4,5] Migration results in a massive loss of human capital for developing countries already struggling to address poverty and the growing health crisis.[5]

In addition, the loss of skilled personnel has resulted in the need to use Official Development Assistance (ODA) to build capacity, replace lost capacity and provide technical support.[4] The countries worst affected are the smaller countries, where the loss of a few or even one health worker can result in a crisis in health service delivery.[13] In SA, a regional spinal injuries unit closed following the recruitment of the two anaesthetists by a Canadian spinal injury unit.[16]

The brain drain and resultant loss of capacity has also affected developing countries' capacity to train new health professionals and to provide support and supervision in the workplace.[4]

New Partnership for Africa's Development

In its plan for human resources development in Africa, NEPAD aims to reverse the brain drain and turn it into a brain gain for Africa; to build and retain within the continent critical human capacities for Africa's development and to develop strategies for utilising the scientific and technological know-how and skills of Africans in the diaspora for the development of Africa.[31]

To this end NEPAD aims to create the necessary political, social and economic conditions in Africa that would serve as incentives to curb the brain drain and attract much needed investment; establish a reliable data base of the brain drain; and to develop scientific and technical networks to channel the repatriation of scientific knowledge to the home country, and establish the cooperation between those abroad and at home.[32]

Within the NEPAD Human Resource Development document, a number of health system problems are highlighted, including the need for adequate human resources. The document highlights the need for countries to prioritise human resources for health, allocate more finances for human resources, provide career pathways, training opportunities, adequate remuneration and better management and retention strategies to help ensure adequate staffing of the health system.[33]

The NEPAD Health Strategy document highlights the need for an appropriate mix of health workers, including the need for mid-level workers, and acknowledges the problems within the health system, the inability of countries to retain staff and the impact of migration and HIV and AIDS on the health workforce. It highlights the need for better coordination between the public health sector and traditional healers and better protection and regulation of traditional healers. While the Health Strategy speaks of the need to develop an international agreement on migration, and the need for ethical recruitment of health workers from Africa, it deals with the push factors but does not look in any detail at the pull factors.[34]

Conclusion and recommendations

In this chapter, we have reviewed the international factors influencing human resources for health. One of the major factors impacting on HRH is international migration, yet information and data available are inadequate to effectively monitor the flow of health workers.

The global shortage of health workers is linked to a number of health system issues including poor planning and under-production of health workers in developed countries. The push and pull factors influencing migration of health workers interlink and cannot be looked at independently. Many of the pull factors, such as remuneration, are the reverse of push factors. Developing countries are subsidising the training of health workers at a huge cost, yet they cannot afford to compete with remuneration offered by developed countries. The liberalisation of trade in health services has and will continue to influence the internal and external brain drain.

A multi-faceted response is required to deal with the health system issues influencing peoples' decisions to migrate. This should include policy interventions that address country specific needs with regard to health worker retention, recruitment, deployment and development. Incentives, both financial and non-financial (e.g. training, study leave and supervision) can assist in motivating and ultimately retaining health workers.[11]

Developed countries must become more self sufficient, to plan for and train the human resources necessary to satisfy their needs, and to identify strategies to attract more people into the health professions.[3,11] They also need to identify ways of improving retention of health workers, which will ultimately reduce the number of positions open to migrants.[11]

Developing countries must look at local solutions in terms of human resource requirements and ensure that the skills mix is appropriate for their needs. Mid-level workers and community health workers can assist in improving access to health and related services. They are also less likely to migrate or be poached by developed countries or the private sector.[3,11] Developing countries also need to ensure that the curricula and training of all health professionals is relevant to the countries' needs. National governments and local health service providers should also establish closer working relationships with traditional health practitioners.

Proposals have been made around the establishment of a voluntary educational investment fund that would assist in developing the capacity of developing countries to produce health workers.[3] Some have argued for compensation to exporting countries[4,5] while others have said this would be too difficult to implement.[3]

The development and implementation of international codes of practice on ethical recruitment to protect individuals migrating and protect countries from unethical recruitment practices have also been proposed.[3,15] At the 58th session of the World Health Assembly (WHA), in May 2005, the Minister of Health Dr Manto Tshabalala-Msimang, tabled a resolution challenging the Director General of the World Health Organization to strengthen the WHO division on HRH and ensure full implementation of the resolution on international migration of health workers that was adopted at the WHA in 2004.[34]

Attempts to manage the migration of skilled health care professionals must take place within both a national and a regional framework. A regional response to brain drain presents opportunities for strategic policy and resource allocation issues and creates the policy environment for the development of the region as a whole.

Developing and strengthening health systems and human resources management

"The primary response to brain drain must be to redress second-class health systems that reflect widespread violations of the right to health and other rights."[19] There is consensus that despite the lure of pull factors, push factors play a critical role in the migration of skilled health care workers. Vulnerable and inadequate health systems coupled with low remuneration, poor working conditions and political uncertainty operate as significant variables in decisions to migrate.

SADC health ministers statement

In a strong statement issued in June 2001, SADC health ministers suggested that the 'active and vigorous recruitment' of their health professionals 'could be seen as looting from these countries and is similar to that experienced during periods of colonisation when all resources, including minerals, were looted to industrialised countries'. The statement re-affirmed the need of the SADC for its health staff, especially in the face of the HIV and AIDS crisis. It also raised concerns that the movement of skilled people 'further entrenches inequitable wealth and resources'.[10] The SA resolution regarding the ongoing migration and recruitment of health workers from developing countries, tabled by the MoH at the WHA in Geneva this year, was strongly supported by other African Ministers of Health present at the WHA.[35]

Strengthening national capacity and coordination for international trade negotiations

GATS has a potentially powerful role to play in the HRH arena. The strengthening of national capacity and coordination for trade negotiations on all aspects of GATS is crucial. Consultation with all national key stakeholders must happen before international negotiations take place. This includes understanding the implications of acceding to general obligations of GATS for all service sectors in the country and their interdependence on each other. Increased discussion and consultation between the Department of Trade and Industry and the DoH is necessary to ensure that international trade negotiations do not compromise South Africa's vision for its health service.

Other proposals have included:

- Exporting countries such as Cuba and India accelerating or 'redirecting' their health workers to countries with shortages so as to render their shortages less acute in the short-term.
- Encouraging health workers to return to their country of origin through the use of incentives.
- Expanded production of mid-level workers and training of CHWs as well as of volunteers and greater involvement of non-governmental organisation activities.[3]
- Greater investment of global funds (e.g. the Global Fund for AIDS, TB and Malaria) in human resources and capacity development.[8]

While this chapter has focused on HRH from an international perspective, we have attempted to highlight specific concerns and issues affecting South Africa specifically and also those in the context of the region. Sub Saharan Africa has specific challenges with regard to addressing the current crisis in human resources for health. The HIV and AIDS pandemic is increasing demands on the health system, increasing psycho-social stress of health workers and health workers themselves are becoming infected and sick from HIV. It is clear this situation will worsen unless there is a coordinated and proactive response to addressing national, regional and global inequities in human resources for health.

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