### Stock 1NC UTIL

#### I value morality, per the term ought in the resolution and defined as principles concerning right and wrong or good and bad behavior

#### The standard is maximizing expected well-being. Prefer:

#### Pleasure and pain are intrinsically good and bad and explain all our actions. Moen 16 Ole Martin Moen, PhD, professor of philosophy at University of Oslo. “An Argument for Hedonism.” Journal of Value Inquiry, Volume 50, pp.267-281. AHS/mhg Let us start by observing, empirically, that a widely shared judgment about intrinsic value and disvalue is that pleasure is intrinsically valuable and pain is intrinsically disvaluable. On virtually any proposed list of intrinsic values and disvalues (we will look at some of them below), pleasure is included among the intrinsic values and pain among the intrinsic disvalues. This inclusion makes intuitive sense, moreover, for there is something undeniably good about the way pleasure feels and something undeniably bad about the way pain feels, and neither the goodness of pleasure nor & Ole Martin Moen o.m.moen@ifikk.uio.no 1 Centre for the Study of Mind in Nature, Department of Philosophy (IFIKK), University of Oslo, Box 1020, Blindern, 0315 Oslo, Norway 1 By ‘‘value’’ I mean prudential value. Presumably, however, those who believe that all value is value simpliciter will also find my argument useful. I do not discuss moral value. 123 J Value Inquiry (2016) 50:267–281 DOI 10.1007/s10790-015-9506-9 the badness of pain seems to be exhausted by the further effects that these experiences might have. ‘‘Pleasure’’ and ‘‘pain’’ are here understood inclusively, as encompassing anything hedonically positive and anything hedonically negative.2 The special value statuses of pleasure and pain are manifested in how we treat these experiences in our everyday reasoning about values. If you tell me that you are heading for the convenience store, I might ask: ‘‘What for?’’ This is a reasonable question, for when you go to the convenience store you usually do so, not merely for the sake of going to the convenience store, but for the sake of achieving something further that you deem to be valuable. You might answer, for example: ‘‘To buy soda.’’ This answer makes sense, for soda is a nice thing and you can get it at the convenience store. I might further inquire, however: ‘‘What is buying the soda good for?’’ This further question can also be a reasonable one, for it need not be obvious why you want the soda. You might answer: ‘‘Well, I want it for the pleasure of drinking it.’’ If I then proceed by asking ‘‘But what is the pleasure of drinking the soda good for?’’ the discussion is likely to reach an awkward end. The reason is that the pleasure is not good for anything further; it is simply that for which going to the convenience store and buying the soda is good.3 As Aristotle observes: ‘‘We never ask [a man] what his end is in being pleased, because we assume that pleasure is choice worthy in itself.’’4 Presumably, a similar story can be told in the case of pains, for if someone says ‘‘This is painful!’’ we never respond by asking: ‘‘And why is that a problem?’’ We take for granted that if something is painful, we have a sufficient explanation of why it is bad. If we are onto something in our everyday reasoning about values, it seems that pleasure and pain are both places where we reach the end of the line in matters of value. Although pleasure and pain thus seem to be good candidates for intrinsic value and disvalue, several objections have been raised against this suggestion: (1) that pleasure and pain have instrumental but not intrinsic value/disvalue; (2) that pleasure and pain gain their value/disvalue derivatively, in virtue of satisfying/ frustrating our desires; (3) that there is a subset of pleasures that are not intrinsically valuable (so-called ‘‘evil pleasures’’) and a subset of pains that are not intrinsically disvaluable (so-called ‘‘noble pains’’), and (4) that pain asymbolia, masochism, and practices such as wiggling a loose tooth render it implausible that pain is intrinsically disvaluable. I shall argue that these objections fail. Though it is, of course, an open question whether other objections to P1 might be more successful, I shall assume that if (1)–(4) fail, we are justified in believing that P1 is true.

#### That outweighs---[1]Governments use util to make policy decisions---with so many variables the only thing they can do is work to make people’s lives net better

#### [2] Threats to bodily security make it impossible to make decisions under any other framework --- we always act to preserve well-being. Means util is a prerequisite.

#### And stopping extinction comes first under any framework

Pummer 15 [Theron, Junior Research Fellow in Philosophy at St. Anne's College, University of Oxford. “Moral Agreement on Saving the World” Practical Ethics, University of Oxford. May 18, 2015] brett

There appears to be lot of disagreement in moral philosophy. Whether these many apparent disagreements are deep and irresolvable, I believe there is at least one thing it is reasonable to agree on right now, whatever general moral view we adopt: that it is very important to reduce the risk that all intelligent beings on this planet are eliminated by an enormous catastrophe, such as a nuclear war. How we might in fact try to reduce such existential risks is discussed elsewhere. My claim here is only that we – whether we’re consequentialists, deontologists, or virtue ethicists – should all agree that we should try to save the world. According to consequentialism, we should maximize the good, where this is taken to be the goodness, from an impartial perspective, of outcomes. Clearly one thing that makes an outcome good is that the people in it are doing well. There is little disagreement here. If the happiness or well-being of possible future people is just as important as that of people who already exist, and if they would have good lives, it is not hard to see how reducing existential risk is easily the most important thing in the whole world. This is for the familiar reason that there are so many people who could exist in the future – there are trillions upon trillions… upon trillions. There are so many possible future people that reducing existential risk is arguably the most important thing in the world, even if the well-being of these possible people were given only 0.001% as much weight as that of existing people. Even on a wholly person-affecting view – according to which there’s nothing (apart from effects on existing people) to be said in favor of creating happy people – the case for reducing existential risk is very strong. As noted in this seminal paper, this case is strengthened by the fact that there’s a good chance that many existing people will, with the aid of life-extension technology, live very long and very high quality lives. You might think what I have just argued applies to consequentialists only. There is a tendency to assume that, if an argument appeals to consequentialist considerations (the goodness of outcomes), it is irrelevant to non-consequentialists. But that is a huge mistake. Non-consequentialism is the view that there’s more that determines rightness than the goodness of consequences or outcomes; it is not the view that the latter don’t matter. Even John Rawls wrote, “All ethical doctrines worth our attention take consequences into account in judging rightness. One which did not would simply be irrational, crazy.” Minimally plausible versions of deontology and virtue ethics must be concerned in part with promoting the good, from an impartial point of view. They’d thus imply very strong reasons to reduce existential risk, at least when this doesn’t significantly involve doing harm to others or damaging one’s character. What’s even more surprising, perhaps, is that even if our own good (or that of those near and dear to us) has much greater weight than goodness from the impartial “point of view of the universe,” indeed even if the latter is entirely morally irrelevant, we may nonetheless have very strong reasons to reduce existential risk. Even egoism, the view that each agent should maximize her own good, might imply strong reasons to reduce existential risk. It will depend, among other things, on what one’s own good consists in. If well-being consisted in pleasure only, it is somewhat harder to argue that egoism would imply strong reasons to reduce existential risk – perhaps we could argue that one would maximize her expected hedonic well-being by funding life extension technology or by having herself cryogenically frozen at the time of her bodily death as well as giving money to reduce existential risk (so that there is a world for her to live in!). I am not sure, however, how strong the reasons to do this would be. But views which imply that, if I don’t care about other people, I have no or very little reason to help them are not even minimally plausible views (in addition to hedonistic egoism, I here have in mind views that imply that one has no reason to perform an act unless one actually desires to do that act). To be minimally plausible, egoism will need to be paired with a more sophisticated account of well-being. To see this, it is enough to consider, as Plato did, the possibility of a ring of invisibility – suppose that, while wearing it, Ayn could derive some pleasure by helping the poor, but instead could derive just a bit more by severely harming them. Hedonistic egoism would absurdly imply she should do the latter. To avoid this implication, egoists would need to build something like the meaningfulness of a life into well-being, in some robust way, where this would to a significant extent be a function of other-regarding concerns (see chapter 12 of this classic intro to ethics). But once these elements are included, we can (roughly, as above) argue that this sort of egoism will imply strong reasons to reduce existential risk. Add to all of this Samuel Scheffler’s recent intriguing arguments (quick podcast version available here) that most of what makes our lives go well would be undermined if there were no future generations of intelligent persons. On his view, my life would contain vastly less well-being if (say) a year after my death the world came to an end. So obviously if Scheffler were right I’d have very strong reason to reduce existential risk. We should also take into account moral uncertainty. What is it reasonable for one to do, when one is uncertain not (only) about the empirical facts, but also about the moral facts? I’ve just argued that there’s agreement among minimally plausible ethical views that we have strong reason to reduce existential risk – not only consequentialists, but also deontologists, virtue ethicists, and sophisticated egoists should agree. But even those (hedonistic egoists) who disagree should have a significant level of confidence that they are mistaken, and that one of the above views is correct. Even if they were 90% sure that their view is the correct one (and 10% sure that one of these other ones is correct), they would have pretty strong reason, from the standpoint of moral uncertainty, to reduce existential risk. Perhaps most disturbingly still, even if we are only 1% sure that the well-being of possible future people matters, it is at least arguable that, from the standpoint of moral uncertainty, reducing existential risk is the most important thing in the world. Again, this is largely for the reason that there are so many people who could exist in the future – there are trillions upon trillions… upon trillions. (For more on this and other related issues, see this excellent dissertation). Of course, it is uncertain whether these untold trillions would, in general, have good lives. It’s possible they’ll be miserable. It is enough for my claim that there is moral agreement in the relevant sense if, at least given certain empirical claims about what future lives would most likely be like, all minimally plausible moral views would converge on the conclusion that we should try to save the world. While there are some non-crazy views that place significantly greater moral weight on avoiding suffering than on promoting happiness, for reasons others have offered (and for independent reasons I won’t get into here unless requested to), they nonetheless seem to be fairly implausible views. And even if things did not go well for our ancestors, I am optimistic that they will overall go fantastically well for our descendants, if we allow them to. I suspect that most of us alive today – at least those of us not suffering from extreme illness or poverty – have lives that are well worth living, and that things will continue to improve. Derek Parfit, whose work has emphasized future generations as well as agreement in ethics, described our situation clearly and accurately: “We live during the hinge of history. Given the scientific and technological discoveries of the last two centuries, the world has never changed as fast. We shall soon have even greater powers to transform, not only our surroundings, but ourselves and our successors. If we act wisely in the next few centuries, humanity will survive its most dangerous and decisive period. Our descendants could, if necessary, go elsewhere, spreading through this galaxy…. Our descendants might, I believe, make the further future very good. But that good future may also depend in part on us. If our selfish recklessness ends human history, we would be acting very wrongly.” (From chapter 36 of On What Matters)

### Contention 1 is Healthcare Workers

#### HCW strikes cause exploding mortality rates and push thousands into poverty--- empirics from Kenya prove Waithaka et al. 20 Waithaka et al. International Journal for Equity in Health (2020) 19:23 <https://doi.org/10.1186/s12939-020-1131-y> //AHS

Also, important in the nature and length of the strikes, particularly the nurses’ strike, was the timing coinciding with national and local elections. Elections were already expected to be associated with unrest and to undermine the fragile public healthcare system [65]. While the timing may have been a strategy intended to add pressure on the government to meet the nurses demands, in fact it led to national and county leaders being distracted from the strike and its’ effects on patient and public safety. Our findings suggest a wide range of negative experiences. **Disruptions to services** and reduced admissions have also been documented by other studies by our group: one documented that the strikes **resulted in marked reductions in admissions** with 4 out of 13 county hospitals having almost no admissions throughout the strikes another found that the nurses strike **severely affected immunization services** in government-run referral health facilities across the country [27, 30]. Our finding of no obvious dip in outpatient service utilization during the doctors’ strike specifically is potentially linked to the presence of nurses **and** other cadres (such as clinical officers) in outpatients, but a forthcoming paper will characterize further the effect of both the nurses’ and doctors’ strikes on in-patient admission. Our interviewees highlighted the **devastating effects** of service disruption on staff morale and on households, particularly **for the poorest households**. Given that about **620,000 Kenyans are** **pushed below the** national **poverty line** every year **due to** transport costs and **health care** payments even **under ‘normal’ conditions** [33], **the impoverishing effect of the strike** for the poorest households **is** likely to have been **enormous**. As with other sudden shocks to the health system [66], our findings support that the impoverishing effects of the strike are disproportionately felt by the poorest and most vulnerable. Beyond impoverishment, interviewees talked in dramatic terms about negative health-outcomes linked to the strikes, including deaths, with the poor again being the worst affected. A recent analysis of **the effects** of six previous nation-wide Kenyan strikes on mortality data in Kilifi County (before the 100 days doctors and the 150 days nurses strike) **found a 75% increase in mortality among children** aged 12–59 months during the strike period, but no change in overall mortality [24]. The authors noted that the lack of change in overall mortality could have been because the strikes between 2010 and 2016 were relatively short, with only one lasting for more than a month (42 days). Evidence from other settings suggests that the effects of strikes on health outcomes are increased where emergency services are not available or the affected populations are not able to access viable (available and affordable) alternate healthcare services [1, 3, 19, 67, 68]. In Kenya, the Irimu et al (2018) study reviewing admissions in 13 public hospitals during the 2017 doctors’ and nurses strikes noted that ‘**preventable deaths** likely occurred **on a massive scale’**, particularly for the poor [27]. We identified similar perceptions in our study, but this may be in contrast with the more modest effects reported for prior strikes [24] . Given that the Kenyan public health system has faced a series of shocks and stressors over the decades, additional research that can provide more detailed data on the impact of the prolonged strikes on mortality over time is important

#### And it's not just one country---health care strikes disproportionately affect healthcare in LDCs Chima 13 Chima, S.C. Global medicine: Is it ethical or morally justifiable for doctors and other healthcare workers to go on strike?. BMC Med Ethics 14, S5 (2013). <https://doi.org/10.1186/1472-6939-14-S1-S5> //AHS

**Doctor and HCW strikes** have become a global phenomenon with increasing incidence in many countries [1, 2] and the potential to **impact negatively on the quality of healthcare** service delivery and the doctor-patient relationship which is based primarily on the fiduciary duty of trust [3, 4]. HCW strikes are not limited to any society, group, or country regardless of their level of socio-economic development. In most democratic societies, strikes are a legitimate part of collective bargaining during labour negotiations [2–4]. Doctor and HCW strikes have been reported in highly developed countries such as USA [2, 5–7], UK [8]; New Zealand [9–11], Germany and France [2, 12]; middle income countries such as Israel [13, 14], India [15], Czech Republic [16], and South Africa [17–19]. Also in less developed countries such as Nigeria [20–22], Malawi [23] and Zambia [24] to name but a few. While HCW strikes occur globally, it appears **the impact of strikes are more severely felt in less developed countries because of** the **poorer socio-economic** circumstances **and** embedded **infrastructural** **deficiencies. Such countries are** generally **confronted by issues** **of** inadequate manpower, poor wages and working conditions [25], poor organizational ethics [26–28], and **lack of viable alternative means of obtaining healthcare for the general population** [29], thereby fulfilling the international criteria for vulnerability as defined by UNAIDS and other authorities [29, 30].

#### And quality healthcare in developing countries would prevent 6 million deaths per year---turns case and outweighs Goldschmidt and Pate 19 hGabriel Goldschmidt and Muhammad Ali Pate, November 25, 2019, World Economic Forum. <https://www.weforum.org/agenda/2019/11/effects-and-costs-of-poor-quality-healthcare/> //AHS

What is the **number one cause of death** for sick people seeking treatment **in developing countries**? If you think it is lack of access to healthcare, think again. A recent report by The Lancet Global Health Commission on High Quality Health Systems found that **5.7 million people die** in low and middle-income countries **every year from poor quality healthcare** compared with the 2.9 million who die from lack of access to care. In other words, in many countries, **a person has a greater chance of dying from receiving poor quality care than from going without care entirely**. At the UN General Assembly in September, heads of states and governments adopted a high-level declaration committing to achieving Universal Health Coverage (UHC) by 2030. This was an important political moment for global health and most welcome development. As we head down the path of UHC, we at the World Bank Group believe that **now, more than ever, we must** translate this commitment to concrete actions and **place** the issue of **quality at the** front and **centre** of our efforts.

### Contention 2 is The Brain Drain

#### Massive reverse brain drain now---COVID spurred return of millions of high skilled workers to their home countries Bakalova et al 21 Bakalova, Irina and Fidrmuc, Jan and Fidrmuc, Jan and Berlinschi, Ruxanda and Dzjuba, Yuri, COVID-19, Working from Home and the Potential Reverse Brain Drain (2021). CESifo Working Paper No. 9104, Available at SSRN: <https://ssrn.com/abstract=3862238> //AHS

#### We construct estimates of the share of white-collar workers who could work from home for each occupation and sector. According to our estimates, countries of residence which are most likely to be affected by the departures of skilled migrants are the UK, France, Switzerland and Germany: in each of these countries, around half a million migrants originating from the EU or European-neighborhood countries could potentially perform their activities from home. The countries most likely to receive return migrants are the EU 15, where up to 2 million skilled migrants could potentially return, and the new EU member states, with up to half a million skilled potential return migrants. Other European and MENA countries may expect the return of several hundreds of thousand migrants. For decades, developed countries have benefited from inflows of highly-skilled workers from the less development countries in Central, Eastern and Southern Europe or from the European periphery. Indeed, brain drain may have been one of the reasons why such countries often end up in the so-called middle-income trap: with the convergence process stalling after they have achieved an intermediate level of per capita income. The greater prevalence of WFH spurred by the Covid-19 pandemic could help reverse this brain drain, if some migrant workers relocate internationally while working from home. Our estimates gauge the potential size of such a reverse brain drain of white- 11 collar workers to their home countries or other countries. If it occurs, it will have a number of potentially important implications. First of all, by allowing the migrants to live closer to their friends and families, such return migration will raise the migrants’ and their loved ones’ wellbeing (Crosbie & Moore, 2004; van Leeuwen & BourdeauLepage, 2020). Physical separation between family members is an important cost of migration; working from home will allow the migrants to continue enjoying the professional and economic benefits of being employed in the destination country without having to leave their home country. Second, even though these workers will continue working for employers in the destination countries, while being in their home countries they can also participate in professional networks, engage in political activism and various undertakings there too. Therefore, their home countries have a chance to benefit, even if only partially, from the human capitals of these migrants, as well as from their professional networks in the destination countries. Their presence and the positive effects of their human capital can have important developmental implications. Third, migrants returning from developed and politically and socially liberal countries can exert a positive influence on their home countries through transfers of modern political views and social norms: this process is often referred to as social/cultural remittances. Such favorable effects are likely to be reinforced further if the migrants are physically present in their home countries. Finally, return migrants would continue earning their income in the destination country but a large part of their consumption would be in the home country. Therefore, their return will translate into higher consumption and perhaps also investment in the home country. The home countries of these migrants could implement policies incentivizing the return of their bright teleworkers, in order to benefit from their consumption and investment, political participation, cultural remittances and professional networks.

#### And there’s no functional right to strike in sub-Saharan Africa for healthcare workers Le Roux and Cohen 16 Le Roux R and Cohen T"Understanding the Limitations to the Right toStrike in Essential and Public Services in the SADC Region" PER / PELJ2016(19)-DOI //AHS

It is concluded that –with the exception of South Africa and Namibia –the **limitations to the right to strike of public sector employees exceed those endorsed by international conventions,** **and the broad definition of essential services** generally relied upon effectively **results in an outright ban of public sector strikes in the sub-region**. In the early 1990s, major labour law reforms were implemented **in Southern Africa.** These reforms were driven by the adoption of new national constitutions (some entrenching the right to strike), a desire to democratise the workplace, and trade liberalisation.1The countries analysed in this article have all formally endorsed the instruments of the International Labour Organisation (ILO)2and have signed the Southern Africa Development Community (SADC) Social Charter (Charter of the Fundamental Social Rights in SADC (2003)). Despite this, and despite the ILO's active role in the region in promoting these standards,3the right to strike remains poorly developed in the countries –outside South Africa.**The right to strike in the essential services** and public sector in the region **is severely restricted**. **Given** that the rate of informal employment in the region is high and that **the public sector is the most important provider of** formal **employment** in most of these countries, **strikes are rare** –with the exception of South Africa.4This article examines the nature of the limitations to the right to strike in essential and public services in the nine sub-regional countries of Southern Africa: South Africa, Botswana, Lesotho, Namibia, Swaziland, Malawi, Mozambique, Zambia and Zimbabwe. **While**  **all of these countries share** common influences and face **common challenges** posed by high unemployment rates, dire poverty, and bleak economic development, there appears to be **a vast disparity in the** approaches taken to the **right to strike in public and essential services in the region**.

#### And healthcare strikes hurt the workers who participate and lead to massive brain drain regardless of success Chima 13 Chima, S.C. Global medicine: Is it ethical or morally justifiable for doctors and other healthcare workers to go on strike?. BMC Med Ethics 14, S5 (2013). <https://doi.org/10.1186/1472-6939-14-S1-S5> //AHS

It would appear that **strikes may have a disproportionate deleterious impact on doctors** and other HCWs when compared to patients. Striking HCWs frequently face a loss of income, job insecurity, and emotional distress, plus long hours of work for those who choose not to participate in the strike action. Further, there could be derangement of working relationships as well as loss of established leadership [11, 41]. **Whether or not** their **demands are** eventually **met, doctors** who have been **involved in strikes** usually **end up** disillusioned and **demotivated** and many end-up **emigrating overseas or relocating** within the country thereby **leading to** either internal or external **brain drain.** For example, striking doctors in Timaru, New Zealand reported an "overwhelming feeling of complete lack of confidence and trust in the hospital management team" [11, 16, 25, 55, 66]. **The impact** of such movements **could be** as **severe** as occurred in Malta, where the Maltese medical school lost its GMC accreditation due to a prolonged doctor's strike [9]. **It could also lead to a situation where** close to **25% of** a national **doctors threatened to quit their jobs and leave the country** unless they received wage increases, as reported recently from the Czech Republic [16]. The **brain drain** which occurred in Malta, New Zealand and Israel following doctors strikes **led to major disruptions in healthcare service** delivery in the centers and regions affected [9, 14].

#### African health care brain drain *will* cause the spread of disease Haseeb 18

(Saud Haseeb, researcher and writer for the ysjournal, who did a meta analysis of the effects of brain drain in Africa, “The Critical Shortage of Healthcare Workers in Sub-Saharan Africa: A Comprehensive Review”, YSJournal, <https://ysjournal.com/the-critical-shortage-of-healthcare-workers-in-sub-saharan-africa-a-comprehensive-review/> recut 11/4/21 AHS

Contributing Factors The critical shortage of human resources for healthcare in sub-Saharan Africa is an incredibly complex issue influenced by numerous political, environmental and social forces. However, by analysing data from individual countries and across the region, the greatest contributing factors can be identified as the emigration of healthcare workers, the effects of diseases and infections and the scarcity of medical graduates. Emigration of Healthcare Workers Throughout history and in the modern day, healthcare workers have been emigrating from lower-income countries in sub-Saharan African to higher-income countries within North America and Europe.6 This pattern of emigration has decimated the medical workforce in several areas. For instance, 70% and 75% of the physicians originally from Angola and Mozambique, respectively, are currently practising abroad.12 In total, approximately 65,000 doctors and 70,000 nurses from sub-Saharan Africa, which is equal to approximately 28% of the region’s medical workforce, are working internationally.12 The outward flow of healthcare workers from sub-Saharan Africa is related to several push and pull factors. The push factors identified by emigrant healthcare workers include low salaries, poor working environments, underfunded healthcare facilities and the lack of opportunities for career advancement.13 Furthermore, there is a strong correlation between political instability in a country and its loss of medical personnel.12 The pull factors for emigration include higher salaries, better healthcare facilities and more opportunities for career advancement.14 To limit the emigration of healthcare workers from sub-Saharan Africa, it is necessary to minimise the influence of both the push and pull factors. Table 2: Summary of the push and pull factors for the emigration for healthcare workers from sub-Saharan Africa.3,12-14 Diseases and Infections The spread of diseases and infections has directly led to the loss of a significant number of medical workers in sub-Saharan Africa. It is estimated that, since its emergence, HIV/AIDS has caused the healthcare workforce of sub-Saharan Africa to decrease by as much as 20%.15 More recently, the Ebola crisis decimated the medical workforce of Liberia and Sierra Leone, decreasing the number of doctors by 7% and the number of nurses and midwives by 8%.16 These significant decreases are mostly observed among frontline workers controlling the spread of disease.5 These workers incur the greatest numbers of occupational hazards, such as working with diseased patients and handling infected items. Lack of Medical Graduates One of the root causes of the crisis in the human resources for healthcare in sub-Saharan Africa is the scarcity of medical graduates. It is estimated that, on a yearly basis, only 10,000 to 11,000 medical students graduate from the region.4 This substantially low number is directly tied to the shortage of medical schools. In total, sub-Saharan Africa contains only 87 medical schools, with an average of 1.8 medical schools per country.4 This statistic includes 11 countries that have no medical training facilities at all and 24 with only one such institution.4 Moreover, the medical schools that are present in sub-Saharan Africa often lack access to essential resources. For example, a study conducted in 2010 found that a university in Ethiopia had no reliable sources of power, water and telecommunications.4 Other medical schools across the region faced shortages of technological equipment and proper student housing.4 Implications of the Shortage The lack of adequate human resources for healthcare has negative impacts on almost every facet of public health in sub-Saharan Africa. Not only does this shortage lead to an overall increase in mortality rates, but it also has an adverse effect on maternal health and the treatment of HIV/AIDS within the region. Adult and Child Mortality Mortality rates in the general population of sub-Saharan Africa are among the highest in the world. A male between the ages of 15 and 60 within this region has a 39.1% probability of death, while a female in the same age range has a probability of 33.2%.17 Similar statistics describe child mortality; the United Nations Children’s Fund (UNICEF) estimated in 2015 that a child born within sub-Saharan Africa has an 8.1% probability of death before the age of five.18 The extremely high rates of mortality in sub-Saharan Africa are strongly linked to the lack of healthcare workers within the region. Figure 1 shows the density of physicians within individual countries of sub-Saharan Africa compared to the mortality rate of children under the age of five in each country.9,19 A linear increase in the density of physicians is correlated with an exponential decrease in the mortality rate of children under age five. WHO establishes a similar correlation in its 2006 World Health Report.3 Figure 1: Mortality rates of children under age five compared to the density of physicians in the population. Each point represents data from an individual country within sub-Saharan Africa.9,19 One possible explanation for the correlation between the healthcare worker density and child mortality rates within sub-Saharan Africa is that the low number of healthcare workers reduces the availability of basic health services, such as vaccinations and antibacterial treatments. Sick children may be unable to access treatments and, as a result, may die of preventable causes. This interpretation is supported by the fact that the majority of the world’s child deaths, and a significant fraction of its adult deaths, are preventable and simply due to a lack of treatment.20 Furthermore, several public health systems in sub-Saharan Africa claim to have closed their treatment centres because they lacked sufficient staff.21 Maternal Health The quality of maternal healthcare within sub-Saharan Africa is the lowest of any UNICEF-defined region in the world.22 It is estimated that 546 out of every 100,000 live births in sub-Saharan Africa result in maternal death.22 This number accounts for 60% of the total maternal mortality within the region, with the other 40% occurring in the period of time immediately after childbirth.2 Much like child mortality, maternal mortality also exhibits a correlation with healthcare worker density. Figure 2 shows the maternal mortality rate compared to the physician density in each country.7,9 As the physician density increases linearly, the maternal mortality rate decreases exponentially. The same correlation has been found by additional studies conducted across several countries in sub-Saharan Africa.23 Similarly, studies have found that an increase in the number of deliveries with health professionals present is associated with a decrease in maternal mortality rates.24 However, due to the low number of healthcare workers in sub-Saharan Africa, doctors, nurses and midwives are frequently unavailable at the time of childbirth.25 This is the case in several countries that have an extremely high maternal mortality rate, such as Ghana, where there is a vacancy rate of 57% for the relevant professions.25 Figure 2: Maternal mortality rates compared to the density of physicians in the population. Each point represents data from an individual country within sub-Saharan Africa.7,9 HIV/AIDS Treatment HIV/AIDS continues to be one of the most pressing public health issues in sub-Saharan Africa. In 2016, approximately 24 million individuals were living with HIV/AIDS in this region of the world.26 In some countries, such as Botswana and Swaziland, HIV/AIDS patients represent more than 25% of the adult population.27 The issue is exacerbated by the low rates of treatment for this disease; only 54% of the individuals living with HIV/AIDS in sub-Saharan Africa are receiving antiretroviral therapy.28 Figure 3 illustrates the antiretroviral therapy coverage across individual countries in the region.9,28 Figure 3: Percentage of people with HIV/AIDS receiving antiretroviral therapy in individual countries of sub-Saharan Africa.9,28 Antiretroviral therapy coverage is also linked to the density of healthcare workers. The countries with the lowest coverage rates, such as Somalia and the Central African Republic, also have the lowest density of healthcare workers.9,28 Many of these areas have tried to increase their rates of coverage by implementing HIV/AIDS treatment programs.29 However, several of these initiatives have failed due to a lack of resources.29 In fact, many sub-Saharan African countries, like Rwanda, would require an increase in their healthcare workforce by as much as 50% to administer antiretroviral therapy on a national scale.30 Strategies to Address the Crisis The crisis in the human resources for healthcare in sub-Saharan Africa is an extremely multifaceted issue; it is as much of a medical problem as it is social and political. As such, the crisis can only be fully addressed via a variety of short and long-term strategies on the regional, national and international levels. Task-Shifting StrategiesShort-term strategies that require minimal resources will likely be the most effective. Ideally, these strategies will be available to all types of public health facilities and will involve no delay prior to implementation. One approach that fulfils these criteria is task shifting.Task shifting is the transfer of responsibilities from a healthcare worker with a high level of training, such as a physician or surgeon, to a healthcare worker with a lower level of training, such as a nurse or community healthcare worker.31 This approach allows staff with less training to complete tasks that otherwise would have been left unfulfilled due to a shortage of staff with more training. This strategy is highly effective in areas where there are significantly more nurses than doctors, like sub-Saharan Africa.32Many parts of sub-Saharan Africa have already implemented task-shifting strategies with overwhelming success.33 For example, in 2004, Malawi began allowing nurses and other healthcare workers to administer antiretroviral therapy, which had previously been provided exclusively by doctors.33 As a result, approximately 130,000 more patients in that country received antiretroviral therapy in each of the following years. Other studies performed on task-shifting strategies in sub-Saharan Africa have concluded that this approach generally improves health outcomes.34However, while task-shifting strategies have certainly shown promise, they do have some shortcomings. Most importantly, when a healthcare worker of a lower skill level performs a more demanding task, the quality of the healthcare may decrease. Therefore, task-shifting strategies should not be considered a panacea and must be used in conjunction with other techniques to combat the healthcare crisis in sub-Saharan Africa.Mobile WorkforcesOne of the best ways to minimise the adverse impacts of disease and infection outbreaks within sub-Saharan Africa is through the use of a mobile workforce. WHO defines a mobile workforce as a group of doctors, nurses and other healthcare workers of varying skill and training levels that travels to locations in dire need of additional health resources.3 A mobile workforce implemented nationally and internationally within sub-Saharan Africa has the potential to significantly slow the spread of diseases and infections. However, to prepare for the implementation of this strategy, a variety of tasks must be performed. First, a region or country must gather the healthcare workforce that will constitute its mobile unit. This will require substantial financial investments from public organisations. A successful mobile workforce requires the establishment of adequate support and resources for the frontline workers.3 Last, the ability to easily travel among sectors or districts must be provided to the mobile unit through both the proper means of transportation and the legal freedom of movement.Policies to Minimise EmigrationTo truly overcome the crisis in the human resources for healthcare in sub-Saharan Africa, the emigration of healthcare workers from this region must be minimised. One of the best ways to do so is through large-scale policy implementation. An example of this is the WHO Global Code of Practice on the International Recruitment of Health Personnel, which serves as a policy framework for the ethical recruitment of medical professionals.6,35 Its main purpose is to address the healthcare worker shortage on the international level. However, compliance with this policy is voluntary, so its actual impact on the healthcare crisis in sub-Saharan Africa is questionable.

**Extinction---disease spread from the next pandemic kills at least a billion and destroys the global food supply Fletcher 20** <https://www.newstatesman.com/politics/2020/08/why-stephen-emmott-fears-the-next-pandemic-could-kill-a-billion-people> //AHS

A **coronavirus**-type pandemic was inevitable, Emmott, presently professor of biological computation at University College London, tells me by telephone from his home in Camberwell, south-east London. “This one is a very small glimpse – thankfully **not as severe as it could be – into a potential and likely future**.” **The next pandemic could kill a billion** people, he warns. “The population is set to increase from 7.7 billion to at least ten billion, and possibly more, before the end of this century. Urbanisation is increasing rapidly. ‘Wet markets’ have proliferated over the past two decades. The proliferation of habitat destruction, forcing animals into direct contact with humans, is increasing rapidly,” he says. All that, allied with the relentlessly escalating movement of people and goods around the world, means “we are increasing every day the likelihood of a Spanish flu-type pandemic that would **make this one pale by comparison**… We have no idea whether that’s around the corner in a month’s time, a year’s time or two or three decades’ time, but it’s almost certainly going to happen **and** that one is going to be really quite **deleterious to the human species**.” Of course, there have been plagues and pandemics in the past, he adds, but “this burying our heads in the sand, this view that we have this once a century so we just have to get over it, I think that’s nonsense”. Nor are zoonotic pandemics – those caused by pathogens jumping from animals to humans – the only threat to modern man. There could well be **a “crop pandemic**”, Emmott says. The “Green Revolution’” of the late 20th century vastly increased food production, but it did so by breeding genetic diversity out of cereal crops, leaving “monocultures” of wheat and corn. At the same time fungicides are becoming less and less effective. That means a range of novel plant pathogens **has the potential to destroy** much of **the world’s food supply**. “The **consequences** of that **on political stability and forced migration are** unforeseen, unknowable and probably **unprecedented,**” he says.

### On Case

#### Strikes fail and lead to backlash---decks solvency

Grant and Wallace 91 [Don Sherman Grant; Ohio State University; Michael Wallace; Indiana University; “Why Do Strikes Turn Violent?” University of Chicago Press; March 1991

3. Violent tactics.-Violent tactics are viewed by RM theorists exclu- sively as purposeful strategies by challengers for inciting social change with little recognition of how countermobilization strategies of elites also create violence. The role of elite counterstrategies has been virtually ig- nored in research on collective violence. Of course, history is replete with examples of elites' inflicting violence on challenging groups with the full sanction of the state. Typically, elite-sponsored violence occurs when the power resources and legal apparatus are so one-sidedly in the elites' favor that the outcome is never in doubt. In conflicts with weak insiders, elites may not act so openly unless weak insiders flaunt the law. Typically, elite strategies do not overtly promote violence but rather provoke violence by the other side in hopes of eliciting public condemnation or more vigorous state repression of challenger initiatives. This is a critical dynamic in struggles involving weak insiders such as unions. In these cases, worker violence, even when it appears justified, erodes public support for the workers' cause and damages the union's insider status.

#### Increased strikes sabotage the economy – they cause major disruptions and lower income for workers.

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Labor strikes can cause major disruptions to industry, commerce and the lives of many people who aren't even connected to the strike itself. The Professional Air Traffic Controllers Association strike in 1981 resulted in the firing of thousands of air traffic controllers, and the New York City transit strike in late 2005 affected millions of people. The history of strikes and labor unions is a key chapter in the story of the Industrial Revolution. While the reasons behind strikes can be complex, they all boil down to two key elements: money and power. In this article, we'll find out how labor strikes have affected the balance of power between corporations and workers, what laws regulate strikes and learn about some important strikes in history. It's difficult to say when the first real labor strike occurred. The word "strike" was first used in the 1700s, and probably comes from to notion of dealing a blow to the employer [ref]. In 1786, a group of printers in Philadelphia requested a raise and the company rejected it. They stopped working in protest and eventually received their raise. Other professionals followed suit in the next few decades. Everyone in a city who practiced the same profession agreed to set prices and wages at the same rate. Members would shun anyone who diverged from the agreement, refusing to work in the same shop and forcing employers to fire them. By the 1800s, formal trade societies and guilds began to emerge. To have a strike today, you must have a union (though not necessarily an official union) -- an organization of workers that bargain collectively with an employer. Workers form unions because an individual worker is powerless compared to an employer, who can set low wages and long working hours as long as it adheres to labor laws. When workers combine to form a union, they collectively have enough power to negotiate with the employer. The main weapon the union has against the employer is the threat of a strike action. At its most basic level, a strike occurs when all the workers in the union stop coming to work. With no workers, the business shuts down. The employer stops making money, though it is still spending money on taxes, rent, electricity and maintenance. The longer the strike lasts, the more money the employer loses. Of course, the workers aren't getting paid either, so they're losing money as well. Some unions build up "war chests" -- funds to pay striking workers. But it isn't usually very much, and it's often not enough for a prolonged strike.

Strikes help explain why unions are more powerful than individuals. Imagine if an employer refuses to give a raise to an individual worker. She then decides to stop coming to work in protest. The employer simply fires her for not coming to work. That one worker has no power to influence the employer. However, it can be very costly for an employer to fire every single worker when a union goes on strike (though it has happened).

#### Labor unions effective – no need for more strikes

Graham 16’ Graham, James. "A Reconsideration of the Right to Strike." *The Catholic Lawyer* 9.2 (2016): 4.

Employers in certain industries almost always bow to union demands because, having banded together in collective bargaining associations with their competitors, they are in a position to make the public pay the price of increased wages or shorter hours. This is an oversimplification, of course, but it would not be naive not to suppose, for example, that at least one effect of the inflated wage scales in the building trades is to make it more difficult for the lowerincome groups to increase their earnings and someday to buy a home. Conclusion In any 'event, it would appear that government neutrality in labor disputes is fast becoming a thing of the past. The Kennedy administration has to date shown no reluctance to invoke the Taft-Hartley injunction procedures in labor disputes affecting the national welfare. A proposal by former Secretary of Labor Goldberg that government representatives participate as "observers" in major negotiations was greeted with a cry of indignation from George Meaney and a chilly "no thanks" from management spokesmen, but Goldberg's proposal does reflect an increasing concern for the public interest in labor-management disputes. It seems that government mediators often will intervene in disputes that only remotely affect national defense interests. Perhaps this tendency has been influenced by the widely-held view among labor practitioners that public tolerance for strikes is much lower today than during the years when unions were organizing in the mass production industries.3 6 In conclusion, it is safe to say that additional legislation to curb illegal strikes and to compel arbitration in certain industries may not only be inevitable but necessary as well. We also can expect government regulation over other areas of collective bargaining unless the powerful unions pay heed to the principle enunciated by Pope Pius XI in Quadragesimo Anno that the right to strike should be exercised only as a last resort and in situations where it needs no justification.

#### Thumpers to collective bargaining – employers use legal intimidation tactics that strikes can’t solve

Lafer and Loustaunau 20 - Gordon Lafer and Lola Loustanunau, [Gordon Lafer is a political economist and is a Professor at the University of Oregon’s Labor Education and Research Center. He has written widely on issues of labor and employment policy, and is author of The Job Training Charade (Cornell University Press, 2002). Lola Loustaunau is an assistant research fellow at the Labor Education and Research Center, University of Oregon, Eugene.] 7-23-2020, "Fear at work: An inside account of how employers threaten, intimidate, and harass workers to stop them from exercising their right to collective bargaining," Economic Policy Institute, <https://www.epi.org/publication/fear-at-work-how-employers-scare-workers-out-of-unionizing/>

What this report finds: Most American workers want a union in their workplace but very few have it, because the right to organize—supposedly guaranteed by federal law—has been effectively cancelled out by a combination of legal and illegal employer intimidation tactics. This report focuses on the legal tactics—heavy-handed tactics that would be illegal in any election for public office but are regularly deployed by employers under the broken National Labor Relations Board’s union election system. Under this system, employees in workplace elections have no right to free speech or a free press, are threatened with losing their jobs if they vote to establish a union, and can be forced to hear one-sided propaganda with no right to ask questions or hear from opposing viewpoints. Employers—including many respectable, name-brand companies—collectively spend $340 million per year on “union avoidance” consultants who teach them how to exploit these weakness of federal labor law to effectively scare workers out of exercising their legal right to collective bargaining.

Inside accounts of unionization drives at a tire manufacturing plant in Georgia and at a pay TV services company in Texas illustrate what those campaigns look like in real life. Below are some of the common employer tactics that often turn overwhelming support for unions at the outset of a campaign into a “no” vote just weeks later. All of these are legal under current law:

Forcing employees to attend daily anti-union meetings where pro-union workers have no right to present alternative views and can be fired on the spot if they ask a question.

Plastering the workplace with anti-union posters, banners, and looping video ads—and denying pro-union employees access to any of these media.

Instructing managers to tell employees that there’s a good chance they will lose their jobs if they vote to unionize.

Having supervisors hold multiple one-on-one talks with each of their employees, stressing why it would be bad for them to vote in a union.

Having managers tell employees that pro-union workers are “the enemy within.”

Telling supervisors to grill subordinates about their views on unionization, effectively destroying the principle of a secret ballot.

#### Labor unions corrupt and they don’t help the people

Graham 16’ Graham, James. "A Reconsideration of the Right to Strike." *The Catholic Lawyer* 9.2 (2016): 4. //RD Debatedrills

We need not conclude from all this that the right to strike is, or shoud be, obsolete. 4 Baerwald, The Labor Encyclicals Today, 49 CATHOLIC MIND 622, 629 (1951). 35 WEBB & WEBB, THE HISTORY OF TRADE UNIONIsm 664 (1920). Proposed alternatives which have been successful in other nations, such as compulsory arbitration and the formation of a Labor Party, might prove unworkable here and even obnoxious to the American eco-political system. It is also true that in this country most employers will never welcome unions with open arms and in the last analysis, despite the protections and prohibitions of the federal and state labor statutes, unions, in most cases, will be forced to resort to a show of economic strength to force recognition and/or just bargaining demands upon recalcitrant employers. But the point sought to be made here is that the right to strike is by no means absolute. A democratic desire to sympathize with the "underdog" should not obscure the fact that the entire community, including employers, has a legitimate interest in industrial peace. Mr. Justice Brennan argued in his vigorous dissenting opinion in the Sinclair case that the justification for the Norris-LaGuardia Act in 1932 was that federal court injunctions had stripped unions of their strike weapon without substituting any reasonable alternative. However, an agreement, freely made, to arbitrate all disputes arising during the term of the contract obviously does offer such an alternative. Ironically enough, the Sinclair decision will also add to the woes of many harassed union leaders. It is unfortunate but true that those labor organizations which are most democratic in their internal affairs are often most guilty of illegal strike activities;

either the leaders cannot control dissident elements in the ranks or, facing re-election difficulties, must cater to the desire of the members for dramatic action to protest real or imagined grievance. In the past, the threat of an imminent injunction has been urged when necessary by union officials, 9 CATHOLIC LAWYER, SPRING 1963 without losing face, as a compelling reason for resorting to arbitration rather than a work stoppage for satisfaction of the grievance