### CP – MSAs

#### Counterplan text: A just government ought to recognize a right to strike conditioned on the enactment of minimum service agreements for health care workers

#### MSAs are a necessary condition to avoid the potential impacts of healthcare worker strikes and doctor unions agree 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

This analysis shows that the right to strike is so important to the functioning of modern democratic societies that its suppression would be unjustified. The right to strike is now accepted as an indispensable component of collective bargaining and perhaps a fundamental human right. However **minimizing the impact of doctor and HCW strikes** **will require** improved organizational ethics and the **recognition by both employees and employers**, especially elected officials **that they are equally morally obligated to serve the interest of society**. In other words they are two sides of the same coin. For the incidence of strikes to decrease both employers and employees must be ethical in their approach to resolving labour disputes. For example, legitimate collective bargaining agreements must be respected and honored in a timely manner. Similarly, employees including doctors and other workers must resist the impulse to make economic demands which are beyond the capacity of the employer or which could hamper the provision of other social services, such as education and public utilities. Furthermore **when HCWs embark on a strike action,** **they must** endeavor to **provide** a certain level of **minimum service, e.g.** continue providing **emergency medical services, thereby minimizing the impact of strikes on the general public.** In this regard, **it is imperative that** agreements such as the **minimum service** level **agreements** which are being **advocated by doctors unions as a means of assuring minimum coverage** during strikes **should be speedily agreed upon**. Governments as employers should also resist the urge to arbitrarily designate certain groups as "essential services", outside of established international law, simply in order to deny such employee groups the right to strike. Arbitrary actions such as mass firing of striking doctors or threats of unjustifiable disciplinary action by regulatory authorities, will not encourage speedy resolution of HCWs, and may lead to undesirable consequences such as brain drain. If some workers or employees are considered 'essential', then society should endeavor to treat such employees as such, by devising mechanisms to pay appropriate wages which justify such 'essentiality'. It may be useful to appoint an independent mediator or administrative body to advice on special salary packages and conditions of service for essential workers rather than grouping every worker together under the rubric of public service employees. Finally, it has been observed following strikes by HCWs in some jurisdictions, that while the public is generally supportive of HCW strikes which are designed to improve the quality of healthcare service delivery for all, society is generally unsupportive of strikes where the sole purpose is the increment of wages and improved conditions for HCWs alone.

#### It competes: it’s mutually exclusive it puts conditions on the RTS (2) solves all the impacts of the aff and avoids the disads

#### 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 MSAs would have preserved the right to strike while avoiding the impacts Waithaka et al 2 Waithaka et al. International Journal for Equity in Health (2020) 19:23 <https://doi.org/10.1186/s12939-020-1131-y> //AHS Recognising that strikes remain a real possibility, there needs to be adequate planning and preparedness in advance of a potential crisis [71]. Given their key intermediary roles, and the challenges they faced in the prolonged 2017 strikes, middle level managers should be better supported by managers higher up the system to design and implement effective and sustainable responses to sudden shocks, including strikes. Responses to shocks should not only seek to preserve core services but also to ensure that the poorest households and communities are protected from health-related and financial losses. This would support a move towards more ‘ethical’ strikes where at a minimum emergency and essential services are sustained throughout a strike, threats and intimidation of striking and non-striking health workers are minimized, demands by workers are reasonable, and governments respect and honor agreements.

#### And it's not just one country---HCW 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.

### DA – Brain Drain

#### Massive reverse brain drain in the squo---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.