The report of the Commission for Africa has tried to chart the way forward, calling for an additional increase in overseas development assistance of up to \$25bn a year by 2010, and a further investment of the same amount by 2015, subject to a review of progress. The report provides bold and innovative targets to which members of the G8 and others are expected to commit at their summit this week. The report is labelled by some the Marshall plan for Africa, a reference to the European recovery programme followed by the United States for the reconstruction of Europe after the second world war and named after the former US secretary of state George Marshall.

The commission's report rightly identifies strengthened health systems, good governance, peace, and security as central to the efforts to stem Africa's downward spiral. It also acknowledges the importance of partnerships supporting pan-African institutions and regional organisations, and a framework that recognises the need for partners to respond to both regional and national priorities. The commission urges that immediate attention is given to the deficits in Africa's health workforce, information and management systems, and essential medicines and other health commodities; it also highlights the need for investments to follow the NEPAD health strategy and invest in regional institutions.

Health workers comprise the core of the healthcare system in Africa. Several groups have called on the G8 to invest in Africa's efforts to stem the brain drain and to produce the right multidisciplinary workforce to improve the performance of health systems and meet regional and global targets for health. Africa does not simply need more health workers; investments must also help to increase the motivation, retention, and accessibility of the workforce to make a real difference. Regional cooperation is crucial to solving the human resources crisis. This could include support for "brain sharing" between the nations in the region that produce health workers, such as South Africa and Nigeria; negotiation of expansion in fiscal space (the flexibility of financial management often restricted by conditions of loans and grants) in national budgets; and technical cooperation in medical education and training.

In addition, many public-private partnerships in Africa are starting—with variable success—to expand access to medicines, health commodities, and services. This expansion includes franchising of health services, outsourcing, and cooperative arrangements for pooled procurement and distribution of medicines and other commodities. Such models may be useful, but to sustain any initial gains and reverse the continent's poor record on health and development, African institutions will need global support to track achievements; learn lessons; document success; produce and manage knowledge; and share vision and experiences.

As the leaders in the industrial world meet this week to focus on Africa and deliberate on its future, they must go beyond the traditional strategy of counting numbers and examine the critical shifts in thinking that are required to make any greater investment succeed and move the continent forward. Increasingly, that success will depend on partners being willing and able to respond to the priorities of national governments and regional institutions in Africa. The commitments are pouring in, and Africa is once again the focus of global attention. But much still needs to be accomplished.

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Stopping Africa's medical brain drain

The rich countries of the North must stop looting doctors and nurses from developing countries

Africa will be the major focus of the G8 summit in Gleneagles next week, and rightly so. Nearly 11 million children aged under 5 years are dying every year worldwide from treatable diseases. Most of them are living in developing countries, with more than four million of these deaths in sub-Saharan Africa.¹ Along with the disastrous effects of warfare, HIV/AIDS is wiping out young adults and leaving frail, malnourished children in the care of their siblings and grandparents.

It is difficult to see how the countries of sub-Saharan Africa can develop economically and politically when such large proportions of their adult populations are liv-

ing with chronic diseases such as HIV/AIDS, tuberculosis, malaria, and other tropical diseases. Antiretroviral drugs could make a dramatic difference, and so could appropriate aid. Although the developed countries of the North are giving aid with one hand, they are robbing African countries with the other by siphoning off their most precious resource—trained doctors and nurses. The Commonwealth's developing countries are particularly hard hit because their health professionals speak English and are therefore a valuable commodity to plug manpower gaps in the United States, Canada, the United Kingdom, New Zealand, and Australia.

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Large parts of sub-Saharan Africa have effectively no health care at all, with only 600 000 healthcare workers for a population of 682 million.² For example in Ghana, faced with a ratio of nine doctors to every 100 000 patients,³ is it any wonder that young, talented health professionals are burnt out and despairing, and that they leave for a better life in the North? Only 60 of the 500 doctors trained in Zambia since independence are still there.⁴ Mozambique has only 500 doctors for a population of 18 million.⁵

What can be done? We cannot and should not prevent completely the migration of doctors and nurses. Medicine has a strong tradition of international collaboration, with doctors moving around the globe to gain further training and different clinical experience. Indeed, we like to think that international exchange and diversity enrich us all. This is a romantic delusion. We gain in the North, but developing countries lose out by losing their doctors permanently.

Any number of incentives have been tried to persuade doctors to remain in or return to their countries of origin—enhanced salaries, better pensions, cars, and housing allowances. Ethical recruitment codes may make us feel that we occupy the moral high ground. But, as long as the rich countries have plenty of vacancies, the flow of healthcare professionals from South to North will continue.

The most important element of the solution is self sufficiency. The BMA and the Royal College of Nursing have urged the prime minister and the chancellor of the exchequer to commit the UK to training enough people to become self sufficient in workforces of doctors and nurses. This would not be a huge leap for the UK since we have been expanding the number of medical school places year on year since 1997. Over the same period, we could radically expand the number of exchanges, overseas elective periods, and twinning programmes that would help our very hard pressed colleagues to feel less isolated and overburdened.

But what of the US? Already, it employs half of all English speaking doctors in the world. And it wants more. By deadly coincidence, the US wants to employ one million more healthcare workers in the next 15 years⁶—exactly the extra number needed for sub-Saharan Africa to fulfil the millennium development

goals.⁷ The US system regards healthcare professionals as a commodity to be purchased in the market and is making little provision currently to increase the number of doctors and nurses it trains at home. Nurses in the US, with an average salary of \$65 000 (£36 000; €53 000),⁸ are the most highly paid in the world.

The US is a great place to live and work. Unless it can be persuaded to think and act differently, it will soak up skilled workforce from every available source, including the UK. We would find it difficult and irksome to spend UK taxpayers' money training doctors to care for American patients. But we are a rich country, and many of those doctors would eventually return home. Ghana is already contributing to an obscene reversal of the flow of aid: it spends around \$9m each year on medical education⁹ only to lose its doctors to a voracious and insatiable health market in the North. The African initiative of the G8 countries will fail spectacularly if the richest nations of the world do not allow the poorest to maintain the bare essentials of healthcare provision.

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Do white British children and adolescents get enough sunlight?

Probably, and calls to abandon campaigns for skin cancer awareness are misguided

Fear of skin cancer, prompted by campaigns such as "SunSmart" (www.sunsmart.org.uk) in the United Kingdom, may have led to children spending less time exposed to sunlight, reducing opportunities for the production of vitamin D in the skin and resulting in a consequent detriment to bone health.¹ Furthermore, recent evidence shows that sunlight exposure and the resulting synthesis of vitamin D might reduce the risk of certain cancers² and, perhaps, of other diseases such as multiple sclerosis.³ In response, there have been calls for current skin cancer

awareness campaigns in the UK to be abandoned.⁴ Are such calls justified?

Adequate sun exposure is not easily defined,¹ but one of the leading proponents of the beneficial effects of sun exposure has indicated that exposing the face, hands and arms two to three times a week to a third to a half of the exposure necessary to result in a just perceptible reddening of white skin (the so called minimal erythema dose, MED) in the spring, summer, and autumn is more than adequate to satisfy the body's requirement for vitamin D throughout the year.⁵ In other words,