

EDITORIAL

## The Health Professional Brain Drain

One doesn't have to look hard to find many challenges to global health. The existence of HIV/AIDS, SARS, and bioterrorism are but a few examples. A well-functioning healthcare system is becoming even more necessary, if that is possible! Having the proper number of human resources is critical to a well-functioning health system. As a recent WHO report puts it, "Human Resources are Vital" (World Health Report, 2000).

However, in most of the countries in Southern Africa, for example, there is a very great discrepancy between what is needed and what exists. It is estimated that Zambia needs 15,000 physicians for its health care system to work properly (Bundred & Levitt, 2000). However, only about 800 are registered. Other countries worldwide have similar problems. On the other side of the situation about 23,000 qualified academics emigrate each year from Africa alone (McMichael, 2002). This phenomenon, called the "brain drain", has been around for a long time. Mejia *et al.*, for example, wrote of it in a WHO book published in 1979. They said then that "the migration of health professionals (is) . . . the result of the interaction of pull forces in recipient countries and push forces in donor countries" (WHO, 1979). In another report, a publication of papers from an international conference held by the Macy Foundation, Viel concluded that "those who have the greatest need for improved medical care become the 'donor' countries of doctors and other health professionals to the 'recipient' countries, which have already reached a satisfactory standard. . . ." (Viel, 1971). In spite of its acknowledgement in the 1970s and attempts to "fix" it, the brain drain continues to this day as a problem both intra-country as well as inter-country. In fact, both the less and more developed countries have maldistribution of health professionals. However, the inter-country form is my concern as I write. This is a phenomenon that is far greater than the health workforce, being a problem in engineering, information technology (computers), and physics to name but a few. Our concern, of course, is the health workforce, mainly physicians and nurses.

Simply put, inter-country "brain drain" is the worldwide problem of professionals being educated by and then moving from poor countries (e.g. The Philippines, India, South Korea) to a few of the richer countries (e.g. USA, UK, Australia, New Zealand, and oil-rich countries such as The Kingdom of Saudi Arabia and The United Arab Emirates). It is estimated, for example, that 31% of the physicians in the United Kingdom are born overseas as the authors in the British Medical Journal put it (Pang *et al.*,

2002). To make the situation a little nicer, the literature talks about “migration”, “donor” and “recipient” countries.

To understand the implications of this problem further, an example—recently written up in a Manila newspaper—may help even more. In the year 2001, 13,536 Filipino nurses left the country whereas only 4780 graduated. The *Philippine Star*: “More nurses would leave if they had the money to go abroad” (Roces, 2002). In other words, this problem is costing the less developed countries in both money and health care services. In hospitals it is bad and Filipino hospital administrators predict it will get worse. They base this prediction on the fact that people live longer and need more care in the more developed countries.

As usual it is not a clear cut issue. The richer countries address, but don't by any means solve, their shortages of health personnel in urban and rural areas through the immigration of health professionals, particularly in primary care specialties. That is to say, in the more developed countries the underserved get healthcare that they would not get otherwise. And, no one would want to take away from each individual the right to choose where he/she wants to practice his/her trade. There are professional reasons for emigrating and personal ones as well. On the professional side, there are such considerations as remuneration, status, working conditions, political climate. On the personal side, there are things like security, threat of violence, education for their children (Pang *et al.*, 2002).

In the less developed countries there are things that could be, and have been done. They could increase wages, demand more service in public hospitals, educate only for their country's problems and not prepare graduates for residencies out of the country, etc. In the more developed countries there is also more that could be done. They could limit the time in the country, pay for the health professionals' education, provide more funding for jointly conducted research, etc. International organizations could prepare ethical guidelines, as is the case of the World Organization of Family Doctors, and publicize manifestos as is the case of the Melbourne Manifesto.

This journal, and The Network: TUFH that sponsors it, address education that is relevant (socially accountable) to the needs of the society in which that education occurs. In other words, both less and more developed countries should identify why people of a country need health care as the basis for what is learned rather than to let discipline-oriented scientists decide exclusively what the students need to know.

Clearly, there is more that could be said. However, when everything that needs to be said, is said, it comes down to ethics—should the more developed countries take from the less developed countries without thinking about the consequences of their actions on the less developed countries? My answer is: “No”. Why should the US, for example, pay over US \$4000 per capita per year and Zambia US \$27, and not pay to have an adequate number of properly distributed health professionals in the country without taking them from the

less developed countries? (World Health Report, 2000). In a piece written by Boelen and Heck (1995), published by WHO's Division of Human Resources for Health, they speak of equity—that is, does the health care system treat everybody the same? While they were raising the concept of “equity” with regard to country-specific health systems, I think the same applies to global health. Put simply, a wealthier country should not solve its problems on the backs of the poorer countries because behind all of this policy talk are people in need who can't afford to do anything about that need. And we don't seem to be listening to their pain.

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