Health workers here and there

The brain drain

By **Peter S. Heller and Anne Mills** (IHT)
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WASHINGTON: The problems of global poverty and the shortages affecting the delivery of medical care in the industrial countries are important but seemingly unrelated concerns. Yet the two problems are vitally intertwined. We believe that a solution lies in partnership between the developing and developed worlds to deal constructively with the brain drain of medical expertise.

A dramatic scaling up of public health and medical care in developing countries has been advanced by a number of recent initiatives, including the recent World Health Organization Commission on Macroeconomics and Health and the Global Fund to Attack HIV/AIDS, Tuberculosis and Malaria. But all such initiatives depend critically on the availability of trained nurses and paramedics.

Yet all efforts by developing countries to expand their training programs are being undercut by the active international recruitment of such workers.

Throughout Africa and the Caribbean, in developing countries as widely dispersed as Jamaica, South Africa and Ghana, a large proportion of newly trained local professionals are being enticed by higher incomes to work in developed countries, particularly Britain, Canada and the United States, or in more advanced developing countries. In coming years, aging populations in the industrial countries will increasingly exacerbate the other factors that have made nurses and paramedics in short supply, such as low relative incomes, poor status and unpopular working hours. Thus the brain drain constitutes a Sisyphean obstacle to developing countries seeking to scale up their medical care systems.

Piecemeal approaches will not solve this problem. Railing against the brain drain as another downside of globalization will not dissuade trained nurses and paramedics, not to mention doctors, from seeking to better their lives by emigration in response to the prospect of higher incomes.

Neither is it feasible to increase dramatically the salaries paid to these workers in their home countries. Raising the salaries of nurses to internationally competitive levels would prove unaffordable to already starved government budgets and would create unrealistic imbalances in local salary scales relative to other valued government workers, such as teachers or civil servants.

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So some brain drain is inevitable and, given the role of hard currency remittances income, beneficial to developing countries. But if this is true, what will be the source of the trained people required to address the critical health problems of developing countries? And why should these countries invest scarce resources in training of personnel if the resources will only end up, de facto, subsidizing in-dustrial countries?

There is a win-win solution to this apparent conundrum. Properly structured, a partnership approach between the developing and developed worlds can result in increased staffing for developing countries' health systems while at the same time it facilitates subsequent recruitment of paramedical personnel to industrial countries.

Industrial countries must recognize their interest in providing financial assistance to developing countries to train nursing and paramedical workers, since many will ultimately work in industrial countries. In effect, the interests of industrial countries' health departments and aid agencies can coincide.

Developing countries should recognize that for the foreseeable future, a balanced approach is required that trains different kinds of workers for the various medical and public health needs confronting these countries.

For the rural and urban poor, the diseases of poverty and the absence of effectively functioning basic health systems outside the major urban centers must both be confronted. These are problems that can be addressed by basic paramedical workers.

Relying on fully qualified doctors to work in these environments has always proved problematic, since they seek more glamorous and remunerative working situations. At the same time, to address medical care emergencies, chronic conditions and the principal noncommunicable disease problems, developing countries' medical care systems still require a cadre of medical and paramedical staff trained to an international standard.

A partnership approach can be envisioned. Developing countries would continue to finance first-level training for medical auxiliaries, nurses and maternal/child health workers.

Medical auxiliaries are particularly important, since they can provide primary care for the kinds of common illness and health problems experienced by the poor, while also being pivotal in identifying patients needing more sophisticated medical care in hospitals. They can also monitor antiretroviral treatment for HIV/AIDS, provide immunizations and administer medications for tuberculosis and other infectious diseases.

The effectiveness of such basic paramedical workers has been demonstrated in many developing countries - for example, China's "barefoot doctor" concept. Such workers should be seen as highly valued members of the medical system and should receive remuneration and status sufficient to make these jobs as attractive for secondary school graduates as teaching positions or other civil service appointments.

The key factor is that these workers, while fully effective and functional in a primary health care system, would still have less than the professional training required for overseas medical work.

The role of developed countries would be to finance and partner the training of nurses and paramedical workers to internationally approved standards. The candidates for such local training programs would be those paramedical workers described above who have worked several years in the public health system and demonstrated competence and effectiveness. Graduates from this higher-level program would be expected to serve several years, either in the private or in the public health sector of their country. Such workers would then, by agreement between the partnering countries, be eligible, if they wished, to apply for positions in the partnering industrial country.

country.

Such an approach would scale up significantly the staffing of developing countries' medical care systems while ensuring that industrial countries contribute to the provision of the medical care skills they absorb from developing countries.

Of course, such a partnership approach would need to be adapted to the specific developing country medical care system and the recruitment characteristics of the partnering industrial country. But this approach addresses the present failure to recognize that the status quo, while advantageous to the industrial countries, runs counter to global goals for poverty alleviation.

Peter S. Heller is deputy director of the International Monetary Fund's Fiscal Affairs Department. Anne Mills is professor of health economics and policy at the London School of Hygiene and Tropical Medicine. They both participated in the WHO Commission on Macroeconomics and Health. They contributed this comment to the International Herald Tribune.

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