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Justice and the Reversal of the Healthcare Worker ‘Brain-Drain’

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Statistics such as “Uganda has only 86 pediatricians for its 15 million children under the age of 15” years and “[Uganda has] only one doctor for about 24,000 people—one of the biggest patient/doctor ratios in the world” are all too common when analyzing the healthcare worker ‘brain drain’ in sub-Saharan Africa (Mwesigye 2008). The ‘brain drain’ is hardly a new phenomenon and has been documented back to the 1960s when mainly high-income countries experienced health worker emigration to other high-income countries, partly due to a perception at the time that medical graduates from low-income countries were inferior to those in more developed countries (Wright et al. 2008). The emphasis towards foreign-born and trained health workers as cost-effective resources evolved as high-income countries needed more health workers, thus contributing to the present where in Africa 3% of the world’s health workers confront 24% of the global disease burden with 1% of global health financing (World Health Organization 2006).

As failures of the duties of beneficence and non-maleficence, Snyder (2009) argues that by encouraging migration of health workers from lower-income countries destination communities (DC) can be charged with moral wrongs in part by undermining local health infrastructure in source communities (SC). I discuss ways in which DCs and SCs can minimize incentives for healthcare worker emigration while encouraging social responsibility in both by highlighting current policy and activism efforts that seek to reverse the ‘brain-drain’ through infrastructure and capacity-building in sub-Saharan Africa. In doing so, I consider the justice rationale behind these initiatives and discuss how migrant health worker agency can be positively shaped by DCs and SCs.

If health is a human right, then by extension access to an adequate healthcare infrastructure, including an adequate healthcare worker force, is a requisite state obligation nested with individual responsibilities contributing to one’s health. In a global ‘brain drain’ that works counter to requisite components of health, we must define stakeholders and responsible parties implicated. At the SC level, health workers and their national governments shoulder some responsibility. Migrating health workers could be blamed for failing to honor presumed social contracts in the countries that help subsidize and provide their educations, while SC governments could be blamed for inefficiency, corruption, and not improving working conditions and health worker infrastructure needs (Benatar 2007). While DCs capitalize on recruitment of health workers *vis-à-vis* a construed human right of ‘freedom of

migration', they actively contribute to the 'brain drain' through such recruitment and in paying less attention to rectifying their own domestic healthcare worker shortages.

With patients hanging in the balance, these many stakeholders each contribute to wide global health disparities in terms of access to care, healthcare infrastructure, and health worker support. Despite an aforementioned 'freedom of migration' entrenched in the Universal Declaration of Human Rights, DC and SC governments still play large roles in shaping a health worker's decision-making process and sense of responsibility to a community. But while the public 'brain drain' debate has focused culpability on DCs, health workers lie at the nexus of these complex relationships affecting patient care, ultimately exerting their agency to stay or leave. Therefore, solutions to the issue of health worker emigration from SCs to DCs must start and end in their domain. Where do we go from here?

If a goal is to maximize the number of health workers from lower-income countries who choose to stay where they are trained rather than leave for better paying, resource-rich DCs, then governments and institutions must pay attention to incentivizing and capacity-building strategies that foster such an ideal outcome. To do this, current global trends exacerbating the 'brain drain' must be reversed through listening to health workers, healthcare infrastructure improvements and capacity-building in SCs. Accordingly, both SCs and DCs play roles in delivering the necessary social goods presumed to maximize the retention of health workers in SCs.

With limited financial capital compared to that in DCs, SCs have begun to call loudly for improved healthcare infrastructure and capacity-building efforts to address disparities in healthcare access and delivery. For example, Ghana's health ministry has urged district assemblies to sponsor health professional students with an expectation that these students return to serve in their districts (Physicians for Human Rights (2008)).¹ The African Health Strategy 2007– 2015 directs African Union members to develop packages and incentives for working in disadvantaged areas and that healthcare workers receiving public funds for their training have compulsory community service for a given time as a means of paying back to society (African Union 2007). Although nascent, SC efforts such as these have started the long road to improving healthcare infrastructure.

Many plans, however, inadequately address core issues that health workers face in SCs and find solutions to in DCs: low salaries, poor working conditions, and inadequate job protections. As a matter of promoting justice and health equity in light of their involvement, DCs should be key players in supporting SC initiatives to stem emigration. The invocation of health worker 'freedom of migration' by DCs does not ethically abrogate DCs from redressing their contributions to rising global inequality. Indeed, recent efforts in DCs to address the 'brain drain' suggest an understanding of their role in growing global healthcare inequities.

¹From the Ministry of Health, Republic of Ghana. 2005. Dealing with the human resource crisis in the health sector: Draft policy on the way forward towards a sustainable human resource development. (cited as [http://www.interchurch.org/resources/uploads/files/\[292Addressing_the_HR_crisis_MID_level_care.doc](http://www.interchurch.org/resources/uploads/files/[292Addressing_the_HR_crisis_MID_level_care.doc) at the Physicians for Human Rights (2008) website].

Concerned members from groups such as Physicians for Human Rights, American Medical Student Association, and Health Gap have been key players in driving United States (US) policies that help create sustainable improved healthcare infrastructure and human workforce capacity-building in SCs. For example, one complementary set of bills in the US Senate and House of Representatives, S. 805 and H.R. 3812 (both named “African Health Capacity Investment Act of 2007”), has a stated purpose to:

amend the Foreign Assistance Act of 1961 to assist countries in sub-Saharan Africa in the effort to achieve internationally recognized goals in the treatment and prevention of HIV/AIDS and other major diseases and the reduction of maternal and child mortality by improving human healthcare capacity and improving retention of medical health professionals in sub-Saharan African, and for other purposes” (US Senate 2007).

In addition to provisions for healthcare infrastructure building in Africa, included in S. 805 is a call for the US to address its own need for capacity building by increasing domestic healthcare workers. Unfortunately, these bills will likely expire at the end of the current Congressional session, but there is promise that they may be re-introduced and some parts were integrated into the 2008 re-authorization of the President’s Emergency Plan for AIDS Relief (PEPFAR) (personal communication, Emily Bancroft, Senior Coordinator, Health Action AIDS Africa Campaign, Physicians for Human Rights, November 25, 2008).

The AIDS International Training and Research Program (AITRIP), funded by the Fogarty International Center at the US National Institutes of Health, addresses HIV-focused capacity-building in Africa through US training program grants used to train scientists and healthcare professionals from institutions in low- and middle-income countries (US National Institutes of Health Fogarty International Center 2008). For example, at the Makerere University—Case Western Reserve University (CWRU) collaboration in Kampala, Uganda, AITRIP funding has trained 53 Ugandan health professionals at CWRU with 51 of those trained currently working in Uganda. Collaborations such as this one potentially address two core aspects of the ‘brain drain’ – healthcare infrastructure-building and healthcare worker capacity-building. Health professionals in these research collaborations receive advanced training in resource-replete environments that they can in turn apply in their home countries. If they stay employed within the collaboration, they also have a level of job security that is often lacking in the public health sector in their home low-income country. Although programs such as this one do not correct the public sector deficiencies directly, their provision of advanced research training for clinicians and scientists in low-income countries is crucial for capacity-building and creating research that can then guide health sector policies and drive increased governmental attention towards the health sector.

All of these aforementioned efforts to reverse the healthcare worker ‘brain drain’ represent promising steps towards justice in global health, a justice that prudentially entails that health workers feel supported with adequate resources for good clinical practice and professional development. Much more work and a refocused approach to health worker training in both DCs and SCs will be needed to seriously restructure the flows of people, capital, and healthcare resources in both SCs and DCs so that access to healthcare becomes more equitable. Yet ultimately, the future of the ‘brain drain’ depends on the agency of health

workers themselves. Without proper healthcare resources, training, and financial compensation, these ‘free agents’ will continue to make the often difficult but sometimes easier choice to leave the places where they are most needed. Therefore, even though the issue of health worker agency sits at the center of the ‘brain drain’ dilemma, it is incumbent upon governments and institutions to address the social good of health through increased efforts to reduce global health inequities, especially through policies that will reverse the ‘brain drain’ and bring healthcare investment in both DCs and SCs alike.

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