Report of the WPA Task Force on Brain Drain

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The brain drain of health professionals is an issue of continuing interest and debate. The WPA set up a Task Force to examine the phenomenon as it relates specifically to mental health professionals. This report provides a description of the work of the Task Force and its recommendations in regard to how the WPA might act to help address the issue.

Key words: Brain drain, mental health professionals, low- and middle-income countries

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Healthcare workers are unevenly distributed around the globe, with countries carrying the highest burden of diseases having the lowest numbers of health workers while those with relatively low need have the highest numbers. Africa, for example, carries 25% of the world's disease burden, yet has only 3% of the world's health workers and 1% of the world's economic resources to meet the challenge. The World Health Organization (WHO) identified 57 countries with critical shortage of healthcare workers, and 36 of these countries are in Africa (1). Assessment of global shortfall for health workers using the Joint Learning Initiative (2) analysis revealed the greatest shortage in the health workforce to be in South-East Asia, and the largest relative need to be in Sub-Saharan Africa, where an increase of almost 140% is necessary to meet the threshold (1).

Emigration of highly skilled health professionals from less developed to developed countries, a phenomenon popularly known as "brain drain", has been recognised since the 1960s and has attracted frequent commentaries (3-5). The brain drain of skilled healthcare personnel creates imbalances in global health workforce (6) and serious human resource problems to health ministries of the home countries (7). In sub-Saharan Africa, brain drain in the health field severely limits even basic health service infrastructure (8-11). Highly qualified doctors and nurses who would have played important clinical and supervisory roles in their health system emigrate to industrialised countries, causing a weakening of the capacities of such system to provide essential services to those in need. The current situation in Africa is different from that of the 1980s, when skilled professionals emigrated to developed countries to acquire knowledge and skills but then returned home, better equipped to serve their countries (12).

THE WPA TASK FORCE ON BRAIN DRAIN

The Task Force on Brain Drain was formed by the WPA Executive Committee towards the end of 2006. It was mandated to examine issues relating to the brain drain of psychiatrists from low- and middle-income countries and make recommendations to the WPA on possible action to address the problem.

The Task Force conducted its activities through face-to-face meetings, a literature review, e-mails, teleconferences and consultations of special advisors. Discussions were held with senior officers of the WHO Department of Mental Health and Substance Abuse. Small surveys were conducted among two groups of psychiatrists to compile information about patterns of migration, consequences of migration, and reasons for migration. One group was composed of immigrant psychiatrists working in the UK and the other group was made of home-based psychiatrists working in Nigeria, Kenya, and Tanzania.

The survey questionnaire for migrant psychiatrists covered the experience of migration, the reasons for migrating, and the likelihood of the psychiatrists being prepared to provide clinical or academic assistance to their home countries and the modalities that might make this possible. The survey questionnaire to home-based psychiatrists covered the basis for the decision to stay at home, whether there had been a consideration of emigrating, and the experience of working in their home countries. Questionnaires were posted to convenience samples of 65 immigrant psychiatrists in the UK, 30 home based psychiatrists in Nigeria, 8 in Kenya, and 4 in Tanzania. Migrant psychiatrists in the UK were approached through their national associations in the UK with the help of Sheila Hollins (President of the Royal College of Psychiatrists at the time). Twenty-one (32%) of the immigrant psy-

chiatrists and 28 (67%) of the home-based psychiatrists returned completed questionnaires.

RESULTS OF THE LITERATURE REVIEW AND THE SURVEYS

The literature review showed that the US, the UK, Canada and Australia are known to be the main recipients of immigrant physicians over the past half century (13,14). However, movement is not only to those countries. Asians move to North America, Egyptians move to oil exporting countries, and Eastern Europeans to an expanding European Union (15). Even in Africa, doctors from neighbouring African countries migrate to South Africa, while South Africa exports doctors to developed countries. Trained doctors from sub-Saharan Africa represent almost one quarter (23%) of the current doctor workforce in Organisation for Economic Cooperation and Development (OECD) countries, while nurses and midwives trained in sub-Saharan Africa constitute about 5% of the current nurse workforce (1).

The literature review also indicated that the earnings of health workers affect healthcare and health systems. It affects motivation, performance, morale and the ability of employers to attract and retain staff (16). The tendency when pay is low is for health workers to look for various ways to supplement their incomes (17). Working conditions emerge as the single most important predisposing factor for health professional emigration (18).

However, emigration can occur at different times in the careers of health professionals and, on the basis of this fact, migrating health professionals can be classified into three categories: those who go overseas for training and fail to return after completing their studies; those who go overseas for advanced training, return to work for some time after their studies and then emigrate; and those who train locally and emigrate after the completion of their programmes or after working for a period of time (19).

Movement of health professionals from low-income countries results from a combination of "push" factors from the source countries and "pull" factors from the recipient countries. Push forces include: lack of research funding, poor research facilities, limited career structure, poor intellectual stimulation, threats of violence and social turmoil, lack of good education for children, low remunerations, poor living conditions, insecurities at work place, lack of clear career development paths, and lack of professional development opportunities (20-23). Other reasons include lack of recognition of research findings in national health policy and planning and lack of evidence-based decision making culture (19). Factors that pull these professionals to developed countries are the opposites of what exist in their own countries: these include targeted recruitment to fill vacancies in richer countries, better remunerations and working conditions, secure and conducive living conditions, available employment opportunities, and opportunities for intellectual growth (24).

The review further suggested that emigration of physicians to wealthier countries is a growing hindrance to global health and that less developed countries lose health capacities as a result of the loss of physicians (5). Brain drain has a direct negative impact on population's health status and associated consequences on the productivity and welfare of the population. Migration from certain Asian countries, especially China, has grown significantly, with 30% of Chinese doctors migrating to Australia in 1995-1996 (25). Reports from the Afro-Arab Conference in Addis Ababa in 2003 showed that 54% of doctors from low-income countries (Arab and African Universities) work in Europe or North America. The United Nations Development Program report indicates that over 15,000 Arab doctors emigrated to industrialised countries between 1998 and 2000, and 25% of the 30,000 graduates from Arab universities practice abroad.

Compared to information on the migration of physicians in general, there is paucity of data on migration of psychiatrists. In general, the US, the UK and Canada have recruited specialists widely from developing countries. No doubt the demand for labour of skilled health professionals is great in industrialised countries. The UK has the highest proportion of doctors from low-income countries (5), with psychiatrists accounting for a large proportion of those employed (26). Among UK consultant psychiatrists, 26.4% in general psychiatry, 32.2% in old age psychiatry, and 58.9% in learning disability were trained overseas (27). Australia has about 2,200 psychiatrists to a population of just under 20 million people. Of these, it is estimated that about 15% are foreign trained doctors, many of them from developing countries of South-East Asia.

The striking difference between the gaining and losing countries is exemplified by the UK, which has about 40 psychiatrists per million population, compared to much of sub-Saharan Africa which has less than one and India with about four per million (28). Yet, India and some sub-Saharan African countries are the most important contributors to the mental health workforce in the UK. Ghana, for example, has 13 psychiatrists (with 8 of them retired) to a population of 20 million, and it has been estimated that there are more Ghanaian psychiatrists practicing in the city of Toronto, Canada than there are in Ghana. The return home of Nigerian psychiatrists working in the UK would change the ratio of psychiatrists to the population from from 0.09 to 0.26 per 100,000.

The UK National Health Service (NHS) International Fellowship Scheme targeted senior consultant psychiatrists, often those working in medical schools, simultaneously undermining clinical resources and the training capacity for the next generation of specialists (29). Inevitably, there are now reports of unfilled vacancies in public mental health services in developing countries (30).

It can be assumed that the effect of emigration on mental health service will be dramatic in some countries. This is because in many developing countries the specialty of psychiatry is still very unattractive for medical graduates for many reasons, including perceived stigmatization and low

professional status in the public and within medical colleagues.

The same factors that lead to emigration of other health professionals as discussed above probably account for the brain drain of mental health professionals, including psychiatrists. However, other issues peculiar to the practice of psychiatry in low- and middle-income countries may also be important. The Task Force survey of migrant psychiatrists in the UK conducted in 2007/8 showed that issues such as professional isolation and search for better training opportunities were among the reasons mentioned for emigrating. Some of those who had gone overseas for higher training were subsequently unable to return because their overseas qualifications were not recognized at home, a situation that may be peculiar to their local psychiatry accreditation process. Some found a stark difference in the way psychiatry is practiced in their home countries compared to what it is in the UK and no longer wished to return home. Some of these differences include inadequate multidisciplinary approach (probably reflecting a paucity of other mental health professionals) and poor treatment conditions for patients, including inadequate attention to their human rights.

In the second survey by the Task Force, 75% (21 of 28) of home-based psychiatrists in Nigeria, Kenya and Tanzania had considered emigrating. Of these, 6 were still hoping to emigrate, while 15 seemed to have given up the idea (11 because of family considerations and 4 because they perceived positive changes in their countries). While poor remuneration, dissatisfaction with job and social conditions and wish for better education for children were the most common reasons for wanting to emigrate, professional isolation was also mentioned.

Lack of local training opportunities or inadequate training programmes are important reasons for emigrating. The profile of the surveyed UK psychiatrists, showing most had originally trained as doctors in their home countries but emigrated for specialist training, as well as the response of the psychiatrists surveyed in Africa, clearly show that provision of local training opportunities may help reduce the urge to emigrate.

The view has often been canvassed about turning brain drain to "brain circulation" by getting immigrant health professionals to occasionally return back to their home countries to provide assistance in clinical service and training. The respondents of the UK survey were asked about their willingness to do this. Everyone, to varying degrees of enthusiasm, reported their readiness to return home to assist in training of other professionals, collaborate in research and, to a lesser extent, provide clinical support. However, 81% of the respondents saw one hindrance or the other in doing this. The commonly identified barriers were those relating to restrictions in their current job contracts in the UK and administrative or bureaucratic procedures in their home countries. So, even though the idea of returning home sounded appealing, the reality of their present circumstances made most immigrant doctors sceptical about the feasibility of the arrangement.

RECOMMENDATIONS

The results of the work of the Task Force show that the scale and magnitude of the problem of brain drain is difficult to grasp, because of inadequate data on the movement of health workers, especially the movement of psychiatrists and other mental health workers. A small range of proposals put forward by Scott et al (31) on national strategies and international cooperative strategies addressing the ethics of "skills migration" from sources such as World Bank, WHO and World Medical Association and from migrant and "stay at home" health professionals is helpful, but much more needs to be done. The results further show that brain drain is a crucial phenomenon damaging mental health care in low- and middle-income countries and that there are particular reasons for migration which can be examined and addressed.

The Task Force recommends that the WPA must take the lead in focussing attention on the peculiar effect of brain drain on the provision of mental health service in low- and middle-income countries. The recent Lancet series provides a compelling picture of this peculiarity (32). The WPA should work with major stakeholders to bring pressure on countries that have benefitted most from brain drain, such as the US, the UK, Australia and Canada, to make specific commitments to provide assistance to low- and middle-income countries for the development of their mental health service, including substantial increase in resource allocation for specific mental health training and service delivery programmes. It should work with the WHO to ensure that the problem of brain drain is listed for discussion at a future WHO Ministerial (or Council) Meeting and with the Global Mental Health Movement to encourage the latter to give prominence to the issue of brain drain in its planned advocacy activities.

The WPA should enlist the active support of member societies in the UK, the US, Australia and Canada to bring necessary pressures to bear on their governments to develop ethical recruitment practices. This should include a commitment not to recruit from the most disadvantaged countries. The WPA should explore ways in which specialist training programmes can be developed in regions of the world where none exists or where training resources are currently grossly inadequate. The WPA should develop partnership with member societies, such as the Royal College of Psychiatrists in the UK, which are interested in supporting such initiatives or are already implementing them through their volunteer programmes.

The WPA should have a programme for supporting psychiatrists working in relative isolation in low- and middle-income countries. Such psychiatrists should be helped to develop networks with colleagues in their region and beyond. One important way of doing this is to offer targeted opportunities for such psychiatrists to attend WPA meetings and conferences. As indicated in the responses from our two surveys, professional isolation was a factor for emigration and respondents recommended, among steps to stem brain drain, opportunities for international networking. The WPA

can do a number of specific things for these professionals: a) advocate for major member societies, such as those of the UK, the US, Canada and Australia, to consider providing these psychiatrists with free supplies of their society journals; b) develop a special fellowship for them to support attendance at meetings; and c) encourage the development of a dedicated website for these professionals for the purpose of networking among themselves and with other colleagues within the WPA.

The WPA can help immigrant psychiatrists put something back to their countries of origin. Our survey of UK-based psychiatrists shows that, while most were willing to do this, they also identified a number of barriers that might make it impossible. The main barriers relate to how their current jobs might allow such time away and problems with recognition of diplomas obtained overseas. The WPA should explore with member societies ways in which such barriers can be removed. An initiative developed by Ghanaian psychiatrists in the diaspora in the last few years has proved valuable in helping to provide training for trainee mental health professionals in Ghana by the immigrant psychiatrists. Other groups can be encouraged to start such a programme.

The brain drain of mental health professionals is a critical issue for low- and middle-income countries. The WPA, in setting up the Task Force to examine the issue, has recognized the importance of the phenomenon and shown its readiness to take up a leading role in addressing it. The Task Force has identified specific roles for the WPA as well as a number of practical steps which can be taken forward and developed over a sustained initiative.

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