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EDITORIALS

The financial cost of physician emigration from sub-Saharan Africa

A whole government approach is needed to mitigate the impact of the brain drain

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In the linked study (doi:10.1136/bmj.d7031), Mills and colleagues attempt to quantify the cost to sub-Saharan African countries of investing in training but then not retaining doctors and nurses. They build on the limited analysis already conducted to assess the costs of "losing" scarce skilled staff to the developed world. They restate the debate about the real impact of the medical "brain drain."[1]

A review of previous costing studies found that most lacked technical merit and focused on gross effects on African countries rather than net effects.[2] Mills and colleagues try to look at some of the possible benefits that may accrue through remittance income and return migrants, but they focus primarily on assessing costs of training and the cost of lost return on investment as the health professionals leave the country that has funded their education.

According to Mills and colleagues' analysis, developed countries have "saved billions of dollars" by recruiting ready trained health professionals without having to bear the training costs. They cite the World Health Organization's 2010 code on international recruitment as a mechanism for achieving a more equitable balance of the costs of training between the developed and developing world.

One crucial question in assessing, and perhaps therefore allocating, the costs of training or the costs of out-migration of health professionals (or both) is: costs for who? Who pays and who benefits? Is it the migrant doctor, the current employer, the new employer, the losing or gaining health system or country, or the training institution? The answer varies for different individuals and for different regions and countries.

In the model that Mills and colleagues developed, the African country pays but it is the African trained doctor and the destination country that benefits. The authors have rightly focused their analysis where the argument in favour of some type of compensation is most compelling. But other models exist. In the case of India or the Philippines the doctor or nurse pays for his or her training, often with the clear intention of moving abroad after qualification and benefiting from the move. Other beneficiaries would be the (usually private sector) training institution that would receive the training fee and the destination country.

This also raises a deeper question—should doctors and others health workers have cost constraints placed on their mobility when other professionals, such as engineers, escape such restrictions? This so called "medical exceptionalism" raises important questions about freedom to move, as well as about how to assess costs and decide who pays, and how.[3]

As Mills and colleagues note, the current main policy instrument aimed at moderating the most pronounced negative effects of health worker migration is the WHO code, 2010. Achieved at the World Health Assembly in 2010 after considerable behind the scenes lobbying, the code is voluntary, makes clear that individual health workers should have the right to move, but also stresses the need for developed countries to aspire to self sustainability in their workforce, and therefore reduce their reliance on international recruitment.

Sustainability could be interpreted as meaning that countries such as the United Kingdom and United States should meet their own requirements for current and planned future staffing from their own resources. Several countries, such as Australia, have made recent commitments to achieving sustainability, but these expressions are aspirational, in the short term at least,[4] given that the average level of dependency on international doctors in the English speaking destination countries of Australia, Canada, the UK, and the US is as high as one third or more of the current medical workforce.[5]

The code may have some impact in moderating the worst excesses of international recruitment, or at least exposing them to more open scrutiny, but it is relatively quiet on the question of financial compensation.[6] The truth is that the code would never have been universally supported at the World Health Assembly if direct compensation for the costs of training had been a core component. The main beneficiaries of the current system, including the countries identified by Mills and colleagues, would have been much less likely to sign up if the code had included a mandatory compensation mechanism. Developing a better understanding of the costs of medical

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migration and what lies behind these costs is one thing. Getting someone else to pick up the tab for these costs is another.

The WHO code may help name and shame aggressive recruiters. Post-recession changes in the labour market and health system funding will also have an effect, in the short term at least. These are causing several of the main destination countries to adjust their projected need for new staff downwards, with some already estimating an oversupply of new doctors. The UK, for one, has drastically reduced its level of active international recruitment for most types of health professionals.[7]

This does not mean that the boom and bust that has characterised the approaches of many developed countries to health workforce planning has ended, or that the commensurate drain on the developing world will stop for ever more. It does, however, provide a period when developed countries can take stock and look to problems in workforce sustainability. What is needed is a "whole of government" approach in the developed world, where aid activities, immigration policy, regulatory bodies, and domestic training of health professionals are better aligned. These countries have the opportunity to develop a more considered and broad based approach to the support of health system development in Africa and elsewhere, rather than undermining this support, as they have done in the past, by draining the health professional workforce.

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