The ‘Brain Drain’: Australian responsibility

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Recent discussion leading up to the G8 summit brought welcome initiatives in addressing the debt burden of some poor countries. The meeting also addressed a hotly debated but less well-reported issue, the economic results of the ‘brain drain’ from poor to rich countries. Immigration has become a common phenomenon in the global economy, although immigration barriers are low for those rich in capital or knowledge and often impossible difficult for refugees. The particular focus of concern has been on African professionals who have been lured to rich countries in global migrations seen as akin to theft. These professionals are expensive to train and their skills are sorely needed in their home countries.

It is difficult to judge the full magnitude of the problem when migrants move to foreign countries to work both formally and informally. Each migrating health professional represents a loss estimated at US$184,000 and the numbers involved are estimated as anything from 20,000 to 70,000 per year. South African medical schools have estimated that up to a half of their graduates emigrate, many to New Zealand, but the loss of nurses is likely to be more significant in a health sector crippled by the demands of the HIV epidemic so that 31% of public health care positions are vacant. The situation is said to be worse in many other African countries with the number of health care workers shrinking: in a few years Zambia has seen a workforce of 1,600 doctors dwindle to only 400. At the 2005 annual conference of the British Medical Association it was noted that Australia, Ghana and Mozambique, all countries with populations of about 20 million, have a total number of doctors of 48,000 to 1500 to 500. As a result, there are parts of Africa with no health care of any sort, with catastrophic results.

The problem is not confined to Africa. The International Monetary Fund identified Iran and Taiwan as also suffering serious losses. To cope with the professional losses, foreign experts are then employed at high cost to provide essential services. To make matters worse, there is the phenomenon of ‘brain waste’ when skilled health workers face restrictive immigration practices in their adoptive countries and end up working as low-paid unskilled labour in health care positions or even in other industries.

If up to a third of trained professionals leave poor countries for rich countries, this represents a substantial subsidy from poor countries to the education and health facilities of rich countries. The United Kingdom has been a major beneficiary. In London the estimate is that 23% of doctors and 47% of nurses are immigrants. After intensive lobbying, the UK Department of Health acknowledged that its recruitment practices for nurses and doctors should take account of the effect on their country of origin. Australia is also a beneficiary of this international phenomenon, but our responsibility for the situation has been submerged by the concern that we ourselves are losing skilled professionals (especially computing experts and accountants) to the United States and Europe. In addition, Australian universities have enthusiastically embraced the lucrative enrolment of international students and the international record suggests that a sizable proportion of these students do not return to their home countries.

One of the most famous expatriates in the United States is Philip Emeagwali, a Nigerian refugee who was hailed as the founder of the supercomputer. Writing from his personal experience, he warns of global economic reasons for the national deterioration in institutions, resulting in the departure of professionals and academics:

Forty years ago, Fourah Bay College, Makerere University and University of Ibadan used to be one of the best in the developing world. Today, these universities are crumbling and have chronic shortage of books and equipments. Student and lecturer strikes create an irregular academic sessions and it is not uncommon for students to take five or six years to complete a four year degree. The problem began in the early 1980s, when many African nations were undergoing structural adjustment programs (SAPs) which required them to both devalue their currency and cut public expenditure.

Devaluation restricted the amount of equipments and books that could be purchased. It also made it difficult to travel abroad to study the sciences, engineering and medicine. A university professor that was earning $1000 a month in 1980 now earns $50 a month and most are forced to emigrate.

When the World Bank and IMF forced Nigeria to reduce public expenditures, Ibrahim Babangida cut the education budget instead of the military budget. While teachers salary were unpaid for several months, Nigeria was spending hundreds of millions of dollars to import arms.11

Faced with these global economic problems (to which Australia and New Zealand are also not immune) an effective solution seems impossible. Restricted immigration could cause more harm than good and suggested repatriation strategies are impractical or too small to counter systemic shifts. The response that is perhaps most appropriate for public health researchers here is to conduct research that establishes the extent to which Australia and New Zealand are recipients of ‘brain drain’ resources. If we are concerned about the loss of our university-trained professionals, then public health researchers are well placed to analyse the effect of ‘structural adjustments’ on our own universities and public institutions.

In July the Public Health Association of Australia (PHAA) participated in a project of Physicians for Human Rights, supported by the World Federations of Public Health Associations, an international effort to focus the attention of G8 countries on the need for a ‘global response to a problem of global proportions’. Included in these demands was debt cancellation for impoverished nations and attention to the macroeconomic challenges faced by poor countries. One clause addressed the need to examine recruitment practices of public and private health providers so that they do not endanger the human health resources of poor countries.
But what then of the large number of public health professionals in Australia who are themselves part of the brain drain from poor countries? We are, after all, a country of immigrants. Both editors were born and received their training in other countries and the same would apply to a fair proportion of our members. We are reluctant for a variety of reasons (some personal) to recommend repatriation but are there any other viable alternatives? We are persuaded that the notion of ‘brain circulation’ offers some possibilities. By this term we mean developing our capacity to contribute skills to sorely deprived settings without permanently relocating to those countries. As expatriates, we are well-placed to identify those centres and institutions in our countries of birth that are worst affected by the loss of resources, both human and financial.

Ideally, we need programs for institutional exchanges and we would like this to be a priority for the PHAA. A first, small introduction to such exchanges is a program introduced by the Trustees of the Public Health Education and Research Trust (PHERT), a trust set up by the PHAA. They will accept donations from individuals and corporations towards making copies of the Australian and New Zealand Journal of Public Health available to health and medical institutions, agencies and centres that are doing good public health work but that cannot afford to subscribe to journals and do not have the Internet access that most of us rely on for accessing the international literature. Our particular focus is on poor countries and we are encouraging people who emigrated to Australia from these countries to make donations back to their countries of birth. Details of the scheme are on the PHAA website.

In this issue

Nick Rogers and Dan Lubman demonstrate the acceptability of an accelerated hepatitis B vaccination schedule for young drug users. Robert Dunstan and a colleague from the Australian Biosecurity CRC for Emerging Infectious Diseases discuss the implications of variant Creutzfeldt-Jakob disease for the health system, and Jeffrey Hanna and Richard Heazlewood describe enhanced identification methods for acute rheumatic fever in Indigenous people in north Queensland.

Rennie D’Souza and colleagues report prevalence estimates for cardiovascular disease, probable diabetes and key cardiovascular risk factors from a NSW prison survey. Similar findings come from Megan Young and colleagues for women imprisoned in Queensland. Given the recent information about prisoners’ health in this Journal alone, prison health must become a higher priority for public health.

The four papers about food start with Mark Lawrence’s Point of View discussing mandatory folate fortification as a key example of the difficulties of making policy in the context of scientific uncertainties. Rosalina Richards and colleagues report on fundraising and sponsorship by New Zealand schools, identifying potential adverse effects of de facto endorsement of the snacks commonly involved. Jo Salmon and colleagues describe the declines in Melbourne children’s physical activity in travelling to school and physical education – though not in school sport – between 1985 and 2001. The increases in weight and height over the same time were greater in areas of lower socio-economic status. Eleanor Dal Grande and colleagues demonstrate substantial increases in adults defined by BMI as obese and severely obese between 1991 and 2003 in South Australia.

In the Cancer papers, Christine Stone and colleagues present an economic evaluation of academic detailing programs for GPs about prostate-specific antigen (PSA) to screen for prostate cancer, finding an overall health benefit at moderate cost and acceptable cost-effectiveness. Karen Hughes and colleagues compare two methods of faecal occult blood screening in four GP practices in north Queensland. A targeted media campaign in NSW was later mentioned by 20% of the women in a BreastScreen survey though it did not increase attendance. Andrew Hui and colleagues show consistent patterns of care in lung cancer in two large NSW areas despite marked socioeconomic differences. Jan Lucas Hoving and colleagues report the need for state and national registries to identify cancer in an occupational cohort. Peter Baade and Michael Coory identify a fall in national melanoma mortality rates in the past 50 years, with no falls in incidence, postulating improved early detection.

References

1. Oyewo A. Brain drain: Colossal loss of investment for developing countries. The Courier ACP-EU, 1996;159:59-60.

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