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SPECIAL PAPER

Recruitment of consultant psychiatrists from low- and middle-income countries

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The UK's 2-year International Fellowship Programme for consultant doctors has inadvertently highlighted the long-standing issues of the costs and benefits of such recruitment for the countries of origin, and of whether it is ethical for rich countries to recruit health personnel not only from other rich countries but also from low- and middle-income countries. The 'brain drain' from poor to rich countries has been recognised for decades; it occurs in the health sector as well as other sectors, such as education, science and engineering. It has had serious ramifications for the health service infrastructure in low-income countries, where poverty, morbidity, disability and mortality are increasing rather than decreasing, and it is a matter of serious concern for both the World Health Organization and the International Monetary Fund (Carrington & Detragiache, 1998; Lee, 2003).

This article seeks to explore some of the ethical issues surrounding the recruitment of psychiatrists from low- and middle-income countries, and to stimulate debate. The UK is not alone in its recruitment from low- and middle-income countries as well as from rich countries, and a number of other articles have drawn attention to the attendant problems (e.g. Ehman & Sullivan, 2001; Pang *et al*, 2002; Patel, 2003; Scott *et al*, 2004).

The ethical issues of international recruitment of psychiatrists as well as other health personnel concern:

- the rights of those who are recruited
- the rights of the population to which they are recruited
- the rights of the population from which they have come.

On the first, the UK Department of Health has gone to considerable lengths to establish a supportive framework for recruitment, and provides an enhanced package, relocation expenses on arrival and return, and refund of pension contributions upon return. Recruits are entitled to participate in a programme of continuing professional development in the same way that all consultants are encouraged to do.

On the second, the UK has long experience of recruiting from low- and middle-income countries, and the clinical and cultural competence of psychiatrists from regions such as Africa and Asia is not in question.

This article is focused on the third aspect – the ethical issues for the population from which the psychiatrist was recruited. What are the rights of people living in poor countries to have accessible health care, which is not doubly disadvantaged by the Western-driven brain drain, as well as by the economic structural adjustment programmes which are imposed by Western aid donors?

This article is focused on … the ethical issues for the population from which the psychiatrist was recruited.

Variation in the distribution of psychiatrists worldwide

The World Health Organization (2001) has recently compiled data from governments on the distribution of human resources in mental health, and the International Consortium for Mental Health Policy and Services has produced detailed country profiles of context, needs, service inputs, processes and outcomes (Gulbinat *et al*, 2004; Jenkins *et al*, 2004; website www.mental-neurological-health.net). While the UK has 1 psychiatrist per 25 000 population, the US has 1 per 10 000,

Denmark and Iceland have 1 per 2000–3000, and Eastern Europe has 1 per 10 000 (although Eastern European psychiatrists have generally received much shorter specialist training than in the UK), there is on average 1 psychiatrist per million in sub-Saharan Africa and in some countries as few as 1 per 5 million.

Kenya is currently depleted of over a quarter of its psychiatrists and nearly all its occupational therapists. Sri Lanka has trained over 70 psychiatrists, of whom 62 have left the country, mostly for the UK.

Costs for low- and middle-income countries

If the UK recruits a consultant psychiatrist from a low- or middle-income country, the opportunity cost for that country is significant. First, there is the cost of training that psychiatrist (6 years in general medicine, 1 year in internship and at least 4 years in psychiatry, comprising at least 11 years' training). These are costs for the health services and the universities which provided the training and clinical supervision, and ultimately costs for the general population, from whom the taxes were raised.

Second, there is the cost of the loss of the accumulated years of consultant experience in service development and policy dialogue, teaching, clinical supervision and direct clinical work, which will not be available to the country of origin while the consultant is absent in the UK. These consequences will be felt for decades, in teaching programmes, which are severely weakened, a lack of mental health input into the health sector reform process, and a lack of consultancy, supervision and support for other mental health professionals and for primary care. For example, Kenya is currently depleted of over a quarter of its psychiatrists and nearly all its occupational therapists. Sri Lanka has trained over 70 psychiatrists, of whom 62 have left the country, mostly for the UK.

Third, there is the cost of trying to find a replacement, the opportunity cost of diverting someone else, for example a senior psychiatric nurse or clinical officer from the job which they are currently doing, with a cascade of consequential opportunity costs down the line, and the cost of living without a replacement. If the UK lives without one consultant, 25 000–50 000 people are deprived. If a middle-income country lives without a psychiatrist, 500 000 people are deprived, and if a low-income country lives without a psychiatrist, 1 000 000 or more people are deprived.

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It has been argued that skilled health personnel are an exportable asset for poor countries, and generate income (in the form of remittances) for the source country, so offsetting the costs of training and other losses. However, remittances by health workers are not directly reinvested in human capital for the health system (Stilwell *et al*, 2003) and cannot match the losses resulting from the exit of experienced health personnel from a grossly understaffed health service (Scott *et al*, 2004).

Case examples of ethical issues posed by recruitment from a middle-income country

South Africa's former President Nelson Mandela has specifically asked the International Fellowship Programme not to recruit from South Africa. If President Mbeki had agreed to active recruitment from South Africa, would this have made it ethical?

The Indian government, on the other hand, has agreed to active recruitment by the UK and so the International Fellowship Programme has established an active and successful recruitment scheme in India. The Indian Minister of Health and Family Welfare responded to a parliamentary question in July 2003 by saying that the overall availability of doctors in India is sufficient.

In this context, it is worth noting that India has only 4 psychiatrists per million population (Khandelwal *et al*, 2004) and that the National Mental Health Programme 2002–2007 for India comments that 'The available resources with regard to trained manpower, infrastructure and fiscal inputs need to be augmented to deal with the immense burden of mental illness'. Even these scarce resources are unevenly distributed and vast sections of the population do not have ready access to mental health care. Only 27 of the 593 districts in the country are covered by the District Mental Health Programme. Furthermore, India is a federal country, and the experience of individual states does not necessarily support the Federal minister's confidence. For example, the government of Gujerat's mental health care policy (draft, February 2004, para. 17.1) states that:

> There is a shortage of trained MH professionals in MH sector. Gujerat has 163 qualified psychiatrists (0.4 per 100,000 of population) and less than 50 psychologists. Despite the fact that Gujerat has 23 general nursing colleges, there are few trained psychiatric nurses. Availability of other para-MH professionals such as trained social workers in this area is also low. Involvement of these professionals is considered to be the basic condition for developing and implementing community based and cost effective interventions in the MH sector. Non-availability of trained human resources hinders the process of developing interventions. This constraint is experienced at all levels and in all settings of care. Lack of professionals also hinders the use of multidisciplinary approaches to improve quality of care.

The advantages of recruitment from low- and middle-income countries

A small number of recruits have come to escape persecution in their own countries; clearly, we would wish to offer asylum as usual in such cases, and the Department of Health has instigated a training programme for refugee health professionals.

The International Fellowship Programme argues that it is of benefit for international recruits from low- and middle-income countries to spend 2 years in the UK learning new skills, and to sample life in the UK. On the first issue, that of learning new skills, there is substantial experience in low- and middle-income countries of the costs and benefits of sending people overseas for training, and there are better ways of learning new treatment and service development skills which can be more appropriately tailored to the service contexts of their countries. This would involve brief training placements in the UK

and training the trainers inside the country of origin, thus avoiding the risk of permanent emigration and ensuring that training is appropriate to the local service context. On the second issue, of sampling life in the UK, there is unfortunately long experience that if health personnel move to a rich country such as the UK for more than a few months, particularly if they bring their families, then they are likely to stay. The decision to stay will undoubtedly be in the UK's interest, but hardly in the interest of the country from which those doctors come.

What are the possible ways forward?

The National Health Service does increasingly fund small numbers of short visits of UK personnel to travel for training and service development purposes to low-income countries; universities have long had such international relationships and the College is exploring the establishment of a database and monitoring system to facilitate tailored placements of senior UK consultants at the request of low- and middle-income countries. The Department of Health is working on an exchange programme of visits, each of 2–3 months, whereby young consultants can visit the UK and be exposed to the areas of work which they would like to develop back home, and where experienced specialist registrars can visit India for short attachments (although there is as yet no agreement that this will count towards higher training, and it will depend on trusts continuing to support their UK salaries as well as any additional living expenses in the host country). However, these welcome initiatives do not begin to compensate low- and middle-income countries for the extensive permanent brain drain which they have suffered and continue to suffer.

It is important to distinguish between the individual liberty to work where one chooses and the systematic exploitation of relatively poor health systems by relatively rich countries. The College has spoken out on a number of occasions about the damage done to low- and middle-income countries through the overseas recruitment of their medical professionals, has an honourable record in not recruiting from South Africa, and has repeatedly expressed disquiet about the International Fellowship Programme. However, the College does have a role in scrutinising initial applications, and has allowed them to go forward from poor countries. Should the College negotiate with the Department of Health to restrict the eligibility of people from low- and middle-income countries? Would this be ethical? What of equal opportunities? Is the current College position on the recruitment of consultants compatible with its approaches to trainees? More strategic action could be taken to find local solutions to developing sufficient numbers of psychiatrists (Jenkins & Scott, 1998; Department of Health & Royal College of Psychiatrists, 2004).

The Department of Health could speedily restrict its active recruitment to rich countries, before substantial further damage is done to poorer countries. Even middle-income countries have much to lose. There are considerable urban–rural variations in the distribution of psychiatrists, so that even in middle-income countries large parts of the population have access to less than 1 psychiatrist per million population. For example, in Egypt there are a number of regions of 3 million population with only one psychiatrist.

There could be an international agreement (e.g. Commonwealth Secretariat, 2003) between all member states of the World Health Organization so that the country of origin is compensated on an annual basis for the cost of the training and experience of the international recruit, preferably multiplied by the relative disparity in the doctor : population ratio. Thus the UK would have to pay proportionately more to a country where the average doctor : population ratio was 1 per million than to a country where it was 1 per 10 000. Then the argument that such recruitment was of benefit to the country of origin would be rather stronger than it is now, and richer countries would be more circumspect in recruiting from low- and middle-income countries. Indeed, it would then rapidly become more cost-effective to design alternative solutions, and to increase local training capacity, than to recruit experienced professionals from poorer populations, take advantage of the training investment previously made by the poorer country, and thereby exacerbate the net flow of resources from poor to rich populations.

Low- and middle-income countries perforce have to design service structures that are tailored to their human resources. There is much that the UK can learn from some of these service designs (Jenkins *et al*, 2002), with their emphasis on primary care and on nurse leadership, so that it does not continue to recruit from poorer countries in order to achieve a gold standard service which can be maintained only at the expense of the poor populations of the world.

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Conclusion

In conclusion, the damage to low- and middle-income countries caused by the emigration of psychiatrists as well as of other health personnel is all too apparent, and continues to be of substantial concern. The World Health Assembly recently passed a resolution on migration to the developed world (WHA57.19 on the WHO website www.who.int). We welcome debate on potential ways forward to protect the health investments made by low- and middle-income countries, including in their psychiatrists.

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The Editor invited the Department of Health to respond to the issues raised by David Ndetei *et al*, and Catherine Jenkins, NHS International Fellowships Project Manager at the Department, does so in the article 'Ethical international recruitment'.

SPECIAL PAPER

Ethical international recruitment

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Right from the start of our international recruitment campaign the Department of Health was determined to ensure that international recruitment takes place using a planned and managed approach. Now, the UK leads the way in developing and implementing the types of international recruitment policies called for by the World Health Assembly.

The UK is:

- the first country to produce international recruitment guidance based on ethical principles and the first to develop a robust code of practice
- the only country to produce a list of developing countries from which active international recruitment should not take place, because we are concerned to protect the health care systems of developing countries
- the only country to publish an approved list of commercial recruitment agencies and to monitor their activities abroad
- the only country to commit publicly to recruit via government–government agreements.

National Health Service (NHS) trusts work to a Department-approved Code of Practice, which can be found on the Department's website (www.dh.gov.uk). The principle we follow is that there should be no international recruitment which harms either health care staff or the health care system of the country from which they come. The NHS does not actively recruit from developing countries unless they invite us to do so.

Where a developing nation has invited us to recruit health care staff, then we do so in full consultation with its government. This applies both to the Philippines in the case of nurses and to India in the case of medical specialists and some nursing staff.

We have worked closely with the Indian Ministry of Health in the development of the campaign in India and it has been very supportive of the opportunities we are offering doctors who have trained in India. The Indian Minister of Health and Family Welfare responded to a parliamentary question in July 2003 by saying that the overall availability of doctors in India is sufficient. We meet with the Indian High Commission regularly and have asked the Indian government to alert us to any changes in the position.

It is vital to stress that we would not recruit from India if the Indian government did not want us to. We take our responsibilities to developing countries very seriously, and we work closely with India and other developing countries to support them in developing programmes to retain and develop their staff. In some cases, we offer fixed-term placements in the NHS as part of their health care professionals' career planning.

Medical personnel from India move all over the world. They do so to improve their prospects and opportunities, quality of experience, standard of practice, and chances for development and training. If the doctors relocate without support there is greater risk of exploitation by agencies and of being isolated and unsupported when they arrive. The Department's international recruitment programmes offer:

- routes to appointment as consultants
- support for obtaining registration
- a good relocation package, including support for the doctor's family
- induction, mentoring and pastoral support while they are in the UK.

The NHS International Fellowship Programme was launched in spring 2002 and is designed to recruit qualified specialists to work in the NHS for 2-year Fellowships. It is particularly targeted at North America, member states of the European Economic Area, Australia and New Zealand. We also recruit Fellows from India with the agreement of the Indian government. So far over 200 Fellows have accepted offers of appointment in the NHS and over 100 are now in post.

Compendium of the NHS's Contribution to the Developing Nations – see www.dh.gov.uk/assetRoot/04/06/88/33/04068833.pdf