

Plugging the pharmacy brain drain

FIP's Young Pharmacists Group held a symposium on 7 September on the moral and ethical issues surrounding the migration of health care professionals. Speakers look at the issue from a range of perspectives and suggested possible solutions. **Lindsay McClure** reports

Migrating to a different country can offer health professionals a wealth of benefits but if large numbers of health professionals leave a country, the outcome can be devastating.

There are many reasons why health professionals choose to move abroad. Giselle Gallego, University of Sydney, Australia, shared her experience of moving from Colombia to Australia to undertake postgraduate education. Some of the challenges that she has had to overcome include obtaining a visa, improving her English language skills and finding a job to help finance her studies. She has also had to identify and adapt to practice differences between the two countries. For example, in Australia, pharmacists engage with patients in shared decision-making but, in Colombia, it is common for pharmacists to be the sole decision maker.

Ms Gallego commented that she had gained a huge amount of experience through migrating to another country but she has also experienced home sickness, cultural shock, language problems and isolation. She also noted how difficult it can be to return home. As an individual, your experiences may set you apart from old friends and colleagues and the skills that you have gained may not be required or be appropriate in your home country.

Hans-Petter Johannessen, a director of Apotek1, the largest community pharmacy chain in Norway, spoke about his own experiences of recruiting pharmacists from other Scandinavian countries. The reason his company looked to recruit from abroad was simple: there is a shortage of pharmacists in Norway. He commented that when looking to recruit from abroad, employers are likely to target countries with similar education systems and language.

The loss of large numbers of health professionals can greatly reduce the quality of a country's health care system, said Grace Allen-Young, of Jamaica, president of the Commonwealth Pharmaceutical Association. Speaking on the impact that pharmacist migration had on the home/source country, Mrs Allen-Young commented that a lack of pharmacists can lead to reduced access to pharmacy services and long waiting times for dispensing services in clinics and hospitals. Nationally, the regulatory system may be weakened, with regulators forced to be flexible to ensure that the service can be maintained.

An outcome that is harder to quantify is the social cost of migration. For example, if a family member leaves the country, there is an impact on the remaining family. This effect is particularly important when it is a parent that leaves.

Fortunately, the "brain drain" also offers some benefits to countries. Mrs Allen-Young commented on the "reverse brain drain", where health professionals return home to their source country, bringing new skills and financial resources. Nationally, this can make a significant contribution to a country's economy.

Possible solutions

Migration flows are changing, with migration now shaped more by market forces than cultural ties, reported Sabine Kopp, of the World Health Organization. In the past, health workers mainly migrated from a small number of developing countries to developed countries, whereas now migration flows are more complex, encouraged by targeted recruitment and including inter-regional movement.

Dr Kopp suggested a number of solutions to the "brain drain", including managing migration through agreements and ethical recruitment. Some success has been seen with bilateral agreements between countries and, although codes of practice need more evaluation, they appear to be having a limited effect.

Consideration should be given to investing in education, said Dr Kopp. This could be through investing in education in the source country. For example, if a country knows that 20 per cent of its workforce is likely to leave the country, the student intake could be increased accordingly. Recognising the benefits for the economy of workers moving overseas, some countries are capitalising on the movement. For example, the Philippines purposely trains more nurses than the country requires.

Distance learning provides a method of educating professionals remotely. Alternatively, rapid, competency-based education could be developed to prepare non-pharmacists to practise in primary care settings. Dr Kopp recognised that this was an imperfect solution but may be necessary to ensure continued provision of the service.

Developing policies around pay are often unrealistic in developing countries because the differences in the economy of countries often make it impossible to match pay between developing and developed nations but Dr Kopp suggested that since health workers



Grace Allen-Young: migration of health care professionals has a social cost

want good working conditions and continuing professional development, there may be ways to create packages of incentives to help retain them. Non-financial incentives that could be considered include training opportunities, study leave, providing day care and allowing staff to combine posts in both the public and private sector.

Dr Kopp also suggested improving workforce planning, facilitating the return of skilled professionals and encouraging "medical tourism", with lower cost health care in developing countries providing an opportunity for patients from developed countries to travel abroad to receive care.

(During a panel discussion, a number of other solutions were proposed. Mabel Torongo, of Zimbabwe, commented that her country had recently introduced compulsory service of one year in the public sector for all recent graduates, and Ms Gallego, who had spoken earlier, suggested only providing scholarships for courses or work experience in line with a country's national priorities.)

In 2004, the World Health Assembly, through Resolution WHA57.19, mandated the WHO to explore mechanisms to strengthen the capacity of member states to manage migration flows and to develop systems to monitor and account for the impact of such flows. During the 2005 World Health Assembly, the WHO director-general announced that the WHO will be dedicating the 2006 World Health Report and the 2006 World Health Day to "Human resources for health".

The "brain drain" is a complex issue in times of increasing global mobility and because of the international nature of the prob-

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lem, the solution lies in international collaboration. Dr Kopp confirmed that the WHO will continue to help facilitate dialogue on solutions to the problem.

A concern expressed by all speakers was the lack of available data on the migration of pharmacists. Although a large amount of re-

search has been done on the migration of other health workers, including doctors and nurses, there is only a limited amount of information available on pharmacist migration flows.

Linda Stone, of the UK, reported that the Royal Pharmaceutical Society of Great

Britain closely monitored the number of overseas-trained pharmacists who registered in Britain but commented that there was no information available on the number of overseas trained pharmacists who have been unsuccessful in their bid to register in Britain but have remained in the country.

Enhancing access in Tanzania

A session jointly organised by FIP and the International Pharmaceutical Students Association on 6 September looked at issues surrounding access to medicines and equity in health care. **Lindsay McClure** reports

Establishing a network of non-pharmacy accredited drug dispensing outlets has greatly improved access to medicines in a region of Tanzania, reported Keith Johnson, director of the MSH SEAM programme, US. He said that in December 2000, the Management Sciences for Health (MSH) Strategies for Enhancing Access to Medicines (SEAM) programme collaborated with the World Health Organization to develop a framework for measuring access to medicines. During the development of the framework, four "dimensions of access" emerged, said Mr Johnson. They were physical accessibility, affordability, geographical accessibility and acceptability.

Physical accessibility can be defined by the relationship between the type and quantity of product or service needed, and the type and quantity of product or service provided. Affordability can be defined by the relationship between prices of the products or services and the user's ability to pay for them. Geographical accessibility, can be defined by the relationship between the location of the product or service and the location of the eventual user of the product or service. (For example, access is restricted if a drug is available but a patient has to walk 20km to obtain it or if a person's availability does not match the opening hours of the service provider.) Acceptability is defined by the relationship between the user's attitudes and expectations about the products and services and the actual characteristics of products and services. (For example, if a particular treatment is available but unacceptable to a patient this will impact on their ability to access care.)

In addition, one cross-cutting characteristic of access was identified: the quality of the products and services provided. "Ultimately, what is access worth if you have poor quality drugs and services," commented Mr Johnson.

Six countries, including Tanzania, were chosen by SEAM to field-test the framework. In Tanzania, medicines can be accessed through a number of channels, including from 339 "Part I" drug stores, which stock all medicines, or from approximately 4,000 "Part II" drug stores, which are known as *duka la dawa baridi* and stock only a limited list of medicines. The Part II stores operate without a pharmacist and although Mr Johnson



Keith Johnson: key gaps in access

recognised that this was an undesirable situation, he commented that it was essential to ensure that the population can access medicines.

An assessment of the country by SEAM showed that key gaps in access in Tanzania were the availability of pharmaceuticals, the quality of drug products and services and the affordability of products and services. Only 17 per cent of the Tanzanian population have access to a Part I outlet.

In light of the assessment, MSH chose to target its "access intervention" at the Part II drug outlets, which are geographically accessible and the first stop for over 60 per cent of the population for accessing medicines.

Some of the challenges faced by MSH included unqualified and often untrained staff in the Part II stores, unknown drug quality with often an unreliable source being used to obtain drugs, high drug prices, inadequate regulation and an insufficient variety of legally available drugs.

With funding from the Bill and Melinda Gates Foundation, MSH ran a pilot project in Ruvuma, a region of Tanzania, to help the Tanzanian Food and Drug Authority to establish a network of accredited drug dispensing outlets, or *duka la dawa muhimus* (essential drugs shop).

The project strategy included introducing regulations and standards of practice, training staff in both business and dispensing skills, in-

roducing incentives — such as loans — for drug shop owners and mentoring and expanding the list of drugs that could be legally sold.

The project proved to be highly successful. Mr Johnson reported that the average availability of antimalarials in the region rose from 74 to 90 per cent compared with 60 to 71 per cent in Singida, the control region. Product quality improved with patients having a one in 50 chance of buying an unapproved drug in the region, compared with a one in 10 chance in the control region, and the medicine prices in Ruvuma changed to be more in line with national market prices.

MSH in partnership with the government of Tanzania is now looking to roll out the initiative nationally and is in the process of testing roll-out strategies and refining the arrangements for training and the inspection of drug shops.

The IPSF and pharmacy schools have a key role to play in helping future pharmacists gain the technical expertise needed to help improve access to health services in developing countries, said Mr Johnson.

As well as general sensitisation to issues surrounding access to medicines, pharmacy schools should include training on essential medicines in undergraduate programmes, should encourage students to undertake internships with international development organisations and, during career counselling, should support students in considering options to work in international development.

Twinning schools of pharmacy in developing and developed countries provides students with a unique insight into the challenges faced by the profession in different countries and as a means of giving pharmacy students the opportunity to gain hands-on experience of projects designed to improve access to health care services. Mr Johnson encouraged the development of village concept projects, such as the IPSF Neema project.

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IPSF currently represents over 350,000 pharmacy students in over 60 countries worldwide. More information is available on the IPSF website at www.ipsf.org or by e-mail to ipsf@ipsf.org