

How global health ethics and plugging the brain drain apply to pharmacy

A one-day conference brought together practitioners and academics across disciplines and from around the world to discuss global health ethics.

Rebecca Shah, who organised the conference, reports

The brain drain of health workers has had a devastating impact on health systems serving some of the world's poorest populations. There are currently 57 countries with critical shortages in health workers, predominantly across Africa and South Asia, according to the World Health Organization. Although Africa carries a quarter of the global disease burden it is home to only 3 per cent of global health workers and receives less than 1 per cent of world health expenditure.

Given these challenges, low-income countries can ill afford to lose skilled health workers to richer countries. Yet examples abound; Lalaine Siruno, of the University of the Philippines, indicated that 85 per cent of the Philippines's nurses and 65 per cent of its doctors are working abroad, despite the fact that 40 per cent of Filipinos will never see a trained doctor in their lifetime. Similarly, Thomas Dokotala and Gerald Bwemba of the Christian Health Association of Malawi said that 55 per cent of nurses' and 45 per cent of doctors' posts in Malawi were unfilled, with shortages rising above 75 per cent for specialists, and much of this can be attributed to attrition through migration.

Health workers trained in low-income countries have little incentive to stay in weak health systems with insufficient resources, remuneration and prospects for career development. Better working and living conditions either in higher-income countries with health worker shortages or in urban areas of low-income countries have induced millions of health workers to migrate, leaving some of the world's most vulnerable people, particularly the rural poor, desperately under-served. High-income countries have been implicated in the targeted recruitment of health workers from low-income countries with critical shortages of health workers, courting criticism that they are actively perpetuating the deprivation of the right to health for the global poor and reaping the benefits from poor countries' investments in health-worker training.

UK research

To date, brain drain research has focused on doctors and nurses and has yielded little indication of the extent of the problem in pharmacy. The keynote address from Karen Hassell, senior research fellow at the University of Manchester, presented research exploring migration and pharmacy in the UK. Information about migration in pharmacy is scarce and confusing, partly because



Tana Wuliji: real drivers of migration are often social and related to perceptions of the status of pharmacy

the way pharmacists are registered in the UK makes it difficult to measure all the relevant changes to the workforce.

It is clear, however, that the percentage of overseas students joining pharmacy training in the UK has continued to rise in recent years (currently standing at 16 per cent), as has the number of pharmacists trained abroad moving into UK practice (currently 7 per cent of the Register of Pharmaceutical Chemists).

Britain currently has 78 pharmacists per 100,000 people, dwarfing the numbers that work in low-income countries, such as Kenya and Ethiopia (which have 10 and one pharmacist per 100,000 people, respectively). So although the proportion of foreign-trained pharmacists in the UK workforce may be relatively low, the impact of even small numbers leaving countries for the UK may be great.

Professor Hassell put the problem of brain drain into context by presenting research findings that while the UK is a destination for migrant pharmacists it also has a domestic shortage of pharmacists, which is exacerbated by emigration from the UK. A research project led by Professor Hassell found that most

of the emigrants were heading to other developed countries for reasons of family unification, return to their home countries, career opportunities or perceived lifestyle benefits. Although many went on to work in community pharmacy, some joined the pharmaceutical industry. The research suggests that better methods of recording and monitoring the pharmacy workforce are necessary to assist with workforce planning and ethical decision-making in the UK.

The UK has been a leader in creating some of the problems of health worker migration through intrusive international recruitment campaigns but it has now become a leader in developing and

using guidelines for ethical recruitment (the "Code of practice for the international recruitment of healthcare professionals").

A significant problem with this code, however, as Professor Hassell pointed out, is that it does not apply to the private sector, where most UK pharmacists work. The Royal Pharmaceutical Society and pharmacist employers should start to consider their ethical obligations associated with pharmacy workforce and practice given the evident global context to their work.

Professor Hassell's questions for pharmacy policy included whether and how to address the loophole in the NHS code, to pursue ethical international recruitment policies for pharmacists and to support low-income countries with training and retention of pharmacists.

International research

Moving beyond the UK context, Tana Wuliji, a project co-ordinator for the International Pharmaceutical Federation (FIP), reported on the first international research to investigate the migratory intentions of pharmacy students and to identify root migration drivers, which she conducted with the FIP and the University of London. Pharmacists are an untapped resource for public health and have a crucial role to play in improving health outcomes in poor countries. The number of pharmacists entering developed countries has increased in recent years, as have the numbers of pharmacists attempting to leave poor countries.

The findings of pilot studies with final year pharmacy students from Australia, Bangladesh, Croatia, Egypt, Nepal, Portugal, Singapore, Slovenia and Zimbabwe revealed that over 50 per cent intended to migrate. Although as much as 90 per cent of students

The Global health, justice and the brain drain conference was held at Keele University on 17 September

from some low-income countries, such as Bangladesh, planned to migrate, the trend should not be understood merely as a matter of economic push and pull factors, Ms Wuliji said. The real drivers of migration are often more social and related to perceptions of the status of the pharmacy profession in their home countries, prospects for career development abroad, the social and political environment at home and students' experiences of life in other countries.

Ms Wuliji stressed that health worker migration should be understood as a symptom of greater problems rather than as a primary cause of human resource shortages in low-income countries. Policy attention should be focused on sustainable, long-term solutions that address the causal problems driving staffing crises in poor countries, such as creating opportunities for workforce development, rather than on short-term migration-focused projects.

Her claims found some resonance in the discussions of other conference participants not specialising in pharmacy. Although there have been innovative approaches to stemming the brain drain that have proven effective (eg, reducing state retirement ages in poor rural areas to encourage migration into these areas), many policies targeted at reducing or mitigating the health worker brain drain also have the capacity to cause harm and violate rights. For example, restrictions on emigration, such as bonding health workers to the low-income countries where they trained, may violate rights to freedom of movement.

Training intermediate-level health workers may prevent them from migrating but it may also be perceived as paternalistic and as justifying lower standards of care for the global poor than for the global rich. Even in countries that encourage the emigration of its skilled workers in order to benefit from remittances (such as the Philippines) this money may circulate within the elites and middle-classes and fail to trickle down to benefit the poor majority, who remain bereft of adequate health services.

Policies

These challenges suggest that as well as designing targeted strategies, policies must also be designed to focus on the bigger problems of poor social conditions and social injustice which give rise to brain drain in the first place. It is not morally irrelevant that brain drain is symptomatic of and reinforcing to an unequal and unjust world. Thomas Pogge, professorial fellow at the Centre for Applied Philosophy and Public Ethics at the Australian National University, presented a concrete proposal of particular relevance to pharmacy ethics.

Ethics has been relatively under-developed in pharmacy compared with other health-disciplines, particularly medicine, but one side of pharmacy has received plenty of ethical attention for all the wrong reasons. The pharmaceutical industry is flourishing and is one of the world's most lucrative industries but despite its role in producing drugs that improve and save lives it has been reviled in the bioethical literature and the popular press over recent years. Some of the reasons for this include accusations of exploitation of vulnerable low-income populations in human drug trials, the concerted pursuit of patent-protection legislation that acts to keep drug prices beyond the reach of the global poor and prevents the manufacture of cheaper generic versions, the near total neglect of the diseases of poverty that claim the lives of a third of the human population in favour of enhancement medicines for the global rich, and the marketing of treatments known to be, at best, ineffective or, at worst, unsafe or harmful to patients.

Professor Pogge presented a controversial proposal that could bring the pharmaceutical industry in from the ethical cold: allowing it to assume its crucial role in combating the diseases of poverty without sacrificing its business interests. He contests that the current international patent system (the Trade Related Aspects of Intellectual Property Rights, or TRIPS, agreement which grants inventors of new drugs a 20-year global

monopoly) forces pharmaceutical inventors to recoup their research and development costs from paying patients. This creates perverse incentives for the pharmaceutical industry to produce non-essential drugs for the affluent rather than essential drugs for the poor and to keep patent-protected medicines beyond the financial reach of those in greatest need.

The current provisions for low-income countries to challenge the TRIPS agreement for the health and safety of their citizens, such as differential pricing, are inadequate. Professor Pogge's approach reconceptualises the problem as not being entirely about the pharmaceutical industry, but also its context: "The root of the evil lies not in how corporations do business, but in how we regulate and incentivise them."

"One obvious alternative is a regime under which inventor firms can choose to be rewarded in proportion to the impact of their invention on the global disease burden," Professor Pogge claimed. He detailed his proposal in which international public funds would be payable to drug inventors in direct relation to the number of lives saved by their innovation, thus incentivising the pharmaceutical industry to develop products that will address the neglected diseases of the global poor while also allowing them to recoup the costs of research and development.

Such a system would also mean that drug companies have reasons to try to improve health delivery to the poor to ensure that their drugs are effectively delivered and safely used, including supporting measures to prevent the brain drain of health workers away from populations that need them.

Professor Pogge claimed that his plan is both feasible and politically realistic and could halve the number of annual poverty deaths. It offers an opportunity for the pharmaceutical industry to rise above the criticism of the media and bioethicists and to contribute to the ever more crucial role pharmacy must play in global health and global health ethics.

Meeting reports

Timing and submission *The Pharmaceutical Journal* welcomes submissions about meetings and conferences. Please contact the editorial department before sending in a report, ideally before the meeting takes place, to check that it is not already being covered and to discuss the length of the report. Photographs are also welcome, provided they are of publishable standard.

Reports should be sent in by e-mail or on disk. If the meeting is newsworthy, the report should be sent in by the Tuesday immediately after it takes place to ensure immediate publication. All reports should be sent within two weeks of the meeting to guarantee publication within a month of the meeting. Reports submitted later than this will not always be published in full in *The Journal*. It may be necessary to publish an abbreviated version in print and post the full report on *PJ Online* (www.pjonline.com).

How to prepare a report Readers need to be encouraged to read reports, so start the report with the most interesting item, not with details of what, where and when the meeting occurred.

Concentrate throughout the report on the most newsworthy contributions to a meeting, such as valuable information that has not already been publicised or strongly worded opinions voiced by influential speakers. Reports that repeat

what readers already know or cover old issues will not be interesting. Write about what people actually said rather than what they talked about. Ask speakers for copies of their talks or notes. Do not submit reports that are just lists of speakers' topics; they are of no value to the reader. Instead of writing "Professor Plum gave a fascinating account of continuing professional development," readers will want to know exactly what Professor Plum said that was so fascinating.

Do not give every speaker an equal number of words. With the exception of keynote speakers if someone says nothing of interest, then do not report it, however well-known the person. If the keynote speaker says nothing of interest, consider how valuable a meeting report will be.

Advice for photographers *The Journal* is unlikely to publish more than two or three photographs from most meetings, so it is best to concentrate on the main speakers. The ideal time to take photographs is at the beginning of each address, while the speaker is still involved in introductions and is likely to be looking out at the audience rather than staring down into his or her notes. Take several shots of each speaker and always aim to be as close as possible to the podium, even if it means obstructing the view of the audience for a short time.