

PHYSICIAN BRAIN DRAIN: EXPLOITATION OR HUMAN RIGHT?

UNDERSTANDING THE MULTIDIMENSIONAL PROBLEM

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Abstract

The 'brain drain' of physicians from the global South to the global North is having detrimental effects on the health care systems in the South and is leading to the vastly unequal distribution of physicians worldwide. Physician migration is here analyzed from the perspective of neo-neo-colonialism at the historical-structural level and from the perspective of cosmopolitanism at the level of individual human rights and agency of physicians. Both perspectives are crucial for a full understanding of the phenomenon of physician brain drain and the eventual search for effective and multidimensional solutions to this problem.

Introduction

Medical 'brain drain' refers to the migration of health professionals from one country to another, ultimately resulting in a decreased number of physicians available in the countries of origin (Martineau, Decker, & Bundred, 2004, p. 1), many of which are poor and with higher rates of disease than the receiving countries (Arah, Ogbu, & Okeke, 2008, p. 148). The term 'brain drain' expresses the negative effects of the loss of highly trained individuals from the source country (Marchal & Kegels, 2003, p. 90). Numerous low-income or developing countries are facing crises in the health systems, largely due to a shortage of staff (Martineau & Willets, 2006, p. 358.). Medical brain drain aggravates the concentration of health care professionals in developed countries and prevents the realization of public health goals for developing countries. This has very detrimental impacts on the overall development effort of the poor countries experiencing the 'brain drain' (Kuehn, 2007, p. 1853). These developing countries also lose the huge sums of money that they had already invested in the education of health professionals, who ultimately end up benefiting another, more developed, country (Ahmad, 2005, p. 43).

Brain drain could thus be considered as yet another act of exploitation of the global South by the global North, in which the North appropriates the human resources of developing countries for its own benefit, further strengthening its own healthcare systems at the expense of the South. To analyze the question of the medical brain drain, this essay will apply two theoretical perspectives: post-colonialism and cosmopolitanism. In order to understand the structural causes of the brain drain of medical professionals and its human and financial cost to developing countries, post-colonialism will here be used as an appropriate conceptual framework. Post-colonialism argues that, even after the formal independence of developing countries, North-South inequalities persist and the domination of the South by the North continues through various means and forms of power. From the perspective of post-colonialism, the North still uses its power to control the resources of the South, including human resources, in our case by the recruitment of physicians. While post-colonialism highlights the structural level and causes of physician migration, cosmopolitanism offers a better understanding of the individual

level. Cosmopolitanism, in fact, addresses the equal status of individuals and the human rights of both the migrating physicians and the people in the countries of the South. Physicians are considered active agents and brought into the equation with a degree of personal responsibility in the process of brain drain. Post-colonialism and cosmopolitanism in combination offer a well-rounded framework for understanding medical brain drain on the historical and structural level as well as the individual, human rights level and therefore an understanding of what solutions are feasible and appropriate. This understanding will seek to move away from simplistic explanations or blame in the process and will explore the multifaceted aspects of the issue.

The Postcolonial Perspective

Post-colonialism suggests that colonialism did not end with official independence for colonies, but that colonialism persists in many of the structures created at the time of colonization and continues to strongly affect the domestic and foreign policy of developing countries (Chowdry & Nair, 2002, p. 11). Post-colonialism is relatively new to the study of international relations, but its relevance is already well recognized. Many of the original postcolonial thinkers, such as Said, Mohanty, and Spivak focused on Western representation of the Third World as seen mainly through the literature (Chowdry & Nair, 2002, p. 15). Since the early 1980s, post-colonialism has attempted to reinterpret the ways in which western and non-western relations and peoples are understood (Young, 2003, p. 2). A principle concern of post-colonialism is to examine the complicated shifts that occurred after the end of official decolonization (Shome 1998, p. 206).

According to post-colonialism, the shifts that arose after decolonization are numerous and are studied through culture, identity, race, gender, representation and many other aspects. However, the central idea in all of this is that largely the same previously colonizing countries continue to be dominant over the previous colonies (Young, 2003, p. 3). Whether these were directly colonized countries, or countries affected by colonialism (Childs & Williams, 1997, p. 10), the division in general is between the dominant global North and the global South. Colonialism brought wealth and resources to the countries of the global North, primarily through the economic exploitation of the South. Forms of imperialism today can be seen in the same manner, when countries of the North like the U. S. A. secure their wealth and power through economic exploitation of nations of the South (McLeod, 2000, p. 7-8). In brief, post-colonialism reflects on how colonization had the power to shape events and attitudes in the past and continues to do so in the present at the local, national and international levels (Chowdry & Nair, 2002, p. 12). Power in this context will be understood as the persisting influence of the North over countries in the South, as a result of colonization. This influence originates in the so-called 'right' of some nations to conquer and civilize other nations and their people, which created a lasting connection between a supposedly superior North and a South subject or victim of the North (Doty, 1996, p. 35). The enduring effects of this power relationship occur in a variety of ways and manifest themselves also in the process of medical brain drain.

It is a clear pattern that the majority of physician migration occurs from the South to the North (Astor et al., 2005, p. 2492), and the postcolonial power of the North has a significant role to play in what it has to offer, and also the pressures it imposes on countries and people of the South. It is also

clear physician migration movements are often based on colonial ties (Dodani & LaPorte, 2005, p. 487). The primary argumentation of post-colonialism, as it relates to physician migration, is that it is the continued domination by the North over the South that leads to physician migration. This becomes evident when we look at physicians as a resource and explore the issues of recruitment and the concepts of racism and 'the other.'

Physicians as Resources

A significant aspect of colonial practice was the exploitation of the resources of the colonies in the interest of the metropolis. From a postcolonial perspective, the process of 'brain drain' is part of the same process of exploitation. Professionals are considered to be the most expensive resources a country can have, given the time and effort that goes into their training. Their loss has proven to be extremely costly to developing countries (Dodani & LaPorte, 2005, p. 487). When one considers physicians as a resource, one can easily see that they are indeed being "extracted" from the South and are benefiting the healthcare systems of the North, with little or no regard for the effects on the countries of the South. The continued removal of physicians from their countries of origin in the South is proving to have detrimental effects on the healthcare systems of these countries. In many cases, this leads to heightened maternal and infant mortality rates (Kuehn, 2007, p. 1853). The fact that the North can still exploit to such an extent and with impunity, for its own self-interest, the highly qualified human resources of the South is evidence of the continued colonial domination of the South by the North.

Recruitment

As during the period of official colonization, when the metropolis could actually force labour migration (Childs & Williams, 1997, p. 6), countries of the North still have the power to maintain a significant labour flow of professionals to their advantage. The irony of all this is that a significant proportion of their power and wealth was obtained through colonization, namely through the exploitation of the resources of the South, which allowed them to create stronger economies and healthcare systems. The countries of the North can now entice physicians from developing countries to work in a 'superior' setting to that of the country of origin, with higher standards of living and quality of life, increased salaries, more available technology and a more stable political climate (Dodani & LaPorte, 2005, p. 487). Thanks to these enticing circumstances, the countries of the North are now in a position to draw away many physicians from the health systems of the country of origin of those physicians. In fact, developed countries not only provide appealing opportunities, but actively recruit medical personnel from the South and arguably pillage the health care systems of developing countries (Bundred & Levitt, 2000, p. 246).

Despite the negative outcomes and the strain on their health care systems, developing countries cannot control the outflow of medical personnel or skilled labour in general (Ahmad, 2005, p. 43). Countries of origin lack the power to tackle the poaching of their physicians by more powerful countries, as they may have other types of dependencies on the more powerful countries. Developed countries, therefore, even if they have the ability to increase their own supply of physicians, they use their

supremacy to benefit from the physicians of developing countries (Dovlo, 2005, p. 378). Post-colonialism also notes that implicit in the flow of physicians from the South to the North is the assumption of the superiority of the North over the South, an idea that is reinforced again and again through political discourse, literature and the overall dominant role of the North in the media and other sources.

Race and 'The Other'

Essential to the discussion of North-South hierarchies are the concepts of race and 'the other.' The concept of race, which was constructed during the time of official colonization, has played a key role in the dominance of the North over the South (Chowdry & Nair, 2002, p. 18). 'The other' can be studied from at least two different perspectives. One is to see 'the other' as both similar to and different from one's self. For instance, Bhabha, a key postcolonial thinker, addressed the perception of 'the other' in the context of 'colonial mimicry', where there is the desire to recognize the other as different but yet partly the same as us. A second understanding of 'other' is one of complete difference, which breeds a sense of superiority over what is different (Doty, 1996, p. 40). The argument here is that the concepts of race and 'the other' helped to legitimize colonization. Post-colonialism presumes that the concepts of race and 'otherness' continue to contribute to the North-South division and to the power and sense of superiority of the North, who in fact developed these ideas. Persaud (as cited in Chowdry & Nair, 2002, p.18) noted that it is through these concepts that the U.S. A. legitimized aspects of its immigration policies and also arguably its right to 'use' the others from the South, as they may be needed today. These concepts were essential in the legitimization of colonization and, while perhaps less explicitly, they are still very dominant in the contemporary North-South discourse.

In this postcolonial period, the power of the North over the South appears to be strong in several forms, which confirm the notion that colonialism in many ways is not over yet, and that this power is still used to exploit developing countries. The dominant power of many developed countries is also evident in the migration flow of physicians from the South to the North. The medical brain drain, therefore, is just another instance of the exercise of that power and the persistence of a North-South imbalance, which further exasperate North-South inequalities, even in the health sector.

Persistent Inequality After Decolonization

Post-colonialism seeks to address the wide-ranging inequalities existent today. It emphasizes the fact that the unequal relations present in colonial times continue today between developing and developed nations. Such inequalities can be seen in the disproportionate concentration of healthcare workers in the North compared to the South as well as in the economic losses of developing nations when their physicians migrate.

Physician Concentration

The United States, Canada, the United Kingdom, and Australia are the four countries receiving the highest number of foreign-trained physicians. Some 23-28% of physicians in these countries are international medical graduates, the majority of whom coming from low- to middle-income countries (Arah et al., 2008, p. 148). With the aging of the baby-boomer generation, countries in the North are experiencing an increase in demand for physicians, particularly in North America (Dodani, 2005, p. 489). While countries in the North feel that they have a significant need for more physicians, fact remains the regions with the greatest health care needs, located in the South, have proportionally many fewer professionals.

According to the 2006 World Health Report, regions that constitute "the South" have health workforce densities ranging from 2.3-5.8 per 1000 population, whereas regions of "the North" have densities ranging from 18.9-24.8 per 1000 population (WHO, 2006, p. 5). It is also essential to consider that not only do developing countries have proportionally fewer healthcare workers, but they also have a significantly greater disease burden. While 37% of health workers live in the Americas where there is 10% of the global disease burden, Africa has 24% of the global disease burden and only 3% of the health workers in the world (Kuehn, 2007, p. 1854). It is particularly distressing to look at the shortages in distinct regions and the behaviour of graduates of particular medical schools in developing countries. In Zambia, for example, the medical school in Lusaka has trained over 600 physicians throughout its existence, while currently only 50 of its graduates work in the Zambian health care service (Bundred & Levit, 2000, p. 245). This represents not only a loss of physicians but also of the resources put into the training of these professionals.

Economic Loss

In order to train a physician for practice, a country has to invest not only considerable time and training expertise, but also economic resources (Dodani & LaPorte, 2005, p. 487). India, for example, since 1951, has lost up to US\$5 billion in training doctors, who have left the country, while Ghana has lost approximately US\$60 million in training of health care professionals, who have migrated to other countries (Martineau, 2004, p. 4). The United Nations Conference on Trade and Development (UNCTAD) estimates that the migration of each African professional signifies a loss of \$184 000 to Africa (Pang, Lansang, & Haines 2002, p. 500). These losses of healthcare workers as well as investments tend to strongly and negatively affect the health system in the source country (Ahmad, 2005, p. 43), ultimately increasing the health equity gap worldwide (Pang et al., 2002, p. 499). The WHO estimates that developing nations spend some \$500 million each year on the education of health workers, who then leave their countries to work in the West (Kuehn, 2007, p. 1854). This essentially means that developing countries are subsidizing the cost of training a large portion of professionals for developed countries: something reminiscent of comparable forms of resource exploitation of colonial times.

The postcolonial argumentation, and understanding of the North's dominant role in medical brain drain offers an important insight into understanding physician migration historically and through postcolonial structure. It aids in understanding the power that the North has in the process of brain drain and the limited ability of the South to change this. This argumentation also designates a significant

degree of responsibility for this problem to the North for the damage it has caused. While this is a critical perspective to comprehend the historical-structural causes of the brain drain, additional argumentation is necessary in order to understand the issue at the level of the individual.

The Cosmopolitan Perspective

To develop a more complete understanding of physician migration from the South to North, a liberal cosmopolitan perspective will be used to appreciate the importance of the role and responsibility of the individual in the physician migration process. This perspective will identify the importance of human rights and the physician's right to choose to migrate, as well as the right of individuals in the South to a standard of healthcare, the role of various push and pull factors for migration, and the fact that physicians have at least some degree of agency in choosing to migrate and therefore some degree of responsibility for the status of the healthcare systems in their country of origin. In combination with the postcolonial explanation of the structural causes of the migration of physicians, the cosmopolitan perspective will offer a fuller understanding of the physician migration process at the level of the individual and provides insights into what types of policies will be beneficial in addressing the problem of the medical brain drain.

The primary assumption of cosmopolitanism is that each individual is a 'citizen of the world' with a duty to the global community of human beings (Held, 2002, p. 309). Amongst the different strands of cosmopolitanism exist three key elements shared by all positions. These include (1) individualism: humans as the fundamental unit of concern; (2) universality: this level of ultimate concern attaches to all humans equally, (3) generality: humans are the fundamental unit of concern for all, not only within specific communities (Pogge, 1992, p. 49-50). In other words, the full focus here is on the individual and the idea that this concern is global. At the forefront of this notion is human security, and therefore universal human rights (Vertovec & Cohen, 2002, p. 17). Critics of cosmopolitanism suggest that these human rights standards and values are Western in origin and imposing them universally is another form of colonialism. However, proponents of cosmopolitanism, like Held, argue that there is no reason to dismiss these notions of the importance of the individual and equality, simply because of their Western historical association (Held, 2002, p. 319).

Human Rights and the Individual

Whether understood in moral, institutional or political terms, cosmopolitanism always proclaims the need to endorse standards of justice for the well being of every human being, regardless of their place in the world (Brock, 2009, p. 45). Such a perspective should thus facilitate the understanding of the physician migration through an emphasis on human rights and the role of the individual physicians as agents in the process of medical brain drain. A primary focus in considering the equal importance of all individuals is human rights. Cosmopolitanism puts the importance of the individual above that of the state, and human rights can be considered the point against which states can be judged (Held, 2002, p. 315). Human rights are the main way in which the global importance of individuals is acknowledged and protected (Cheah, 2006, p. 3). Cosmopolitan philosophers have put forth what they believe ought to be

universal human rights, but practically speaking, human rights at this point are essentially defined by the United Nations' Universal Declaration of Human Rights. The Declaration provides the main cosmopolitan orientation to politics and is considered necessary for human dignity and autonomy (Held, 2002, p. 315). In relation to physician brain drain, two key individual human rights need to be taken into consideration.. First, is the physician's right to migrate, and second is the right to a certain standard of health for the people in developing countries, both of which raise concern for a cosmopolitan understanding of medical brain drain.

Physicians' Right to Migrate

Included in Article 13 (2) of the Declaration is the assertion that, "Everyone has the right to leave any country, including his own, and to return to his country." (United Nations) While it may be damaging to the country of origin, it must be recognized that as individual, physicians from countries of the South have the right to choose to migrate. The reasons to migrate vary from physician to physician, and some may be more compelling than others, but regardless it is their right as the cosmopolitan perspective puts forth. It is crucial to consider this factor in understanding the issue of physician migration, given that the issue, while based in the domination of the North, also involves a human right on the part of the physician. Some physicians may feel driven to remain in their country to benefit their healthcare system or may not have the financial means to leave, but others may not feel this drive or experience financial constraints, and may have other more pressing factors that lead them to make use of their right to migrate.

The most common factors amongst physicians who choose to migrate include the quest for higher standards of living, better quality of life, significantly higher salaries, more available technology, the stability of the political climate (Dodani & LaPorte, 2005, p. 487), thus escaping poor working conditions and limited economic prospects in the country of origin (Kuehn, 2007, p. 1854). Astor et al., (2005, p. 2494) found that almost all physicians interviewed considered higher income and increased buying power to be a considerably motivating reason for migration. Also, reasons for physicians not to return to their country of origin after training and to remain permanently in the host country include a lack of good education for their children in the home country, little research funding, poor facilities, lack of intellectual stimulation, and violence in the country of origin (Dodani & LaPorte, 2005, p. 489).

By focusing on the individual, cosmopolitanism ultimately stresses the critical role of human rights and the physician's right to migrate. In fact, the reality is that even if great efforts were deployed to improve conditions in developing countries, many physicians would still wish to migrate and indeed have the right to do so. Cosmopolitanism recognizes that individuals are active members of a political community, which may or may not be beneficial to them (Held, 2002, p. 314) and, if it is not beneficial, they will exercise their right to migrate. Unless this is recognized and it is acknowledged that this flow is unlikely to be fully stopped, in part due to the physician's desire to migrate, an appropriate solution to the problem of the migration of physicians is unlikely to be reached.

The Right to a Standard of Health

Within Article 25 (1) of the Declaration it is stated that, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." (United Nations) Therefore in considering cosmopolitanism's contribution to understanding the issue of physician brain drain it is important to consider those individuals who remain in countries of the South as equal human beings with equal rights to health. Without an adequate number of healthcare professionals in developing countries, it is impossible for nationals of those countries to enjoy the level of health and well-being prescribed by the Declaration. While it is arguable that there are physician shortages in both the North and South, as previously noted, the lack of physicians in the South is drastically greater. Therefore, concern for people in the South must come into play in dealing with physician brain drain and its effects on countries of the South.

Cosmopolitanism calls for efforts to diminish the economic vulnerability of developing countries (Held, 2002, p. 320), and in addressing aspects of this vulnerability, physician brain drain must certainly be considered. Therefore, while respecting the right of physicians to migrate, the vulnerability of the people lacking adequate healthcare in the South must also be addressed. The vulnerability of those needing healthcare in developing countries is, in fact, a common concern of both post-colonialism and cosmopolitanism, although from different perspectives: from an historical-structural point of view in the case of post-colonialism; from an individual agency and universal human rights point of view in the case of cosmopolitanism.

Combining the need to endorse principles of justice (Brock, 2009, p. 45) with the notion of the individual as the equal and ultimate moral unit of concern (Pogge, 1992, p. 49) it is undeniable that cosmopolitanism calls for concern for the damaging effects of physician migration in countries of the South, and specifically for the individuals of those countries. The focus is not on the need for physicians for countries of the North or the South, but on the impacts on the individuals affected, and which of their human rights and needs are or are not being met (Held, 2002, p. 315). The detrimental effects of physician migration for the people in countries with few remaining doctors manifest themselves in multiple ways, notably in the increased maternal and infant mortality rates (Kuehn, 2007, p. 1853), and in the great number of patients whose medical needs cannot be met. It is thus imperative to try to struck a balance between the right of physicians to migrate and the right of patients in developing countries to a decent standard of health care. The conflict between the two human rights shows the complexity of the problem, but also emphasizes the importance of understanding all aspects of the situation in order to search for feasible and positive solutions, that address the rights of both sets of individuals.

Individuals as Agents: The Responsibility of Physicians

Cosmopolitanism recognizes that every individual has the dignity of reason and moral choice (Held, 2003, p. 470), namely that every human has the ability to make decisions, and therefore has some degree of agency and responsibility for the decisions made and the actions taken. As agents and

decision-makers, actively involved in the process of migration, physicians cannot escape their share of responsibility for the impact of their decisions and actions on their countries of origin. This is not to discount the role of the postcolonial situation and the force that it may have on the physician's desire or reason to migrate, however it acknowledges the importance of considering the role and responsibility of the individual physician in the equation.

Migration cannot always be assumed to be a 'choice' for physicians to migrate and the pressures leading to such an action may well be immense. However, if we are to consider individuals as agents, they do play at least some role in perpetuating physician migration. Up to this point, it appears for many physicians that the feeling of responsibility to assist in the development of the healthcare system in their country of origin is outweighed by other factors driving them to migrate, and this must be considered in understanding the problem and considering solutions.

From the postcolonial perspective, the main responsibility for the negative impacts of physician migration on countries in the South is put on the countries of the North, as a result of colonialism and the persistent postcolonial domination of the South by the North. It is reasonable that a significant degree of responsibility should lie there, but it is also critical to acknowledge that the vast majority of physicians migrate willingly and, having the ability to reason, they are likely aware of the impact this will have on their country of origin. The purpose of recognizing this agency and degree of responsibility is not to assign blame, but to better understand the situation and the complexity of the process. Cosmopolitanism focuses on individuals that have multiple loyalties, and they are encouraged to do so (Vertovec & Cohen, 2002, p. 12). This is a highly relevant idea in the context of migrating physicians, who are connected to their country of origin, the country to which they migrate, as well as professional associations in both countries. Consideration of physicians' multiple loyalties and memberships of various communities may be relevant when looking for successful solutions to the medical brain drain problem.

Application of the two Perspectives: Solutions to the Brain Drain

Post-colonialism and cosmopolitanism offer two distinct contributions to the understanding of physician migration. The first emphasize the structural and historical level of analysis, the second the agency or individual level. Neither understanding is adequate without the other, and both are crucial in understanding what solutions, policies or programs might truly improve the situation and address the concerns of all parties involved. Structural solutions addressing solely the economic situation of the countries involved is unlikely to address the immediate reality that physicians will continue to wish to migrate to countries with more stable political climates, higher salaries or better technology. On the other hand, individually focused solutions that simply insist on the right of physicians to migrate or blame them for choosing to migrate are unlikely to address the broader issues at stake. If both aspects can be understood, it may be possible to see what kind of multidimensional solutions will be beneficial and begin to tackle all aspects of the problem. Three of the solutions addressed in the literature will be mentioned here: improved data collection regarding migrating physicians, specific initiatives undertaken by individual countries or organizations, and the larger initiative promoted by the WHO.

Data Collection

One of the primary difficulties in arriving at solutions is the lack of standardized data collection regarding migrating physicians. Countries are currently not obliged to record the migration of their physicians, therefore making it difficult to distinguish if physicians have gone abroad for training, remained abroad, moved to other sectors of the economy. It is therefore difficult to accurately monitor and assess which regions are experiencing a lack of skilled medical workers and where specifically they are going (Ahmad, 2005, p. 44). Interest in measuring and managing flows of health workers is now on the rise, which should help to identify the specific needs of different healthcare systems and eventually determining possible repayments of education costs to the countries of origin of migrating physicians (Dolvo, 2005, p. 376). Within the last several years, the need for the WHO to manage data regarding physician migration has been increasingly discussed. Ideally, the WHO should be able to keep track of all information globally and not simply of information kept by individual member countries (Ahmad, 2005, p. 44). While collection and monitoring of data is not a solution in and by itself, it is a necessary starting point in assessing where specific problems lie and how they must best be addressed.

Country-Specific Initiatives and Organizations

A number of countries that have long experienced brain drain have put in place policies or launched organizations to deal specifically with this issue. Certain countries have made it possible for other health workers to take on additional responsibilities and perform the asks of physicians, nurses and pharmacists, so that increased medical services could be provided (Dolvo, 2005, p. 376). A number of individual organizations working to implement health policies in different countries have also promoted a more ethical and equitable spread of healthcare workers across the national territories (Kuehn, 2007, p. 1854). Thus far, South Africa is the prime example of a country who has developed policies and proposed some long-term solutions to limit the permanent emigration of doctors. South Africa is a country that has long experienced high rates of physician emigration to other countries within and outside of Africa. In response to this, the government of South Africa increased the time for graduates to become fully recognized as doctors and made at least one year of community service mandatory, largely in remote, rural areas (Bundred & Levitt, 2000, p. 245). To limit the loss of medical personnel, South Africa has also been successful in banning the recruitment of South African physicians by other countries (Dolvo, 2005, p. 378). The U.K. and South Africa have an agreement allowing for worker exchanges on a time-limit, offering those in South Africa foreign experience and facilitating sharing best practices (Kuehn, 2007, p. 1854). These practices have been quite successful for South Africa and are positive models, that could be implemented by other countries. These solutions recognize the colonial link of South Africa to the U.K. as well as the reality that physicians will continue to migrate, therefore offering programs to make such a migration either temporary or at least more beneficial to South Africa itself.

Malawi is another country that, having experienced an immense loss of physicians and a severe AIDS epidemics, finally launched an emergency program to decrease emigration of health workers. The program included financial incentives for recruitment and retention, improved living conditions for staff, as well as management of health workers and an expansion of training within the country. The idea

being that the improved conditions will be the main deciding factor in physicians' desire to remain (Kuehn, 2007, p. 1855). While dictated by an emergency situation, this solution too acknowledges the reality of the reasons why many physicians migrate as well as the critical need for healthcare for the people of the country.

The WHO Initiative

Much of the brain drain literature called for the help of the WHO in data collecting (Ahmad, 2005, p. 44). As this issue has become more prominent, the WHO launched the Health Worker Migration Policy Initiative (HWMI). The initiative proposes to create international guidelines and formalize existing national guidelines dealing with physician migration. The idea was that these guidelines would be voluntary and could facilitate agreements between countries. The initiative brings together professional organizations and other groups to develop a roadmap for managing health worker migration (Kuehn, 2007, p. 1854) and is linked with Global Health Workforce Alliance, as part of the WHO initiative to manage migrating health workers. It works toward the establishment of bilateral, regional and multilateral agreements and policies aimed at minimizing the costs and increasing the benefits of health worker migration for all the countries concerned. The initiative also intent to develop, through a multilateral approach, a draft code of practice, which is still under consideration (WHO, 2009). As the different parts of the code are assessed and reassessed, it is probable that the issue will become increasingly well understood in all its aspects and more effective policies will be put in place.

Conclusion

The effects of the brain drain of physicians have put a drastic strain on many countries and peoples of the global South. The roots of this problem are embedded in inequalities and power structures, derived from the colonial era and still persisting today, as argued by post-colonialism. A significant degree of responsibility lies in the North as physicians are being exploited as resources and the South is losing not only skill but also huge sums of money. In addition to this explanation, however, the problem must also be understood at the individual level through the principle of universal human rights and the recognition that physicians as individuals are active agents in the world, as addressed by cosmopolitanism. The full understanding of all aspects of this issue is critical in arriving at acceptable resolutions.

The post-colonial and cosmopolitan perspectives are both useful not only to understand better the causes of the problem of medical migration, but also to look for more appropriate solutions. Given its historical-structural view of the origin of the problem, the post-colonial perspective advocates for radical and long-term solutions: a systemic change that overcomes the North-South inequalities or the general domination of the South by the North. By focusing on individual agency and rights, the rights of physicians and patients, the cosmopolitan perspective has a greater ability to propose more short-term and workable solutions, likely to meet the immediate expectations of both physicians and patients.

Recommendations and solutions that have been put forward include improved methods for data collection and management, programs catering to the specific needs of individual countries, as well as a WHO initiative to gain a better global grasp of the issue and develop a common policy. Ahmad (2005, p. 44) notes physician migration is a global problem, which will require a global solution, and adequate solutions must consider the diversity of affected countries and call for multilateral agreements. Solutions to the physician brain drain problem are evidently a work in progress. They will require a balancing act between the interests of all concerned. Appropriate solutions, however, can be achieved only if all aspects of the issue are properly understood.

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