EDITORIAL

MIGRATION OF HEALTH PROFESSIONALS: BRAIN DRAIN OR GLOBAL SHARING?

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This editorial may be cited as: Mustafa A. Migration Of Health Professionals: Brain Drain Or Global Sharing?. PMSRJ 2025 Jan-April;2(1):85-86

Advocates for global health have long been concerned about the movement of health workers. Is it a way to improve personal prospects, a sign that systems are failing, or a means to promote global fairness? The truth lies somewhere between the ideas of brain drain and global sharing. We must reconsider this issue from the perspectives of fairness, sustainability, and moral duty.

On one hand, the movement of health professionals, especially from low- and middle-income countries (LMICs) to high-income countries (HICs), further weakens health systems that are already overstretched. Many trained healthcare workers are leaving countries like Pakistan, India, Nigeria, and the Philippines. Most of them attended public schools that the government heavily funded. [1] The World Health Organization (WHO) states that sub-Saharan Africa bears 25% of the world's disease burden but has only 3% of the world's health workers. This gap makes it very difficult to achieve Universal Health Coverage (UHC). [2]

The COVID-19 pandemic exposed the vulnerabilities in global health systems. High-income countries (HICs) quickly eased immigration policies to recruit healthcare workers from other nations to fill the shortages. This measure addressed the immediate issue of workforce shortages. However, it also worsened conditions in the countries of origin, where many healthcare workers were already experiencing shortages before the pandemic. For example, over the past ten years, more than 17,000 doctors have migrated from Pakistan to the UK and Gulf countries. The problem extends beyond financial factors; it highlights widespread dissatisfaction with working conditions, poor governance, limited career advancement, and safety concerns. [3, 4]

The COVID-19 pandemic exposed the vulnerabilities of global health systems. HICs quickly eased immigration restrictions to recruit foreign-trained healthcare workers and fill the gaps. While this move addressed the immediate shortage, it worsened the lack of healthcare personnel in the countries of origin, many of which were already facing shortages even before the pandemic. For example, Pakistan has seen over 17,000 doctors migrate to the UK and Gulf countries in the last ten years. [4] The issue goes beyond economics, reflecting dissatisfaction with working conditions, poor governance, limited career advancement, and security concerns.

Creating ethical hiring procedures would be a more fruitful approach than criticizing the mobility of health workers. The WHO Global Code of Practice on the International Recruitment of Health Personnel advocates for member states to balance the health system requirements of their nations with individuals' rights to migrate. [5] Additionally, bilateral agreements between the countries of origin and destination, such as the UK's Health and Care Visa program with Ghana and the Philippines, seek to compensate the countries of origin by investing in infrastructure and training. These agreements frequently lack strong enforcement and consistency. [6]

Instead of criticizing the mobility of health workers, a more effective approach would involve creating ethical recruitment practices. The WHO Global Code of Practice on the International Recruitment of Health Personnel encourages member states to balance their health system needs with individuals' rights to migrate. Additionally, bilateral agreements between origin and destination countries, such as the UK's Health and Care Visa program with Ghana and the Philippines, aim to compensate the countries of origin through training and infrastructure investments. These arrangements often lack consistency and strong enforcement. [6]

Migration can be viewed as a form of knowledge exchange and a means to build capacity rather than just as a loss. Through telemedicine, short-term services, or capacity-building initiatives, many diaspora professionals give back to their home countries. Between the extremes of brain drain and global sharing, the concept of "circular migration," in which professionals return with improved

skills or collaborate remotely, can help bridge the gap. Institutions also play a role. Return-of-service scholarships, partnership programs, and international collaborations can ensure that the development of the health workforce aligns with both national needs and global opportunities.

Instead of viewing migration solely as a loss, it can be seen as an exchange of knowledge and an opportunity for capacity building. Many professionals from the diaspora give back to their home countries through telemedicine, short-term services, or capacity-building programs. The concept of "circular migration," where professionals return with improved skills or participate in remote collaboration, can help bridge the gap between brain drain and global sharing. [7] Institutions also play a role. International collaborations, partnership programs, and return-of-service scholarships can ensure that health workforce development meets both national needs and global opportunities.

CONCLUSION

Health professional migration is a complex and challenging issue that requires clear policies, international cooperation, and an ethical perspective. It is neither inherently harmful nor entirely advantageous. Prioritizing the retention of healthcare workers and ensuring their job satisfaction is equally important for low- and middle-income countries as engaging in international discussions. For high-income nations, ethical recruitment should be complemented by a dedication to self-sufficiency. The movement of the health workforce must be strategically managed in our interconnected world, not just discussed. We need a framework grounded in ethics, equity, and shared benefits rather than unrestricted migration or physical barriers.

REFERENCES

1. Siyam A, Dal Poz MR, editors. Migration of health workers: WHO code of practice and the global economic crisis. Geneva: World Health Organization; 2014.
2. Bongaarts J. World Health Organization: Working Together for Health: The World Health Report 2006. Population and Development Review. 2006 Dec 1;32(4):790-2.
3. Ziemann M, Chen C, Forman R, Sagan A, Pittman P. Global Health Workforce responses to address the COVID-19 pandemic: what policies and practices to recruit, retain, reskill, and support health workers during the COVID-19 pandemic should inform future workforce development?.
4. Athar MW. The Impact of Brain Drain: Assessing Economic Shifts in Pakistan. Available at SSRN 5292332. 2025 May 10.
5. Tankwanchi AB, Vermund SH, Perkins DD. Has the WHO global code of practice on the international recruitment of health personnel been effective?. The Lancet Global Health. 2014 Jul 1;2(7):e390-1.
6. World Health Organization. Bilateral agreements on health worker migration and mobility: maximizing health system benefits and safeguarding health workforce rights and welfare through fair and ethical international recruitment. World Health Organization; 2024 Mar 14.
7. Diallo K. Data on the migration of health-care workers: sources, uses, and challenges. Bulletin of World Health Organ. 2004 Aug;82(8):601–607.

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