Health Crisis in Rural Nepal due to the Shortage of Health Professionals: Challenges, Solutions, and the Role of the International Community

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Abstract

Nepal, considered one of the poorest and underdeveloped nations in the world, has a particularly pronounced health crisis in its rural areas due to extreme shortages of health professionals. Home to 80% of the total population, the rural parts of Nepal are estimated to have a physician ratio of 2.4 physicians per 100 000 people (1), about 100 times lower than the minimum acceptable ratio provided by the World Health Organization (6, WHO 2006). The challenges of the mountainous topography of this Himalayan nation are further compounded by the disastrous scarcity of health professionals, viz. doctors, nurses, public health and biomedical researchers, etc. Consequently, simple and easily treatable diseases such as diarrhea, cholera, etc. take the lives of thousands of Nepali villagers every year. The health status and quality of life along with other grave problems such as poverty, illiteracy, and lack of infrastructures of development are worse in rural areas around the world, especially in developing nations such as Nepal compared to urban areas in developed nations (13, 18). Health crisis, underdevelopment, and poverty entangle rural areas in developing nations in a vicious circle, each contributing to the other, in which ill-health of rural residents negatively affects their productivity, economic output, socio-cultural contributions, and participation in the competitive world of globalization. The health crisis in rural parts of Nepal exists due to the extreme shortage of health professionals resulting from their preferences for working in urban cities in Nepal and in other developed nations, is caused by an intricate fabric of domestic push factors and international pull factors and can only be addressed through sustained cooperation between the national and international bodies.

I. Introduction

The health crisis in rural Nepal, affecting millions of impoverished villagers, is clearly linked to the extreme shortage of health professionals. The rates of avoidable deaths in remote areas such as rural Nepal have been found to be higher compared to cities due to the shortage of health professionals, physical topography, lack of transportation facilities, etc. (18). Women in far-western Nepal have to trek mountainous paths in 'chappals' (flip flops) and 'saris' (dress worn by Nepali women) with babies strapped to their backs. In the absence of awareness campaigns, widespread customs such as 'Chaupadi,' the tradition of considering menstruating women as untouchable and isolating them in sheds or stables without access to communal water or food, take lives of many Nepali women every year (4). Rural residents often have no alternative other than to carry their sick kith and kin on their bare backs and walk for hour or days to reach the nearest functioning hospitals (19). Deaths due to contact with rabid-animals, cholera, diarrhea, tetanus, malaria, complications in childbirth, etc. are widespread as the local health posts are generally devoid of skilled medical professionals, medicines, equipment, etc. and the only remaining alternative of chartering a helicopter to the capital city is often not possible due to financial constraints and urgency (8). As state-sponsored or private health insurance and social-welfare systems are virtually absent in the mountainous villages, a serious illness pushes an entire

family to bankruptcy or indebtedness to the 'Mukhiya' (the head of the village). Due to the shortage of health professionals, foreign aid targeting immunization, nutrition, awareness campaigns, etc. cannot be utilized efficiently (3, 16). As the present and the future generations of rural Nepalis move towards unpreparedness for the global health challenges, many medical professionals move towards urban areas in Nepal and abroad.

II. Mainstream and contemporary narratives and discourses

Several narratives and discourses regarding the health crisis in rural Nepal, the impact due to emigration, and the role of the international community exist, and they have evolved throughout time as more research studies are conducted. Research studies have contradicted the most widespread belief that doctors from developing nations such as Nepal emigrate solely for monetary reasons by showing that the problems are subtler than the simplified narratives and a wide array of national and international factors contribute to the scarcity of health professionals and consequently the health crisis (6). The anti-immigration view that strongly advocates against immigration is also counterproductive as progress in medicine, and science in general, can only take place through global mobility, and exchange of ideas, skills, experience, etc. among health professionals from around the world. However, excess emigration from the Third world to the First world is lead to more benefits to the host country and means that the unique health-related research requirements in the context of the developing nation can hardly be pursued by researchers and scholars. The contemporary debates also include the utilization of community-based health approach with a special emphasis on the local context, age-old healing techniques such as Ayurveda, etc. However, their potential for success in rural Nepal has not been extensively studied and proven so far (17). Many international and national health institutions are also experimenting with techniques such as telemedicine that could eventually be one of the most beneficial approaches to immediately tackle the health crisis in rural Nepal. Despite the differences, diversity, and accuracy of the discourses and narratives, the emigration of health professionals away from rural areas has been proven by facts and research studies to be the cause of the health crisis in rural Nepal.

III. Emigration of health professionals to urban areas and abroad

Rural Nepal is suffering from a grave health crisis due to the scarcity of health professionals which is mainly caused by their preference for emigrating to urban areas in Nepal and abroad. The problem in Nepal is not the production of skilled doctors but challenges in convincing newly graduated health professionals to avoid the mainstream trend of global health professionals' migration pipeline to the First world and encouraging them to choose to work in resource-poor rural areas. Surveys conducted among Nepali medical students have shown that the percentage of medical students' predictions about their future is 88% for practicing in urban areas, 52% for practicing abroad, and 53% for at least thought of emigrating to the US. 75% had relatives in either of the US, UK, Canada, Australia, or the EU, and 75% agreed they needed to leave Nepal to get sufficient training (6). According to Mullan's 'white-follows-green laws,' physicians are motivated to practice in locations that have the possibility of maximizing their financial gains (10). The neoclassical economics theory associates migration with an individual's decision to move to locations with higher wages; and newer theories also consider migration to be determined by a family's choice to diversify risk and human capital (Stark 1991). The most serious problem with the increasing rates of emigration is that hardly anyone comes back (6). A very intricate fabric of domestic and international problems give rise to alarmingly high rates of "culture of medical migration" of health professionals from developing nations such as Nepal to the developed nations causing a burning void in the neediest rural areas.

IV. Push and pull factors and challenges

Various domestic factors such as poverty, underdevelopment, institutional corruption, etc. are responsible for causing the

migration of health professionals, and consequently the health crisis in rural Nepal. Around 63% of medical students in Huntington, et al.'s survey stated that the political situation in Nepal had made leaving the country more necessary (420). In a nation that performs poorly in most metrics such as the Human Development Index, average life expectancy, per capita income, etc., per citizen government spending on healthcare comes down to mere US$ 24 per year. The average salary per month of surgeons with postgraduate degrees in government hospitals is US$ 350 and the private sectors often have worse conditions including excessive responsibilities without proper pay or benefits. Surprisingly, the average tuition fee for medical studies in Nepal is around US$ 31000 which is 30 times the average per capita GDP in Nepal (UNDP 2009). This financial aspect of medical education and health sector prevents the average Nepali student from studying medicine and attracts commercialization and corruption among politicians, ministry officials, administrative staffs, university officials, etc. Due to a wide gap between the upper- and lower- income class citizens in Nepal, only the privileged have access to medical education and service. Philanthropic activist and orthopedic surgeon Dr. Govinda K.C., became popular all over Nepal and the world due to his more than eleven 'ansan' (fast-unto-death hunger strikes) as a form of political activism to pressurize the government to increase access to health services in rural areas by reforming the "corrupt" medical sector policies, controlling institutional corruption, commercialization of healthcare, etc. (12). This shows how the domestic causes of the health crisis have become so problematic that the crisis has taken a political form in which numerous Nepali citizens are expressing their dissatisfaction with the current scenario. These domestic push factors are further supported by international pull factors in causing the scarcity of health professionals in rural Nepal.

The international pull factors in conjunction with domestic push factors result in a mass exodus of health professionals from the Third world to the First world. Many of the migrant-health professionals trying to escape the rural areas in poor and underdeveloped nations are often extracted from their home nations to fulfill the shortages in the rural areas of developed nations (6). Recent studies show that the US will face a shortage of more than 100 000 doctors by 2030 (9). The difference in the shortages faced by developed nations such as the US and by developing nations such as Nepal is that the wealthy nations can afford to import skilled manpower from the Third world in the form of International Medical Graduates (IMGs) by providing special incentives such as merit-based immigration systems. The international medical institutions and research centers are evidently keen on attracting talented scholars from around the world with attractive funding opportunities. The consequence of excess emigration of health professionals is the shortage of health professionals in rural areas of poor nations as developing nations such as Nepal are unable to provide financial incentives to attract and retain skilled health professionals.

V. Efforts against the health crisis

The national bodies such as the Government of Nepal, Ministry of Health, teaching hospitals, Non-governmental organizations (NGOs), etc. have made numerous efforts at tackling the health crisis due to widespread pressure from the Nepali citizens and the international bodies. The governmental and non-governmental institutions have experimented with several plans and policies such as "remote allowance," compulsory medical service in rural areas, scholarship schemes for rural residents, etc. The Nepali citizens themselves are involved in solving the health crisis from the grassroots level. According to Huntington, et al.'s survey, more than 84% Nepali medical students believe in their duty to serve Nepal, more than 63% support medical service in rural areas, and 67% wanted extra pay for rural service (420). Both the Ministry of Health and Institute of Medicine, the premier governmental branch for medical education, provide scholarship seats based on merit, financial need, family background, residency in rural areas, etc. The scholarship opportunity requires students to sign an agreement that requires them to serve in rural areas for at least 2 years. Service in rural areas for a certain number of years has been made a mandatory requirement for promotions in government jobs, postgraduate studies, etc.

In addition, the government requires all private medical colleges to provide scholarships to deserving students from rural backgrounds. These arrangements are the main reasons that many doctors serve in rural areas, even if only for 2 years. Such scholarship quota systems are certainly helping deserving-Nepali students, but their long-term success is yet to be quantified and researched on (11). However, local newspapers often report that most doctors under mandatory rural service set up private clinics in the cities instead of working in rural health posts through several loopholes such as tampering with government records and attendance files. These mandatory requirements have also been criticized by many as being a temporary fix rather than a sustainable solution for the long-term (6, 17). The Patan Academy of Health Sciences, one of the most well-known institutions in Nepal, now selects 60 students out of thousands of applicants, giving special emphasis to students from rural backgrounds, and provides a special curriculum designed to ensure that the graduates serve rural areas (6, 14, 17). As many of the domestic problems are the consequences of deeper problems such as poverty, instability, etc., numerous international efforts aim at solving the health crisis in rural Nepal.

International organizations such as the United Nations (UN), World Health Organization (WHO), governments of developed nations, etc. have made several attempts at helping Nepal in addressing the health crisis. One of the prominent examples is the establishment of the United Mission to Nepal (UMN) Hospitals in rural areas targeting the destitute and needy rural residents (17). These hospitals, called by the Nepalis as "Mission hospital" have historically been one of the few institutions providing health care service in rural Nepal. Famous INGOs such as Doctors without Borders (MSF), Red Cross, etc. have also conducted several programs aiming to provide relief to the rural residents. Many foreign governments such as the US, China, Japan, EU, Egypt, Pakistan, Russia, etc. provide merit-based- and need-based-scholarship opportunities for Nepali medical students. Many of these scholarships are clearly stated to be "aid" helping Nepal develop whereas some of them state the purpose of such scholarships to be aimed at "developing the bilateral relationship" and promote "mutual understanding." Some scholarship opportunities such as the ones provided by the Chinese and the Japanese governments, however, require the students to complete the medical course in their foreign language after around 2 years of language study (2, 15). This prevents a lot of scholarship students from serving Nepal due to their medical education being in Mandarin or Japanese, bureaucratic hurdles of the Nepal Medical Council, etc. (6). The international involvement in solving the health crisis in rural Nepal is also connected with many narratives and discourses around the impact of migration on rural health in Nepal.

VI. Conclusion

The national and international efforts at coordinating the health crisis in rural Nepal due to the shortage of health professionals should be properly evaluated and coordinated for the optimum efficiency and result. Even though the domestic factors such as poverty, institutional corruption, instability, etc. are difficult to solve in the current time frame, their connections with the health crisis must be properly studied as these are the root causes of the health crisis that accelerate the impact of international pull factors. However, excess attention to issues such as poverty and socioeconomic factors should not be allowed to divert the attention from the health crisis itself (18). Immigration should not be generalized as inherently being 'bad,' but the governments of developed nations should form an unambiguous view about the policies that provide special incentives that encourage the "brain drain" of health professionals as this directly or indirectly impacts the rural residents' basic right of access to healthcare facilities. The Government of Nepal should provide special incentives to encourage health professionals to serve in rural areas and to encourage non-residing Nepalis (NRNs) to utilize their skills and experience for their motherland. Sustained involvement and participation of local community members in planning, decision making, and evaluation of health policies is very vital in tackling the health crisis (16-19). Multidimensional programs that include opportunities for career advancement, pension plans, educational opportunities for children, etc. are more

sustainable for the long-term than financial incentives on mandatory requirement of rural service alone (1, 11, 18). The citizens of Nepal, health professionals, national bodies, and international bodies should all be equally involved, invested, and accountable in tackling the health crisis in rural Nepal.

The health crisis in rural parts of Nepal existing due to the shortage of health professionals resulting from national and international factors should be tackled through sustained cooperation between the national and international bodies. Check and balance of the domestic push factors and the international pull factors responsible for the exodus of health professionals from developing nations such as Nepal to the developed nations is important to ensure that people in rural areas around the world have access to health facilities, which are considered as fundamental human rights. The existing efforts made by the national and international bodies should be further studied and evaluated, and necessary modifications must be made where necessary. As the health crisis in rural Nepal is caused by the combination of domestic and international reasons, the national and international bodies must cooperate and collaborate with each other for a sustainable solution to the crisis.

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