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IMPORTATION OF HEALTH MANPOWER: A SOLUTION FOR IRAN'S PRIMARY HEALTH CARE PROBLEMS?*

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INTRODUCTION

Iran, over approximately the last thirty years, has been exportin a large number of physicians and nurses to the United States and othe western countries. However, in the last three years, it has activel recruited physicians from other countries, in an attempt to increase it physician supply. Thus, Iran has entered the category of recipien with respect to physician migration, not simply by passively acceptin those who wish to come, but by active recruitment and importation o foreign physicians. Unlike the physicians entering the United State and European countries, the physicians upon entry have no knowledge of the Persian language. In addition, while the United States, by virtue of the ECFMG examinations, and most recently visa qualifying examinations, has assured itself of obtaining the most qualified of those physicians wishing to enter, Iran has no such procedures for screening applicants. Thus, it seems obvious that, rather than receiving those with the highest qualification and talents, Iran is receiving, at least to some extent, the group which has the greatest difficulty in earning a living in their homeland.

In a previous paper, the reasons why Iranian physicians who are currently in the U.S. prefer to practice in the United States were examined(2). It was found that the greater availability of professional facilities and equipment ranked as the most important reason for failure to return. The physicians entering Iran, on the other hand, are sent in the majority of instances to those assignments for which

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Iranian physicians cannot be found. This consists for the most part of clinics in small towns and villages, where facilities and equipment, even in the most favorable of situations, could only be described as extremely limited. Why, then, do physicians choose to leave their own developing country and enter another where their assignment will almost certainly be one considered the least desirable by native physicians?

In order to gain at least partial answers to these questions, two separate studies were carried out by the authors during the year 1976: first, non-Iranian physicians recruited during that year who were assigned to the province of Fars were asked to complete a questionnaire concerning their reasons for coming to Iran, their projected length of stay, and other items of interest. The second study consists of a sample survey of persons living in a city or village to which a foreign physician had been assigned. These people were asked about their preferences concerning health workers, and their attitudes toward non-Iranian physicians.

METHODS

Out of the 118 foreign physicians assigned to Fars province, 92 completed the questionnaire. The questionnaire was designed so that the physician completing it was entirely anonymous, and it was made clear that the questionnaire was for the Department of Community Medicine and was unrelated to the physician's government employment. All the physicians were from India, Pakistan, and the Philippines.

The areas in which consumer interviews were to be carried out were chosen from four regions of the province representing northern, southern, eastern, and western sections. Areas served by Ministry of Health clinics staffed at least partly by non-Iranian physicians were sampled in each of these regions. The area to be sampled was chosen without knowledge of which non-Iranian physicians were serving it. The majority of towns and villages in each area were covered by the interviewers, who were instructed to take each tenth dwelling for the interview. Each adult (15 years or over) in each household was interviewed. The interviews were conducted between six and nine months after the physicians had begun practice in the area. The persons conducting the interview were not identified in any way with any organization or type of health worker. The final sample included 3058 females and 1497 males.

RESULTS

The display below shows the reasons given by physicians entering from other countries for choosing to leave their home country in order to practice in Iran. Persons were allowed to give as many responses as they felt were correct. The total number of questionnaires with at least one response was 88. The possible answers along with the percent of responders giving that response were:

		No.	%
(1)	salary offered in Iran was better	64	73
(2)	I wish to better my professional skills by receiving speciality in a western country	33	38
(3)	political and/or general economic conditions in Iran were better	14	16
(4)	the government of my country does not encourage physicians	11	11
(5)	there was a position available for me, but it was unacceptable	9	10
(6)	it was not possible to take the ECFMG at home	8	9
(7)	positions in my own country are assigned according to friendship, rather than merit	8	9
(8)	working conditions were poor in my own country	7	8
(9)	physicians have low prestige in my country	3	3
(10)	there was no position available for me in my own country	2	2
(11)	the social conditions in my country were bad	2	2
(12)	other	2	2

By far the most frequently given reason for wishing to leave for a position in Iran was that of salary – almost three-fourths of the physicians responding listed that reason. The next most frequent reason was the wish to receive speciality training in a Western country. Thirty-three persons listed this reason. In addition, five persons listed as a reason for leaving their own country the inability to take the ECFMG did not also list a desire for speciality training. However, since the only reason for wishing to take the ECFMG is to undertake training in the United States*, it may be assumed that these five also came at least partly because of an ambition to undertake

* At the time some of the foreign physicians came to Iran, the ECFMG was still valid.

training in the U.S. Thus, for at least 38 out of the 88 responders, a desire for speciality training in the U.S. or other western country, was one of the reasons for entering Iran.

Physicians were also asked "At the present time, do you plan to eventually leave Iran?" Twenty of the 91 responders (22%) said yes; 16 persons (18%) said no, and the remaining 55 (60%) were undecided. Those who definitely planned to leave, or were undecided, were asked to list to which country they planned to go after leaving Iran. Twenty-one persons of the 75 definitely planned to go to some western country upon leaving Iran (the U.S. and England being by far the most common choices). Eleven persons of the 75 were undecided between their own country and a Western country, while 43 of the 75 indicated they would definitely go to their own country if they leave.

Thus, from Iran's viewpoint, it can probably not expect to gain more than a few years service from many of the physicians now entering Iran. On the other hand, it has gained those few years without the expenses of providing medical training for those physicians who do accept. In addition, physicians accepting these positions can be assigned to remote areas (unlike Iranian physicians, who for the most part will not accept such posts).

A point for consideration is the question of how much this particular approach to bringing health workers to rural areas can achieve, in comparison with other possible solutions. One quality which any health worker must possess in order to achieve success in primary health care is the ability to communicate verbally with his patients. In addition, the health worker must have the trust of persons who he serves, since persons voluntarily seek his services.

Unlike physicians entering the United States, who must have at least a reasonable command of English (enough to pass the TOEFL examination), the physicians currently entering Iran have no knowledge of the language at the time of entry. Although they have received about two months' orientation, including language, at the beginning of their stay, very few persons in this amount of time can gain the fluency in the language needed to permit real communication.

In order to gain insight into the degree of acceptance accorded these health workers by the persons who they are to serve, the survey described previously was carried out. Two questions of major interest were asked to each respondent. The first was "Which type of health worker do you most prefer to see when you are sick?" Responses read to the interviewee included (1) Hakim (indigenous practitioner) (2) someone in the family, (3) foreign physician, (4) self, and (5) Iranian auxiliary health worker.

Those who chose a health worker other than the foreign physician

were asked to give the most correct response to the question "If you said you prefer someone other than the foreign physician, what is the most important reason why you prefer someone else" The responses given were:

(1) just because he is a foreigner,
(2) because of the language problem,
(3) because I feel he doesn't know enough,
(4) because I went to him and did not get better, or just didn't like him.

Table 1 shows the preferences of the respondents with respect to treatment of illness. In every age and sex category the Iranian auxiliary was preferred by the largest percentage of persons. Overall, 48% of females and 57% of males preferred the auxiliary. The foreign physician was the first choice of 7% of females and 15% of males. For both sexes the proportion preferring the foreign physician declined with age.

Females were considerably more likely to give a preference for treating themselves than males, and the proportion preferring to treat themselves showed a clear increase with age. Among females a larger proportion of the total group preferred the indigenous practitioner than preferred the foreign physician (10% compared to 7%). Males were less likely to choose the indigenous practitioner than were females (5% compared to 15%).

Table 2 shows the responses given to the second question concerning principal reason for preferring someone other than the foreign physician, among those who had given a response other than preference for foreign physicians. Persons were allowed to give a response other than those read, although few chose to do so. The most commonly perceived problem was that of lnaguage – 56% of females and 60% of males mentioned language difficulties as their primary reason for preferring another type of health worker. The two categories "he is a foreigner" and the feeling that the foreign physician "would not know enough" probably reflect, for the most part, simple prejudice. Nevertheless, these responses reflect attitudes which will create effective barriers between the physician and potential patients, and will certainly serve to reduce the physician's potential, both for attracting patients and for influencing the behavior of those he does see.

DISCUSSION

There are a limited number of partial solutions for the problem of rural health services. The importation of physicians, who are, by the terms of their contract, required to practice wherever the government chooses is one means of increasing the physician supply in rural areas. The physician does not, however, operate in a vacuum, even the primary-care physician. Even if one assumes that physicians from other countries can acquire during their stage a knowledge of the language sufficient for adequate communication with the patients, there remain still the problems of equipment, laboratory facilities, hospital beds, X-ray and other diagnostic facilities, and drug supplies. If the advantage of the physician over the health auxiliary is his ability to utilize such facilities and drugs for difficult diagnosis and complex treatment, one must then provide these forms of support to the physician, if one is to take advantage of his unique capabilities. Rural areas in Iran cannot even begin to provide such forms of support and the cost of providing even the most basic of these facilities to a large portion of rural areas over a period of a few years would be enormous. Even if such facilities could be provided, the technicians needed could not be supplied. Thus, it is a foregone conclusion that the physician being placed in a rural (Iranian or non-Iranian) must work without the supporting facilities needed to utilize his special skills.

Given these considerations, it seems questionable whether the foreign physician in this situation could be more effective than an Iranian auxiliary who has a knowledge of the language and of local customs and who is not considered a "foreigner" by persons seeking care. There remains another important consideration: even the most basic sanitary measures and preventive health practices are not yet practiced in most rural areas. Most villages do not have sanitary water supplies or facilities for disposal of human waste, and animals are generally kept within the human living area. Childhood malnutrition or at least poor nutrition are common problems in many areas. Under these conditions, how much long term improvement in health will be gained by the symptomatic treatment of such conditions as diarrheal disease? It would seem that a health worker who can also function to improve sanitation, teach basic health practices, give basic prenatal care, provide contraception, and perform other preventive tasks could be of significantly greater long-term value in the improvement of health for a rural population. The importation of health workers from other countries seems to be at the very best a stopgap solution for the huge problems of rural health services in developing countries. In view of the difficulties already discussed, it is questionable whether such

measures even have significant value on a short-term basis.

The question goes even deeper than that of how much value such measures can provide. The expenditures required to pay the salaries of the number of foreign physicians who are scheduled to be imported will be enormous. At present salaries given to the physicians ($1000 per month minimum) the cost of salaries alone for 5,000 physicians would be more than $60 million per year. It is questionable whether such expenditure can be maintained for a period of more than a few years. When the program ends and the physicians leave, what will be residual benefits? It seems probable that the rural health care system will at best return to its former level of efficiency and impact. At the most, deleterious effects which the physician importation program may have on searches for other solutions to health services problems, as well as the siphoning off of huge capital outlays for physician salaries, may leave existing rural health care services in chaos.

It seems evident that searches for workable permanent systems for rural health care would be more rewarding than the wholesale importation of physicians from other countries. Such solutions may be found partly in the training of more local physicians for primary care, or for the training of auxiliaries for rural areas, or the more efficient use of the types of health manpower and facilities already being trained and built. It seems probable that a combination of these methods of attack could provide the most effective long-term solution for Iran's massive health care problems.

Table 1
PREFERRED HEALTH WORKER, BY AGE AND SEX

Age group		% in that age group giving response				
		Auxiliary	Foreign Physician	Indigenous Practitioner	Family	Self
Female						
15–24	(893)*	49	15	7	26	3
25–34	(1093)	54	8	9	18	11
35–44	(677)	39	1	14	8	38
45+	(395)	48	1	7	4	40
All ages	(3058)	48	7	9	16	20
Male						
15–24	(702)	53	19	3	24	1
25–34	(366)	63	16	6	8	7
35–44	(251)	63	6	9	16	6
45+	(178)	54	7	12	8	19
All ages	(1497)	57	15	6	17	5

* Number of persons in that age group

Table 2
REASONS FOR PREFERENCE FOR HEALTH WORKER OTHER THAN FOREIGN PHYSICIAN

Age group		% in that age group giving response			
		"Foreigner"	Language Problem	Doesn't know enough	Previous visit unsatisfactory
Female					
15–24	(750)**	15	55	21	8
25–34	(985)	19	64	8	9
35–44	(649)	26	50	16	8
45+	(374)	14	53	21	13
All ages	(2758)	19	56	16	9
Male					
15–24	(556)	8	63	24	5
25–34	(301)	7	68	20	5
35–44	(221)	34	49	5	12
45+	(153)	23	53	13	11
All ages	(1231)	14	60	19	7

* Persons giving other responses were omitted, since the number was small, and no single response was frequent enough to merit mention.

** Total in the age group

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