



Opinion: The COVID-19 pandemic — peak of solidarity or peak of neocolonialism?

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As the world soars past the mark of 1 million confirmed COVID-19 cases and countries sequentially enter national lockdowns, solidarity brings hope amid public fear.

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protective equipment, citywide standing ovations for health care workers, knowledge-sharing by China, and Cuba sending health workers and supplies to Italy are only a fraction of the growing collaborative sense. Meanwhile, the U.S. Department of State's Bureau of Consular Affairs announced that it is actively seeking to recruit foreign medical professionals, expediting visa processes to allow them to work in the United States.

While low- and middle-income countries have yet to witness a rapid surge in COVID-19 cases — likely due, in part, to lessons learned from severe acute respiratory syndrome, Middle East respiratory syndrome, Ebola, and endemic diseases — the impact of long-term earmarked vertical disease silos will soon become apparent. Decadeslong neglect of horizontal health systems strengthening has persisted the fragility of health system resilience in low- and middle-income countries, where critical care and post-acute care capacity is deeply lacking. At the time of writing, Iran already has tens of thousands of confirmed cases, and testing kit shortages and fears around out-of-pocket payments for medical care may potentiate a current underreporting of cases across LMICs.

The U.S. ranks first on the [2019 Global Health Security Index](#), a theoretical measure of countries' ability to manage infectious disease outbreaks; ironically, it now also ranks first in the number of confirmed COVID-19 cases. States such as New York, Washington, and Massachusetts — world-renowned medical and academic hubs — are among the first in the country to feel the systemic threat of the pandemic. Medical schools expedite the graduation of senior medical students to more rapidly enter the medical workforce, while compensated domestic calls are made to recruit intensive care physicians from out of state and offload critical care patients to out-of-state facilities.

With nearly [300 physicians per 100,000 people](#), the U.S. has tenfold the physician density of low-income countries and double the physician density of middle-income ones. The call to recruit foreign medical professionals is an ironic tangent to the long history of [refusing visas](#) to, often, qualified workers, scientists, and health care professionals. While brain drain is a never-ending process and, in a time of rapid globalization, free movement of skilled people is inevitable, encouraging front-line workers to leave countries in need during a pandemic is not only unethical and immoral but also incredibly harmful.

Intensivists and critical care nurses are grossly lacking in, for example, sub-Saharan Africa and Southeast Asia, and the widespread resource constraints to managing critical patients while protecting oneself may motivate some to respond to such a call.

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The result? Further reductions in the workforce and more lives lost.

Disturbingly, the widespread lack of personal protective equipment in the U.S. — where a single mask is [handed out](#) per health professional in many a facility and garbage bags are being used as gowns — poses another unaddressed question: If health care workers are not adequately protected and equipped, is it morally acceptable to take advantage of the status of one's country to attract more of the best and brightest during these trying times and to thereby put them and their families at further risk?

While this new policy would give an illusion of a larger qualified workforce in the U.S., it does not address the additional strain it brings to an already overwhelmed system: even further increased need for personal protective equipment, adaptation, and training time for this imported workforce and insurance for their basic needs.

Moreover, it is unclear what will happen to these health care workers after the pandemic has been contained. Presumably, they are either sent back home — potentially stigmatized there for leaving their own communities — or forced to work in fields other than those they were once trained in.

It is clear that introspection, grassroots engagement, and respect for domestic medical workers should be prioritized over a further skewing of the global health workforce. In the U.S. specifically, making it easier for out-of-state health personnel to work in different states — perhaps through a universal license — will help redistribute the workforce across the country and disciplines, and enabling the tens of thousands of students and doctors waiting to start residency in the summer to support the front lines earlier may alleviate the burden elsewhere in the system.

We are only at the start of the COVID-19 pandemic, which will show no mercy on the world's health systems. Threats to global health security ought to be drivers of solidarity — falling back to neocolonial thinking will have deleterious effects on countries around the world and, once again, cost the lives of thousands, if not millions, in LMICs. Rather than sustaining crippling sanctions and forgoing governmental agreements, the pandemic is an opportunity to leverage innovative solutions and set aside hidden agendas while protecting the integrity of our neighbors around the globe.

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