Brain drain in africa - migration in the health sector

Health & Medicine, Healthcare

Introduction " African governments have a great responsibility to ensure that brains remain in the continent; otherwise, in 25 years' time, Africa will be empty of brains." This quotation by Dr. Lalla Ben Barka, the Deputy Executive-Secretary of the Economic Commission for Africa, expresses more than clearly the dramatic situation of Sub-Saharan African countries when it comes to their most valuable human resource needed for development – their brains. Migration and the resulting brain drain are a global phenomenon and universal problem. Especially in the health sector, there have been significant shifts of human capital from Europe to the United States, leaving a gap which is quickly filled by high-skilled immigrants from the Southern part of the world. (PSI, 2003). According to the WHO (2006), Africa remains the sole continent still struggling with insufficient development in all fields: education and the health sector continue to deteriorate and cannot keep up with the rising demand due to an annual population growth of about 3%; HIV/AIDS is spreading fast and inexorably, further weakening the countries' systems and economies and increasing the demand for a functioning health system even more. In this context, brain drain is continuing steadily, which deprives developing countries in the Sub-Saharan region of their skilled human capital at costs comprising of their lost value and productivity in their home country but also of their training and education costs. This paper deals with migration and it motivations as well as its impact on the African health sector. Moreover, it will be critically discussed which of the concept – brain drain or brain gain – is prominent in the African health sector and will show some possible strategies to overcome the serious under-supply of health workers in the region. Particularities concerning the African health sector and

migration Migration of health has had a huge impact on African health systems. Generally spoken, a global shortage of health workers exists, which significantly raises demand. In this context, African countries are one the key suppliers of workers in the field. However, shifts of worker do not only happen externally, meaning emigration of workers to another country, but also internally. Health workers also migrate from rural to urban areas or from the public to the private sector, or they completely withdraw from the health sector. (WHO, 2006). According to the (IOM, 2006), main reasons for an insufficient supply of health workers include underinvestment, high work intensity, working conditions, and insufficient remuneration. It is clear that concerning remuneration, developed countries can offer higher incentives for health worker to work in countries in the North. Developing countries are simply not competitive, that is why migration rates of skilled health workers are not likely to decrease in the near future, leaving developing countries in devastating situations. Schrecker & Labonte (2004) state that " a nurse in the United States can expect to earn $3, 000–$4, 000 per month, as compared with $300–800 per month for a doctor in the Philippines" (p. 411). Mass migration has then serious effects on global distribution of health services. Global average in health services is accounted to be 4 health workers per 1000 inhabitants, however, North America's worker base is 10, 9 workers in comparison to Sub-Saharan Africa's worker base of 1. 0 workers per 1000 inhabitants. (WHO, 2007). With his concept of the " global conveyor belt", to be seen in Annex 1, Schrecker and Labonte argue that migration of health workers in Africa not only works internationally but also intra-nationally, with workers moving " from public to private health systems, or

from less to more desirable work situations or regions [with serious consequences]. Nairobi has one doctor per 500 people, while Kenya's remote Turkana province has one doctor per 160. 000 people". (2004, p. 411). It becomes clear that people in rural areas are in most need of health services due to the HIV/AIDS pandemic and other serious diseases but suffer the most from internal migration and the resulting unequal distribution of health services throughout the country. This is what Martineau et al. (2004) call the ‘ downward spirale': " if a vacancy in an urban area is created due to the incumbent moving overseas, a re-shuffle (another form of carousel) takes place with the vacancy being filled by someone from a more rural area and so on. Since the poorest citizens tend to live in the remoter areas, it is they who are most affected by migration" (p. 4). Factors influencing migration of health workers When analysing migration in the health sector, push and pull factors have to be considered in order to counter trends and fight the dramatic consequences for the African continent. Xaba & Philips state the following, most prominent push factors for South African health worker to migrate: " lack of competitive incentives in the public sector, work pressures like long hours, poor resources and high ratios of patients per nurse, few opportunities for career development, escalating crime rates in the country, and the rise of HIV/AIDS in South Africa" (2001, p. 5/6). Obviously, pull factors then represent the mirror image of those reasons, which attract health workers to emigrate. Another important factor concerning migration was brought up by Lien & Wang (2003). They argue that brain drain or gain can be predicted taking some factors into account, such as interactions of imperfect human capital transferability, investment in improving immigration

probability and the budget constraint. Shortly explained, their main argument is that language skills can influence human capital transferability. Language skills often increase the probability of migrating, so often, due to budget constraints, people invest in language skill rather than in education. Until they immigrate, professionals do not invest in their education anymore and can therefore not provide appropriate services anymore - this is when brain drain occurs. In the case of African workers, language barriers are mostly low, which is why migration occurs in large scales and results in brain drain for the home countries. The African health sector: Some important facts and trends Mass migration of health workers has a serious impact on the health sector of African countries and their possibility to develop. According to the WHO (2007), " four doctors and one nurse in 20 trained in Africa is working in OECD countries." This average is already somewhat dramatic, however, still hides the alarmingly trends of some countries, such as Ghana or Zimbabwe, where 29% of all physicians and 34% of all nurses, respectively, are working abroad. The recommended WHO standard is two doctors per 10. 000 people, but ten African countries can only provide one doctor per 30. 000 people. Disparities between developed and developing countries are extremely high with an average of 22, 23 doctors per 10. 000 people in Western countries and 0. 5 or less doctors per 10. 000 people in 13 of the Sub-Saharan African countries. (MSF, 2007). Vacancies in African countries are significantly increasing, however, there are no health professionals available or willing to fill the gaps. (Schrecker & Labonte, 2004) " The Kenyan government in 2001 advertised 100 doctor vacancies; only eight candidates applied" (p. 410). 61% of medical school graduates

immigrated to other countries during 1986 and 1995 (p. 410). Akokpari (n. d.) states that the trend of migration to developed countries is not abating but continuing with an accelerating rate, taking the example that more Beninian doctors work in France than in their home country. He estimates that, by 2015, one out of ten Africans will be working outside of Africa. Arguments for brain gain instead of brain drain – evidence in the health sector? Supporters of brain gain instead of brain drain often argue that migrant workers send remittances home which have a significant impact in people's and the country's development. They then also argue that migrants with higher skills earn more and therefore also remit more. Rodriguez and Horton (1994) analysed the impact of skill on remittances and found no evidence that high-skilled worker remit more than low-skilled workers. Possible explanations for this were that high-skilled workers usually come from relatively wealthy families and do not feel that obliged to remit great parts of their earnings. Also, high-skilled workers normally spend a longer time abroad which weakens the close relations with their home country. Lucas and Stark (1985) also found a negative correlation between the flow of remittances and the time migrants spent abroad, which could partly be explained through reunification with close family members in the host country and the resulting alienation from the home country. Remittances are generally of high value as they amount to much more than official development assistance (ODA) and represent a relatively stable source of foreign investment. However, only two Southern African countries, Lesotho and Uganda, were among the 20 recipient countries where remittances were the highest as a % of GDP. (Schrecker & Labonte, 2004). Moreover, the

immense education costs of migrant health workers have to be taken into account. South Africa claims that the costs for education health workers who then migrated during 1994 and 2000 constituted $ 1 billion, which was 3 times more than the development aid receiving during that time. (WHO, 2006). The Deputy Director-General of the International Organization for Migration (IOM) pointed out in 2002 that: "[A]t a cost of $60, 000 to train a medical doctor in the South and $12, 000 for a paramedical, it may be said that the developing countries are ‘ subsidising' the OECD countries to the tune of some $500 million per year, and what is more, largely financed by . . . development aid." (Schrecker, p. 410). Watanabe (2003) mentions another theoretical favourable effect of migration. He argues that migrants will receive higher education and more skills in their host country and could, in the long-run contribute to their home countries' development with basic research, the invention of new production processes or the development of new products. However, taking the health sector as a judging base, even if health workers acquire new knowledge and new techniques and methods, there is still an immense underinvestment in African developing countries in the health sector, so necessary equipment is largely lacking. Moreover, for instance, doctors, are logically less inclined to go back to their home countries if they are not offered the same possibilities of working, under the same security and safety conditions, career development possibilities and remuneration. Gosh (1996) explained that sending countries could only gain from improved human capital under three conditions: return with more and higher skills, skills acquired show relevance to the home countries' needs and migrants are willing to use their skills. In only a few cases of his study,

all three conditions were met, the last conditions being the most difficult one to meet. (WHO, 2006). Strategies to transform brain drain into brain gain It could be seen that for the health sector, until now, most arguments are against a brain gain, which is also partly due to the immense mal-distribution of health workers in a global field. Push and pull factors are considerably high in the health sector, which also can be seen in the high migration rates among health workers. Dovlo (2003) combined push and pull factors influencing migration of health workers into so-called gradients: the income gradient (differential in salaries and living conditions), the job satisfaction gradient (perception of professional working environment and skills utilization for international recognition), the organizational environment / career opportunity gradient (opportunities for advancement in careers and in specialization), the governance gradient (level of administrative bureaucracy, efficiency of managing services), the protection / risk gradient (lack of protective gear, perceived increase of occupational risk from HIV/AIDS), the social security and benefits gradient (basic comforts during their working life, security after retirement). These gradients should be taken into account in order retain health workers or to motivate them to return to their home countries. Some of the most favoured strategies to transform brain drain into brain gain are the following: Higher salaries and living conditions It is clear that Northern countries are able to pay higher wages than Southern African countries. However, as was mentioned before, by educating health workers who then migrate to the North, Southern African countries lose immense amounts of money, which could be used to pay higher wages. If Northern countries invested money into education of health

workers in African countries, costs of education could be decreased, which would result in higher wages. Development aid, otherwise used to pay migrants' education, could also be used for the paying of higher wages. (Dovlo, 2003). International Recruitment and Inter-country arrangements Many Southern African countries employ health workers from outside their countries o even the continent. Most foreign health workers come from Cuba. However, other arrangements have to be created with Northern countries to regulate migration and maybe also introduce migration limited to a certain period of time. (Dovlo, 2003). Controlled migration by skilled individuals Controlled migration might, in the short-run limit social welfare of people with low skills, but improve their situation in the long run. Especially for health workers, investment in their education and skills through the expected returns to higher education and the possibility to migrate, consequence would be quite positive. As a higher number of people would be educated but less people, proportionally, would migrate later. (Fan & Stark, 2007). Using local language training A recent study showed Thai health workers emigrated less once training became completely conducted in Thais instead of English. This result is, however, not suitable for most African countries, as their official language is English, therefore, also the possibilities to migrate are much higher, as was also mentioned before. (Lien & Wang, 2003). Visas for voluntary recirculation, also enabling career and skill development High-skilled migrants often hesitate to return to their home countries due to their fear of losing the possibility maintaining and developing their skills. They also do not want to be cut off from any further knowledge and skill exchange. Therefore, visas for recirculation would be a

possibility to also strengthen the home base of health workers by acquiring new knowledge and effectively using it in their home country. (Meyer, 2003). Conclusion This paper has highlighted the effects of global migration of health workers and the effect it has on the home country's service provision. Although there is a global problem with insufficient health workers, the Southern African countries suffer most from the unequal distribution of health workers and the massive emigration from their countries. Not only do they lose a significant proportion of their labour force but also immense amount invested in those workers' education. Therefore, it cannot be argued that these trends favour brain gain more than brain drain. Numerous strategies to transform brain drain into brain gain have been mentioned, however, their success are quite limited, due to the never-ending demand of health workers in the North and its comparative advantage, e. g. in paying higher salaries and wages. Annex 1 Bibliography Akokpari. (n. d.). Globalization, Migration, and the Challenges of Development in Africa. Retrieved the 10th October 2007, from the World Wide Web: http://www. codesria. org/Links/Publications/asr4_2full/akokpari. pdf Dovlo, D. (2003). The Brain Drain and Retention of Health Professionals in Africa. Retrieved the 10th October 2007, from the World Wide Web: http://www. medact. org/content/health/documents/brain_drain/Dovlo%20-%20brain%20drain %20and%20retention. pdf Fan, C. S. & Stark, O. (2007). The brain drain, ‘ educated unemployment', human capital formation, and economic betterment. Economics of Transition. Vol. 15(4), p. 629–660 IOM. (2006). International Organization for Migration. International Dialogue on Migration No. 9. Migration and Human resources for Health: From awareness to action.

Retrieved the 10th October 2007, from the World Wide Web: http://www. iom. int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs/serial_publications/lowres%20rb9eng%20complete%20(14). pdf Lien, D. & Wang, Y. (2003). Brain drain or brain gain: A revisit. Journal of Population Economics. Vol. 18, p. 153 – 163 Lucas, R. E. B., and O. Stark. (1985). Motivations to Remit: Evidence from Botswana. Journal Of Political Economy 93(5): 901–18. Martineau, T., Decker, K. & Bundred, P. (2004). " Brain drain" of health professionals: from rhetoric to responsible action. Health Policy (70), p. 1–10. Meyer, J. (2003). Policy implications of the brain drain's changing face. SciDev. net. Retrieved the 10th October, 2007, from the World Wide Web: http://www. scidev. net/dossiers/index. cfm? fuseaction= printarticle&dossier= 10&policy= 24 MSF. (2007). Médecins sans FrontiÃ¨res. Confronting the health care worker crisis to expand access to HIV/AIDS treatment. Retrieved the 10th October 2007, from the World Wide Web: http://www. msf. org/source/countries/africa/southafrica/2007/Help_wanted. pdf PSI. (2003). Public Services International. An Introductory Guide to International Migration in the Health Sector for Workers and Trade Unionists. Retrieved the 10th October 2007, from the World Wide Web: http://www. world-psi. org/Template. cfm? Section= Home&CONTENTID= 6761&TEMPLATE=/ContentManagement/ContentDisplay. cfm Rodriguez, E., and S. Horton. (1994). International Return Migration and Remittances in the Philippines. In D. O'Connor and L. Farsakh, eds., Development Strategy, Employment And Migration. Country Experiences. Paris: OECD Development

Centre. Schrecker, T. & Labonte, R. (2004). Taming the Brain Drain: A Challenge for Public Health Systems in Southern Africa. Impacts in Developing Countries. Vol. 10/NO 4, OCT/DEC 2004. Retrieved the 10th October 2007, from the World Wide Web: http://www. ijoeh. com/pfds/1004_Schrecker. pdf Watanabe, S. (2003). Brain Drain from developing countries to developed countries. Through EBSCO. WHO. (2006). World Health Organization. The world health report 2006 - working together for health. Retrieved the 10th October 2007, from the World Wide Web: http://www. who. int/whr/2006/en/ WHO. (2007). Organizational Website. Indicators for individual countries. Retrieved the 10th October 2007, from the World Wide Web: www. who. int. en Xaba, J. & Philips, G. (2001). Understanding nurse emigration. Final Report. Retrieved the 10th October 2007, from the World Wide Web: http://www. queensu. ca/samp/migrationresources/braindrain/documents/xaba. pdf