



February 2013

The Brain Drain of Health Care Professionals from sub-Saharan Africa

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“There are more Malawian-trained doctors in Manchester, UK, than there are in Malawi.”¹

Introduction

According to the World Health Organization's World Health Report 2006, sub-Saharan Africa (SSA) has 24% of the global burden of disease but only 3% of the world's health care workers (World Health Organization, 2006a; Kumar, 2007). In 2006, the World Health Organization (WHO) reported that 36 out of 57 countries in SSA suffered from a severe shortage of health workers and over 75% of the countries did not meet the WHO minimum standard of 20 physicians per 100,000 people (2006b).

The global free movement of labor and competition for human resources enables developed countries to fill their shortages of health workers with doctors and nurses from less developed countries (Nduru, 2007; Kuehn, 2007). The “brain drain” refers to the emigration of Africa's highly trained professionals in search of a better standard of living, higher salaries, access to advanced technology and more stable political conditions in different places worldwide (Misau et al., 2010). The flight of health professionals to more lucrative jobs in richer countries such as the UK and U.S. impedes Africa's progress toward achieving Millennium Development Goals (MDGs), particularly those related to better health: reduction of child mortality; improvement of maternal health; and combating HIV/AIDS, malaria, and other diseases (United Nations, 2006; Sankore, 2006).

In an increasingly globalized world, African countries are unable to compete with developed countries in retaining their own health professionals, let alone attract the specialized professionals they need from other countries

1. Record and Mohiddin, 2006

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(Gudzer, 2007) yet Africa is helping prop-up the health care systems of Western countries as a result of the exodus of its highly trained health care professionals.

The brain drain: threat to capacity building in Africa

An analysis of 46 African countries showed that only six have the health workforce density of 2.5/1,000 people required to achieve the MDG (Juma, 2006). At an average of 0.8/1,000 people, Africa's health workforce density is significantly lower than world's median of 5/1,000 people (Chukwunwike, 2005). With the exception of South Africa, Namibia, Botswana, Swaziland, Lesotho and Gabon all other SSA countries suffer from critical shortages of health care workers (Kumar, 2007). A spatial map of physician emigration reveals a clearly delineated belt of high emigration from East Africa into Southern Africa. This also happens to be the section of the continent hardest hit by HIV/AIDs.

These statistics are quite troubling, especially when compared to trends immediately following independence in the 1960s and 1970s. With a few exceptions, between 1970 and 2005 the number of physicians per 1000 people increased slightly for many African countries as a result of widespread policies of building medical schools and of sending students abroad to train as physicians (World Bank, 1994). However, beginning in the mid-1980s as African economies retracted, the continent experienced increasing emigration of its health care professionals to developed countries where there were better employment opportunities. That emigration contributed to present-day critical shortages of highly trained physicians (Jack, 2007).

Theoretical perspectives: explaining the brain drain

While there are many theories that help explain the complex process of migration, no single theory captures all the nuances of the migration flows of health care professionals. The push-pull theory, first introduced by Ravenstein, is the most frequent explanation for migration (Lee, 1966): migration results from push/pull factors that operate at areas of origin and destination respectively.

International migration involves a drastic change in life and has important implications for socioeconomic policies; over the past two decades more sophisticated theoretical frameworks have been developed to explain the international flow of workers. As outlined by Massey et al (1993; 1994) and de Haas (2010), these theories either focus on the initiation of migration patterns—neoclassical economics, new household economics of migration, dual labor market, and world systems theory—or attempt to explain the perpetuation of migration using theories of networks, institutions and cumulative causation.

Neoclassical economics theory offers a push/pull conceptualization: countries with growing economies and small labor pools have higher wages than those with less-developed economies and larger labor forces; the wage differential causes people to move from lower- to higher-wage regions (Weeks, 2008). In SSA, social and economic factors—such as structural adjustment programs, inadequate remuneration, sub-standard healthcare systems, limited training opportunities and jobs, political instability and daily security—push qualified healthcare professionals to migrate to industrialized countries in search of better opportunities.

Just as there are powerful push factors at area of origin, there is a powerful set of pull factors at destination areas in developed countries. Countries that offer higher quality of life, freedom from political persecution, freedom of speech, and educational opportunities for children, are attractive migration destinations for health personnel (Loewenson and Thompson, n.d.). These pull factors are best explained using theoretical approaches such as new household economics, dual labor economy, network theory, institutional theory, and cumulative causation.

It is not joblessness in less developed countries causing the brain drain, rather, myriad push/pull factors. In Europe and North America, health professionals experience career advancement and job mobility in workplaces where attention is given to human resource policies, supervision, and training. Hospitals and universities have state-of-the-art equipment and well-stocked libraries. Benefit packages for health care, life insurance, and retirement are guaranteed and often generous. In addition, the U.S. and European countries maintain visa policies that encourage the brain drain (Boratyński et al., 2006), such as employment-based immigrant visas that include persons of extraordinary ability in the sciences, arts, education, business and athletics.

Managing the brain drain

Migrant remittances are an economic asset for targeted households and a major source of external development finance for developing countries, but the impact for African nations of the loss of trained professionals is detrimental. Since a country's economic productivity is linked to the health of its citizens, the impact of poor health systems is much more significant than remittances (Hamilton & Yau, 2004).

The brain drain of trained health professionals has plunged most African countries below the threshold in workforce density that is essential to achieving health related MDGs (World Health Organization, 2006b). Without implementing effective solutions and strategies to retain its healthcare professionals, Africa's insufficient health workforce will continue to be a major handicap in attaining better health (Muula, 2005).

African governments have tried both coercive and conducive strategies to no avail. Evidence suggests that most restrictive policies are ineffective in stemming the brain drain (Cali, 2008; Adepoju et al., 2010). Punitive and coercive strategies have backfired and should not be condoned since they ultimately result in legalized discrimination against Africans who wish to migrate or stay in developed countries.

While SSA has virtually no control over the pull factors, it can mitigate the push factors by working to improve conditions in Africa so professionals stay and emigrants return (Loewenson and Thompson, n.d.). Encouraging results emerged from such strategies in Botswana,

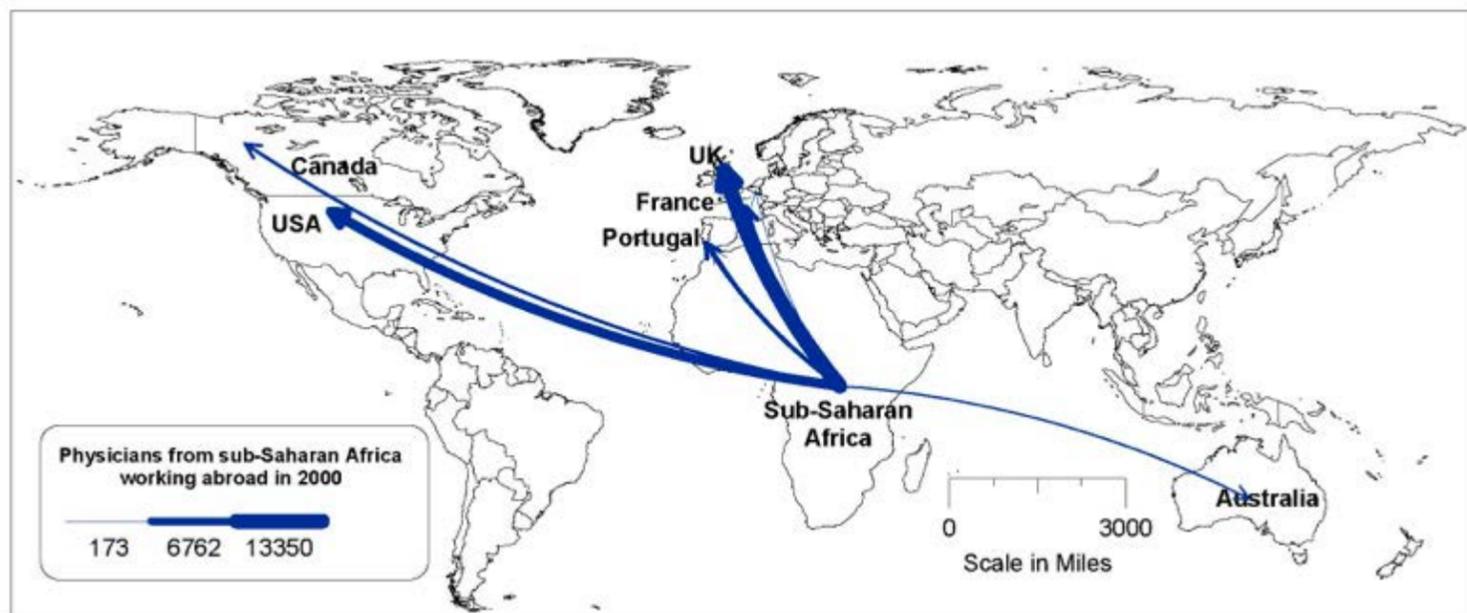
Zambia and Malawi. In its bid to improve retention of nurses, Botswana introduced generous overtime allowances of up to 30% of salaries, part-time employment, flexi-time, and housing (Yumkella, 2006). Financial support from donors enabled Zambia to double nurse salaries in 2001 (Gerein & Green, 2006). In 2004, the Malawi Government launched a \$278 million 6-year Emergency Human Resources Program with funding from several donors including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United Kingdom Department for International Development. The program included financial and other incentives to boost recruitment and retention, salary increases, improved staff housing, better management of health workers, and expansion of domestic training programs (Kuehn, 2007).

To further stem the brain drain, we join the call for African governments to put pressure on the donor community and assistance programs to make greater use of African experts living in African countries (with goodwill and concerted effort, developed countries could help make this dream a reality). Other scholars stress the need for African countries to reevaluate their educational systems to determine if they are producing the skill sets required for critical needs such as HIV/AIDs, malaria and other infectious diseases (Kumar, 2007).

Conclusion

The trends in out-migration of physicians and nurses from the most impoverished countries in SSA are troubling. The migration destinations are rich countries in Africa, notably South Africa, and developed countries in Europe and North America, especially countries having former colonial relationships in Africa. Solutions to the push/pull factors influencing emigration have been elusive. The sad truth is that as long as many African countries are troubled by weak economies, conflict, political instability, poor governance, and a lack of individual freedoms, the brain drain will continue, with increasingly negative consequences for the continent.

Migrant remittances alleviate short-term consumption and emergency needs but do not resolve long-term development needs of the sending countries. Therefore, African countries in partnership with developed countries should find joint solutions to the massive brain drain of African healthcare professionals. Furthermore, there should be more public discussion about social justice and the ethics of developed nations recruiting professional physicians and nurses from poor African countries.



Flows of physicians from Africa in 2000
Source: Authors, data from Clemens and Pettersson (2008).

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This publication is funded in part by a Title VI grant for National Resource Centers through the U.S. Department of Education.