

## CHAPTER 4

**Factors that contribute to migration****4.1 Introduction**

At societal level, the differentials that exist in remuneration between sending and receiving countries have been acknowledged as a key factor influencing decisions to migrate<sup>2,3,4,10,20</sup>. At an individual level the decision of a health worker to migrate is the result of the interaction of “pull” forces in recipient countries and “push” forces in the donor country<sup>2</sup>. For both the exporting and importing countries, the implications of these individual decisions to migrate will depend on whether the moves are permanent or temporary<sup>6</sup>. This Chapter is not a comprehensive account of all the forces that may operate; rather it attempts to summarise those that appear particularly influential in the migration of citizens from developing Commonwealth countries. Some of these have already been alluded to in earlier chapters and many are inter-related.

**4.2 “Push” factors****4.2.1 Tradition of mobility; similarity of professional training; colonial and cultural links**

There has long been a tradition of mobility within the Commonwealth<sup>2</sup> that still operates today<sup>3,4,10</sup>. A key factor is the ability of patients, clients and other health professionals in the host country<sup>47</sup> to communicate in a common language, English. The tradition of mobility has been further enhanced in the case of doctors and nurses by the widespread mutual acceptance of medical and nursing qualifications in member states<sup>2</sup> where similar patterns of medical and nursing education and practice have developed based on the United Kingdom model. Thus in the Pacific region the opportunity provided by a transferable qualification, with the possibility of registration in the target country and the likelihood of permanent residency or citizenship, have been identified as the most important factors in the emigration of health workers along with the availability of sponsorship or donor aid for out-of-country education<sup>2</sup>. The patterns of migration already noted from Africa<sup>10</sup>, Asia<sup>20</sup> and the Caribbean<sup>4</sup> suggest that similar factors are still important to a greater or lesser extent in other parts of the Commonwealth also.

In the African region it has been further suggested that the depletion of expertise brought about by the exodus of expatriate experts, civil servants and professionals when countries gained their independence affected the future development of systems in those countries<sup>5</sup>. It is thought to have fostered the development of elitism amongst the few remaining professionals and this encouraged them to feel a particular kinship with the United Kingdom and other developed countries where they had been trained.

**4.2.2 Production related to demand for education rather than need for services**

In the Asian subcontinent, a key factor appears to be the demand for medical education that is part of a general demand for higher education which is unrelated to employment

opportunities<sup>2</sup>. For example, in 1980, in response to the growing unemployment of graduate doctors and the imbalance in the ratio of doctors to paramedical workers, the government of India decided not to increase the number of medical schools or their capacity. The result was rapid growth of private medical colleges that now constitute 17 per cent of all medical colleges in India<sup>20</sup>. Consequently, India is generating a massive surplus of physicians, and this is the case even when only the output of government colleges is considered<sup>20</sup>. Similar factors seem to operate outside the Commonwealth leading to overproduction in some European Union and many Latin American countries, either because there are no controls over entry to medical school (e.g. Italy) or because of proliferation of private sector and largely unregulated universities (eg. Chile, Costa Rica)<sup>43</sup>.

It is not only unemployment however, that leads to migration: in the Commonwealth, education systems based on imported school models may predispose people to migrate by making them dissatisfied with their surroundings<sup>48</sup>. In the Asian region, the major exporting schools are all elite institutions with high international standing, as indicated by success rates in the Education Commission for Foreign Medical Graduates (ECFMG) examination for practice in the United States that are well above the average of 32 % for graduates from all Indian Universities<sup>20</sup>. These include the Baroda University Medical College, the Seth S. G. Medical College in Bombay, the Madras University Christian Medical College in Vellore, and the All India Institute of Medical Sciences in New Delhi, all of which are public sector institutions and receive high grants<sup>20</sup>. In terms of scale of migration from these institutions, it has been found that 50% of graduates from Baroda University Medical College spent the majority of their most productive years in the USA<sup>49</sup> and at one time Bombay graduates constituted 11% of all Indian medical graduates in the USA<sup>20</sup>. Yet graduates from these schools are the very people who would be likely to get jobs at home even when there are surpluses<sup>20</sup>. The problem seems to be that the expectations of these graduates in terms of high salaries, logistical support and specialised research and development facilities cannot be met at home, particularly in rural areas<sup>20</sup>.

#### 4.2.3 Educational preparation more appropriate for practice in developed country

Somewhat similar factors appear to operate, at least, in some parts of the African region<sup>10</sup>. In Ghana, for example, high proportions of doctors emigrate, yet far more are produced annually (average 97) than medical assistants (average 30 per annum) who are much less expensive to train and invariably almost 100% retained. In part this seems to be because they are selected competitively, trained to international standards and tend to become the elite in society. Yet there is little technical support for them once they are trained. There may be an absence of research facilities and equipment to enable them fully to utilise their training, and many work locations lack libraries and the opportunity for internal conferences and access to knowledge of changing practices<sup>10</sup>. In light of this, the need to be recognised as being on par with international counterparts in developed countries means that a feeling of worth can usually best be derived when working overseas. This can also lead to increased status at home. Information collected from Malawi, for example, indicated that the public held nationals, including health professionals, working in other countries in high regard.

#### 4.2.4 Training of health professionals abroad/lack of local training facilities

Related problems arise when, through lack of capacity or provision of scholarships, health professionals undergo initial or higher/specialised training abroad in a developed country. In both the Pacific<sup>3</sup> and the African<sup>10</sup> regions it is clear that educating doctors and nurses abroad may also fail to prepare them adequately for the public health initiatives and rural

health services that form the basis of health systems in their home countries: tough screening and selection of the best students for medical and other professions result in the creation of elite professionals more primed to practice in an industrialised country<sup>10</sup>.

In the case of higher/specialised training, the planning of health services and training of professionals and specialists may not be adequately linked, so that professional skills are developed when facilities are not ready or visa versa<sup>10</sup>. The result for the individual is a tension between deriving job satisfaction from practising acquired skills and providing services and utilising knowledge well below what has been acquired. Alternatively students may specialise in areas of personal interest and expertise for which the country does not have the appropriate infrastructure and technology and find there are not suitable job opportunities when they return home<sup>10</sup>.

Furthermore, future development opportunities are often limited at home, so once away staff may try to benefit from as many other opportunities and experiences as possible<sup>10</sup>. The longer they stay away, the more incentives there may be to stay in the developed country: staff develop the trust and respect of colleagues; salaries are much higher; spouses and children get the benefits of more comfortable lifestyles and good education (possibly subsidised); and professional interaction and development are possible and recognised.

#### 4.2.5 Public sector spending cuts/low expenditures in health/health sector reforms

The restructuring of public spending following structural adjustment programmes in Africa has often included major cuts in expenditure for personnel<sup>5</sup>. In one African country, for example, the health sector reduced its workforce by about 25% during a redeployment exercise in the late 1980s and early 1990s. Similar policies of cost containment have been carried forward in the country's Five Year Programme of Work, published in 1996, that foresees a reduction in the wage proportion of recurrent budget from about 55% to 36% by 2001<sup>50</sup>. The effect has been to discourage the recruitment of staff into the public services and to restrict incomes<sup>10</sup>.

Similarly in the Caribbean, structural adjustment policies have brought about substantial reductions in government expenditure resulting, *inter alia*, in declining income and rising unemployment<sup>4</sup>. The consequent discontent is a major "push" factor in migration<sup>4</sup>.

#### 4.2.6 Bureaucratic excesses in employment processes

In many African Commonwealth countries bureaucracy seems to be the enemy of efficiency in public service organisations<sup>10</sup>. Even minor personnel management procedures are centralised, with recruitment and promotion processes and approval of minor welfare benefits for health professionals often involving several ministries and departments. Administrative processes are often not computerised and promotions and other service processes are carried out inefficiently, resulting in serious frustration of staff and their consequent lack of motivation.

#### 4.2.7 Occupational risks/poor working conditions

According to the International Labour Organisation (ILO), healthcare work is one of the most dangerous occupations<sup>51</sup>. Risks include the possibility of infection with dangerous diseases, physical harm caused by ill patients and relatives and the problems caused, for example, by looking after fighters on both sides in a war situation<sup>10</sup>. In most developing countries in the African region, protection for health workers is rudimentary, and many cases are not covered by health or life insurance policies<sup>10</sup>. In Ghana, for example, the cases of two

seriously ill young doctors who allegedly did not receive adequate treatment at home were extensively covered in the press and are thought to have created a feeling of insecurity among young doctors. Also well publicised have been a number of senior public figures taken abroad for medical treatment while junior doctors have felt their medical needs are not responded to. As the quality of services decline, health professionals are even more aware of the implication of hazardous illness while working for low salaries and with poor protective support. Specialists are few and far between and in the more remote areas may be several days journey away. Thus health professionals such as doctors may seek to ensure their health and that of their families by earning better remuneration and working in countries where medical services offer modern support systems.

#### **4.2.8 Lack of adequate social security, pension plans, and other benefits**

Pension systems in some countries in the African region, for example in Ghana, Tanzania and Sierra Leone, reflect the low salaries received and are considered to be quite inadequate<sup>10</sup>. Housing and healthcare may also not be adequately provided for (although currently in Ghana free emergency care exists for those aged 70 and over). Interviews with doctors in Ghana cite these factors as determinants in their decision to seek better remuneration abroad. In contrast, good social support systems are cited as one reason for retention of professionals in Namibia, compared with Lesotho (despite similar salaries), with Namibia having provisions for generous end of service payments, subsidised house owning schemes, car ownership and other benefits available for health professionals.

#### **4.2.9 Social and political insecurities, coup d'états, wars and dictatorships**

Dissatisfaction with disturbances and threats to life are also important in pushing people to new environments, although, overall, it may not be as important as the economic factors in stimulating migration of health professionals from within the African Commonwealth<sup>5</sup>. Sierra Leone has experienced a war situation in the last decade that has led to a large number of ordinary citizens and health professionals becoming refugees in neighbouring countries. Recent political tensions in Nigeria may also have created a feeling of insecurity that has fostered migration, although it is not clear whether the presence of Nigerian health professionals in many countries in the region can be directly linked to the political situation in Nigeria. Similar circumstances existed in South Africa, Zimbabwe and Namibia before independence when many black professionals lived and worked in other countries for political reasons. In one country in the African region the rule of the previous government was a factor mentioned by professionals refusing to return home<sup>10</sup>. Safety factors, including justifiable concern about danger to self, family and property in a society which is tribally based or divided either through racial difference or income level have also been noted as factors influencing the decision to emigrate in the Pacific region<sup>2</sup>.

### **4.3 “Pull” factors**

#### **4.3.1 Increased needs for health workers in other countries**

Shortages of health care professionals in some developed and developing countries can act as major “pull” factors for migration, particularly of nurses. In the Caribbean, for example, the cyclical shortages of nurses in the USA and more recently the UK have been observed to result in high impact marketing strategies in the region, causing loss of nurses and further exacerbating domestic problems for those countries that are already experiencing shortages<sup>4</sup>. As the metropolitan markets are now in another cycle of shortage of registered nurses, further

dynamic recruitment is anticipated<sup>4</sup>. In one country in the African region, formal private and public sector recruitment of nurses for the UK took place during 1997-99, including recruitment interviews by three UK National Health Service Trusts for general and psychiatric nurses during the first six months of 1999. A recruitment agency has since opened permanent offices in the country for this purpose. Similar recruitment has been occurring in other African countries<sup>5</sup>. In the Pacific region, recruitment drives were held in Fiji in 1999 to attract nurses to employment in New Zealand<sup>3</sup>. It remains to be seen the extent to which these trends will be altered in future by the growing recognition by developed countries that it is unethical to recruit actively where this might have an adverse effect on the healthcare systems of developing countries<sup>30</sup>.

Shortages of health professionals in developing countries occasioned by loss of professionals to developed countries can in turn result in developing countries recruiting professionals from other developing countries<sup>10</sup>. Jamaica lost a large number of nurses to the United States and Canada, so the Jamaican Ministry of Health and the University of the West Indies teaching hospital have sought to recruit nurses from Ghana<sup>10</sup> and Nigeria<sup>52</sup> where remuneration is lower than in Jamaica. In order to manage numbers, agreements were reached to send a certain number of nurses for a specified period. In the earlier agreement with the University of the West Indies, this was successful in ensuring that several nurses returned to Ghana immediately after the specified period ended<sup>10</sup>. However, there is anecdotal evidence that amongst 20 of one batch of 23 nurses who returned home, some 50% were subsequently trying to obtain visas to go to the United Kingdom<sup>53</sup>. Furthermore, in the Caribbean, the offer of better terms and conditions of service to nurses recruited from Ghana and Nigeria is an area of great dissatisfaction amongst local nurses<sup>52</sup>.

#### 4.3.2 Opportunities for jobs

Shortages in specific fields of work or locations that cannot be filled by residents in a country may also act as "pull" factors for migration or provide job opportunities for new immigrants that allow them to stay. For example, specific shortages seem to be the reason for the UK seeking to recruit psychiatric nurses from countries in West Africa, and in the United States doctors can apparently receive waivers of training visas if service is provided in remote regions and in Native American Reservations<sup>10</sup>.

In Namibia, about 50 % of all doctors in the public service are foreigners<sup>10</sup>. However, in the rural regions the proportion rises to about 90%. A similar situation arises in Lesotho with the majority of public service doctors (68%) in both mission and government hospitals being expatriates<sup>33</sup>. In contrast, in the Pacific region, although the problem of insufficient medical staff has been addressed by the recruitment of relatively large numbers of expatriates, these people generally refuse to go to the rural areas so their employment is limited to the urban areas in divisional and sub-divisional hospitals<sup>3</sup>.

#### 4.3.3 Salary differentials

The differential in salaries between developed and developing countries is huge and it is difficult for most countries to bridge this gap to encourage retention<sup>10</sup>. For example, the average monthly salary of a resident doctor in Ghana is US\$ 200 compared to US\$ 3000 in the United States. Yet not all countries where incomes are low compared to developed countries experience migration losses. In Namibia, for example, migration is not an issue despite only slightly smaller salary differentials with the United States than in Ghana and it has been suggested that terms and conditions of service that include housing, car loans and

other support systems may reduce the attractiveness of migration<sup>10</sup>. Alternatively it may be that where incomes are low emigration only takes place when supply is high relative to the amount of money available for salaries<sup>2</sup>. Then the salary differentials determine the direction of migration<sup>2</sup>.

#### 4.3.4 Provision of scholarships, fellowships and grants to be utilized in developed countries

As mentioned earlier, the availability of sponsorship or donor aid for out of country education seems to be one of the most important factors in the migration of health professionals from the Pacific region<sup>3</sup>. The same appears to be true in the African region<sup>10</sup>. As part of aid programmes to developing countries, several scholarships/fellowships are available for training in more advanced countries. In Lesotho, for example, the non-return of professionals awarded such scholarships/fellowships is quite high<sup>10</sup>. The new qualification increases the chances of a better job in another country and provides opportunities for additional training or work experience, opportunities to seek jobs there and opportunities for the development of professional links that may in future lead to migration.

#### 4.3.5 Career and intellectual enhancement opportunities

Many doctors interviewed in Ghana felt discontented about career opportunities that were considered to be unevenly available or implemented with bias<sup>10</sup>. As training slots are few, career or intellectual development becomes very frustrating for young health professionals who feel that colleagues selected for these opportunities quickly become respected specialists who are well acknowledged in their institutions whilst others take years to achieve professional recognition. This may provide a spur for migration.

#### 4.3.6 Technical support for intellectuals

The presence of research facilities and opportunities, as well as equipment to fully utilise professional training and experience, is likely to be a major pull factor for health professionals and health academics<sup>10</sup>. For example, the only cardiac surgeon in one African country was probably retained because of the availability of an up-to-date and fully functioning cardiac centre<sup>10</sup>. Many workplaces lack libraries and the facilities for internal conferences and access to knowledge of changing practices. Without these, and the attendant opportunities for regular debate and access to new information, professional staff may be attracted to other countries where such facilities do exist.

#### 4.3.7 Freedom from political and administrative interference

Professionals may be attracted to pursue their occupations in places where there is an absence of harassment. In the African region, at times there seems to be routine and casual interference by administrative and political leadership of countries in the running of services<sup>10</sup>. High-level corruption may influence procurement of technical equipment and other logistics, leading to inappropriate tools and supplies in health facilities. Furthermore, health workers and their representatives may not be involved in the decisions on services. Implementation of flawed decisions can lead to extreme frustrations and result in migration of staff to countries that are perceived to have better governance and transparency.