

BRAIN DRAIN AND CARE DRAIN: RESPONSIBILITY OF THE NORTH?

Abstract

The migration of educated, skilled and professional workers from countries of their origin in the developing world to more developed countries in search of better standards of living and quality life, higher salaries, access to advanced technology and more stable political conditions termed as brain drain is a well known phenomenon for decades.

Now, a trend that is less well known, but which is becoming increasingly visible and equally troubling, is the "care drain" - the migration of women from developing countries, where they perform the bulk of care work unpaid, to the developed world, where they can do the same work for pay. The care for children, frail elders, the disabled and chronically ill has emerged as a key policy challenge around the globe. Rising rates of female labor force participation, combined with declining birth rates and rapidly aging societies, have disrupted conventional divisions of labor that assigned care work primarily to women.

Care drain, involves hands-on physical ministrations. It often requires workers to live in the homes of their employers and tends to be conflated with domestic service. Widely regarded as unskilled (though many in the field would dispute this), it is usually low-paid and often, because it is performed in isolation, can become a site for the exploitation and abuse of workers. Care work is also perceived as a dirty, difficult and dangerous work that is widely avoided by native-born workers in developed societies. But women from developing countries where local employment is scarce see it as an opportunity. It is also associated with human trafficking, sex slaves and consequently is a form of modern exploitation.

This migration of professionals seeking for better opportunities is of great concern today worldwide, both from within countries and across international borders due to its impacts on developing countries. The number of professionals and women joining brain drain and care drain respectively has reached a peak in recent years in apparent response to huge demands emanating from developed countries. These demands were associated with demographic changes, aging populations as well as reduction in recruits. Why do professionals leave their countries or place of work and go elsewhere searching for better opportunities? What are the consequences of such migration with regard to care delivery? Why Visa is affecting the developing countries? What policies can be adopted to stop such movements from developing countries to developed countries?

It is now estimated that the proportion of foreign born people in developed countries has tripled since 1960, and the emigration of high skilled people from developing countries has accelerated. Many developed countries tend to attract and retain foreign students which in turn increase the risks of brain drain in the sending countries. On the one hand, brain drain causes labour shortages, and affects fiscal policy, but on the other hand it can also generate remittances and other benefits from expatriates and returnees!! Generally, brain drain is a curse for developing countries as it has been claimed!

The impact of brain drain and care drain on a source country's welfare and development can be beneficial or harmful. But evidence shows that many developing countries are more losing than gaining through this phenomenon.

Introduction

Brain Drain Explained

The term "brain drain" refers to international transfer of human capital resources, and it mainly applies to the migration of highly educated personnel from developing countries to developed ones. Brain drain can also mean the exodus of skilled and qualified professionals out of certain areas in search of better working conditions, salaries, and quality of life. In a narrow sense the term is used to denote the migration of engineers, physicians, scientists and other highly skilled professionals with university training to developed countries. Comparative data show that by 2000 there were 20 million high skilled immigrants (foreign born workers highly educated) living in members countries of the organisation for Economic Cooperation and Development (OECD), a 70% increase in ten years. Two thirds of these immigrants came from developing and transitional countries (Docquier, F. 2014). These are people who were supposed to provide quality health care to the community and now they are doing this in developing countries (care drain)

In the 1970s, the World Health Organisation (WHO) 2004; 82:624-5, published a detailed 40 country study on the magnitude and flow of the health professionals. According to this report, close to 90% of all migrating physicians, were moving to just five countries: Australia, Canada, Germany, UK and USA. **Is the scenario today different? Have health professionals stopped moving to developed countries searching for better living life, high salaries and access to advanced technology and more stable political conditions from developing countries?** It is said that the main donor countries for brain drain reflect colonial and linguistic ties!! **What are**

your opinions? But also evidence shows that highly skilled health professionals migrate from rural areas to urban areas within a given country.

The world economic recession in the 1980s left many African countries destitute as they experienced large drops in national incomes. As a result in order to finance the provision of social services, most countries turned to external borrowing (World Bank 1991). The external borrowing led to increased debt which resulted in preventing countries from allocating a large part of their budgets to health education, and infrastructure development. Many Nongovernmental organisations (NGO) rose as alternative means of providing social services to the public (World Bank 1998). Development aid was channelled through these NGOs which offered better pay and working conditions that lured professionals from the declining public sector.

In Tanzania, the health system suffered from lack of training and poor motivation of doctors and health workers, shortage of supplies, and inadequate management. The quality of hospital care declined and clinics became crowded.

Types of Brain Drain

- i. Global level: Migration of skilled and qualified medical professionals from developing countries to developed countries.
- ii. National level: migration of skilled and qualified medical professionals within the country from rural areas to urban areas to work and from public sectors to private sectors because of high pay and vice versa.
- iii. “Brain waste: refers to the migration of skilled and qualified medical professionals from the health sector to other sectors of work

NB: all three types of brain drain contribute to shortages of skilled and qualified medical professionals in certain areas worldwide and thus affecting the quality of health care delivered to the population. This migration of skilled and qualified health professionals has contributed to the fragile African health system.

Global situation

In 2006 there was a global shortage of 4.25 million doctors, midwives, nurses and support workers (WHO 2006a). 57 countries reported acute shortages, and 36 out of the 57 were in Sub-Saharan Africa (United Nations 2010). The United States and Canada have 37% of global skilled and qualified health professionals whereas Sub-Saharan Africa has only 3% of skilled and qualified health professionals worldwide

but carries 24% of the global burden of disease (Mmbando 2009). In order to decrease this burden of disease, health professionals must be available to give care. The United Kingdom, United States and France have the highest number of doctors from abroad.

Table1: Native African Physicians working domestically and abroad

Sending Country	Domestic	Receiving Country									Total Abroad	%
		UK	US	France	Canada	Australia	Portugal	Spain	Belgium	South Africa		
Tanzania	1'264	743	270	4	240	54	1	1	3	40	1'356	52
Kenya	3'855	2'733	865	0	180	110	1	4	1	81	3'975	51
South Africa	27'551	3'509	1'950	16	1'545	1'111	61	5	0	-834 ^p	7'363	21
Malawi	200	191	40	0	0	10	2	1	1	48	293	59
Botswana	530	28	10	0	0	3	0	0	1	26	68	11
Somalia	310	53	70	0	25	3	0	0	0	0	151	33
Mozambique	433	16	20	0	10	3	1'218	4	2	61	1'334	75
Ethiopia	1'310	65	420	16	30	9	1	1	2	9	553	30
Algeria	13'639	45	50	10,594	10	0	2	60	99	0	10'860	44
Egypt	14'555	1'465	3'830	471	750	535	1	17	31	19	7'119	5
Africa ^b	280'808	15'258	12'813	23'494	3'715	2'140	3'859	1'096	1'107	1'459	64'941	19
Sub-Saharan Africa	96'405	13'350	8'558	4'199	2'800	1'596	3'847	173	696	1'434	36'653	28

Source: Clemens and Pettersson (2008, 8).

Note: The table shows the number of physicians in some African countries who are working within the country and those who have moved to work outside their country of birth. Data for France are from 1999; data from the United States are from 2000; data from the rest of the countries are from 2001.

- a) Number of physicians born in the eight receiving countries and working in South Africa.
- b) Total number of physicians born in Africa who are working in their respective countries and those who migrated.

Situation in Africa

It is difficult to estimate the number and effects of migrating skilled and qualified health professionals because there is no reliable data from the sending countries. Brain drain jeopardises the delivery of health care in many ways, with doctors and nurses making up a majority of the 20'000 health professionals that leave Africa annually (Barka and Ofori Sapong n.d).

According to the WHO 2006a the minimum standard to ensure basic health care services is 20 physicians per 100'000 people. Developed countries enjoy 222 physicians per 100'000 while Sub-Saharan Africa falls short of the minimum standard, and 13 of these countries have 5 or fewer physicians per 100'000 people.

Tanzania and Malawi have the lowest doctor patient ratio, with only 2 doctors per 100'000 people. **What is the current situation with increased production of doctors and nurses in recent years!!**

Countries receiving skilled and qualified health professionals seem to save money by not having to train their professionals. According to Mmbando (2009), 130'000 international medical graduates have saved the US more than US\$26 billion in training. However, these savings come at the expense of countries that trained them. Tanzania, for example, pays for some of its medical students to attend college in two different ways. First, those who excelled in their advanced level education can receive full scholarships. Second, some students receive no interest loans of various amounts, depending on need. These investments become economic losses if the students decide to leave the country to work elsewhere. The loss is, however, more than economic. Coming on top of Africa's high burden of disease and initial low production of health professionals, the transfer of personnel leaves the health system ill equipped to handle its patient burden and hinders the continent's development.

The situation in Tanzania

In 2006 the WHO identified Tanzania as experiencing a critical shortage of health workers (United Nations 2010). Medical professionals in Tanzania are both moving out of the country and moving from rural areas to urban areas. As of 2000, about 52 percent of Tanzania's native-born doctors were working abroad (Clemens and Pettersson 2008). Tanzania has 1'264 native-born doctors working in the country and 1'356 working abroad. In contrast, only 4 percent of Tanzania's nurses are working abroad, a much lower percentage than many of its Sub-Saharan African neighbors (Clemens and Pettersson 2008). Still, Tanzania is greatly affected by the migration of its health professionals, especially doctors, out of the country.

The economic loss to the country is also significant. The Tanzanian government spends US\$27'256 to train each medical student from primary school through medical school. It is estimated that Tanzania has spent US\$3.49 million to train Tanzanian-born doctors who are currently practicing in Australia, Canada, the United Kingdom, and the United States (Mills et al. 2011). Migration of health workers from rural to urban areas is a growing concern, and the shortage of workers in rural areas is severe. In Tanzania, "the capital city of Dar es Salaam alone has nearly 30 times as many medical officers and medical specialists as any of the rural districts" (Anyangwe and Mtonga 2007, 95). A study conducted in Tanzania showed how this

understaffing in rural areas increased the work burden on health workers in these areas. One female auxiliary nurse explained, “Say at every centre you have got one nurse and one doctor. If it happens that the doctor faces a problem the nurse will be alone. Now she will do the cleaning and dispense drugs and deal with patients.... You often find that work to be done by two or three people is performed by a single person” (Manongi , Marchant, and Bygbjerg 2006, 4; Muula 2005). This poor quality of care contributes to Tanzania’s burden of disease and disability, which are disproportionately found in rural areas.

The Causes of the Brain Drain and Care Drain

The exodus of health professionals depends on their personal values as well as an interplay of complex social, political, and economic forces both in the sending and receiving countries. The underlying driving force is the weak health system with poor infrastructure and minimal equipment in the sending countries.

Push factors

We identify as “Push” those factors that occur within the sending country, motivating skilled and qualified health professionals to leave. Push factors in developing countries like Tanzania are low salaries (low remuneration), poor working conditions, including lack of incentives, political and ethnic problems as well as civil strife and poor security. Poor governance (or perceived poor governance) is an important issue for professionals to work elsewhere. The lack of adequate technology and equipment to perform professional tasks for which staff are trained will automatically reduce job satisfaction.

Pull factors

Pull factors are the deliberate and/or unintended actions that attract skilled and qualified health professionals originating from the recipient country policies and actions. Thus pull factors in developed countries, that is countries that receive health professionals are higher salaries, better living standards and facilities. They may arise because of increased demand for health professionals in developed countries (e.g aging populations requiring more care) and economic.

Six gradients

It is a combination of both “push” and “pull” factors that lead to a threshold decision to migrate. The combined “push-pull” ingredients is described in terms of the gradients between situations in the country of origin of the health worker and in the receiving country:

The Income Gradient: the differential in salaries and living conditions between the home and recipient countries

The Job Satisfaction Gradient: the perception of good professional working environment, skills utilisation and technical proficiency that allows international recognition

The Organisation Environment / Career Opportunity Gradient: Health professionals see opportunities for advancement in careers and in specialisation that are fair and accessible. A fair well governed environment for human resource management will help to attract and retain staff

Governance Gradient: it is linked to organisational environment as discussed above and to the level of administrative bureaucracy and the differences in efficiency with which services are managed

The Protection/Risk Gradient: there is some indication that the lack of protective gear and a perceived increased occupational risk from HIV/AIDS when working in Africa, compared to that receiving countries, plays a great role in the decision to leave and work abroad

Social Security and Benefits Gradient: health professionals are concerned with basic comforts during their working life and with security after retirement. Retirement and pension benefits are important motivating factors.

In a nut shell, the following are the contributing factors for brain Drain in Tanzania:

Push: Socioeconomic factors and professional opportunities

Pull: demand in the receiving countries, networking and good living conditions

Effects of the Brain Drain and Care Drain

In Tanzania for example brain drain and care drain have severely affected the distribution of skilled and qualified health professionals and consequently contributing to the weakening of the fragile health system. On the other hand, the flow of remittances has helped some families cope with the increasing cost of living. However, the balance between benefits and burdens is unequal, with developed countries benefiting at the expense of tax payers in Tanzania.

i. Benefits to sending countries

- Financial remittances from workers that have migrated. However, it is difficult to estimate as the transfer of money to Tanzania is done through informal channels
- Professionals who practice in developed countries receive training and experience that may be unavailable in their home countries and may return to their home countries with these new skills. This migration and exchange of knowledge allows professional networks to form between developed and developing countries (Hooper 2008, 685)

ii. Burdens to sending countries

- The migration of medical professionals results in a lack of personnel in the abandoned areas. Rural areas house half of the world’s population but less than 25 percent of doctors and only 38 percent of nurses (United Nations 2010).
- The low doctor-to-patient ratio in developing countries, as discussed previously, shows the unequal global distribution of medical personnel, creating a severe deficiency in care in developing countries.
- Potential loss of tax revenues.
- The government loses its return on an investment made, given the high percentage of government spending on education. Every time Tanzania loses a health professional, it costs the country about US\$27,256 that was invested in education, while the developed country saves on education spending.

iii. Effects on Medical Professionals

- Brain drain affects medical professionals themselves. Those who stay behind often are overworked and overburdened because of the large case load and worker shortage.

Co
pi
ng
St
rat
egi
es

In a nut shell brain drain in Tanzania has the following effects:

- *Increased burden of disease*
- *Poor quality of health care services*
- *Economic loss e.g. tax revenue*
- *remittances*

Countries have attempted to cope with these problems through:

- i. International recruitment and inter-country arrangements: Many countries in Africa such as Botswana and South Africa have recruited from other countries within and without the continent. Tanzania also recruits expatriates from within and outside the continent
- ii. Extended Retirement age: Tanzania formerly compulsory retirement age was 55 but it was extended to 60 years. But after 60 years health professionals are allowed to extend their employment through contractual arrangements up to 65 (of two years, then two year and lastly one year). But still it can go beyond depending on the local institution where the health professional works.
- iii. Bonding or Compulsory Service Schemes: but this has not worked very well due to poor administrative efficiency of HR management systems in public service
- iv. Skills substitution and Delegation: a variety of locally designed health professionals can be found in Africa. For example, the cadre of Clinical Officers – in Malawi, Zambia and Tanzania; Surgical and Medical technicians in Mozambique; Assistant Medical Officers in Tanzania. In general terms the traditional health professionals do not easily acknowledge the efforts done by these groups
- v. Incentives and Motivation Systems: salary levels as the basic factor to retention; then topping up and responsibility allowances; and provision of housing facilities, transport and airtimes.
- vi. Return Management: The International Organisation for Migration and some countries have tried encouraging professionals in diaspora to return to their home countries.

Policy Options

Individuals' right to move (as they please) conflicts with the need to compensate sending country governments for the loss of professionals. Tanzania undeniably suffers from a severe lack of healthcare professionals, and therefore an increased burden of disease. However, an **intertwined structure of pull and push factors**, along with the professionals' own motivations, result in high emigration from Tanzania. Even within the country, rural areas disproportionately struggle with lack of staff and NGOs pull professionals to the private sector. Because this brain drain exists at so many levels, solutions are neither straightforward nor simple. ***In addition,***

the lack of data, especially from the sending countries, makes measuring the exact scope of brain drain difficult. Brain drain is also affected more broadly by the economic and structural changes in the country as a whole. Global and national policy options exist to ameliorate Tanzania's brain drain.

In Tanzania more health professionals need to move to rural areas to close the gap between rural and urban areas and improve rural health care. There is need of concerted efforts by all ministries to create conducive working and living environment in rural areas, affecting not only health professionals, but all rural residents. Additionally, in order to improve on the working conditions of health professionals, administration in the health sector needs to be **decentralized**. Instead of a centralized funding system, lower-tier health facilities should be in charge of their own procurement process, which would meet their own needs. Let there be incentives given to health professionals to work in rural areas. Put a system in the country to track doctors inside and outside the country

Conclusions

Skilled and qualified health professionals who have emigrated for several reasons are recoverable assets who can play a great role providing quality health care which was drained in developing countries. However, recovery requires the opening of diverse and creative conduits. The health services in developing countries must be supported to maintain their skilled personnel. Global and national policy recommendations should balance health professionals' right to move with the need to compensate sending countries for the money spent to train these professionals. A solution will require the cooperation of both sending and receiving countries' governments and, within the country, the public and private sectors.

There is need for various sectors within Tanzania to strive in order to improve the working environment, living conditions, and family ties to provide incentives for health professionals to remain in currently understaffed areas.

+ Thaddaeus S. Ruwa'ichi OFMCap
Archbishop of Mwanza