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The flight of physicians from West Africa: Views of African physicians and implications for policy

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Abstract

West African-trained physicians have been migrating from the sub-continent to rich countries, primarily the US and the UK, since medical education began in Nigeria and Ghana in the 1960s. In 2003, we visited six medical schools in West Africa to investigate the magnitude, causes and consequences of the migration. We conducted interviews and focus groups with faculty, administrators (deans and provosts), students and post-graduate residents in six medical schools in Ghana and Nigeria. In addition to the migration push and pull factors documented in previous literature, we learned that there is now a well-developed *culture* of medical migration. This culture is firmly rooted, and does not simply fail to discourage medical migration but actually encourages it. Medical school faculty are role models for the benefits of migration (and subsequent return), and they are proud of their students who successfully emigrate.
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Introduction

West African physicians have been migrating away from their sub-Saharan home countries since the first medical doctors were trained there in the middle of the 20th century. They go in search of what they describe as "greener pastures"—better working conditions, better pay, and better training and research opportunities. They leave behind communities in desperate need of not only the health services, but also of the leadership and stability that physicians provide to a health system's development.

There are at least 11,000 sub-Saharan African physicians known to be licensed and practicing in the UK, US, and Canada (Lynda Buske, Canadian Medical Association, personal communication, 2/3/03; Bonnie Sibbald, University of Manchester, personal communication 1/24/03; American Medical Association, 2002 data). Physician migration from West Africa, in particular, has accelerated dramatically over the last 20 years. While other countries (for example, India and the Philippines) contribute greater *absolute* numbers to the pool of international medical graduates

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(IMGs) in the US and other rich countries (as defined by the World Bank), the *proportion* of African-trained physicians now practicing in these rich countries is high.

Indeed, if the 515 American and Canadian physicians from Ghana were to return to their country of training, the total physician workforce there would increase by 32.2% above its current 1600 physicians. A 1999 study estimates that of the 489 physicians graduated from the University of Ghana between 1985 and 1994, fewer than 40% remained in the country, with more than half (54.9%) in the UK, and about a third (35.4%) in the US (Dovlo and Nyonator, 1999). In the year 1981, there were 202 physicians in the US who were trained originally in Nigeria or Ghana, but by 2002 that number had grown to 2636—a 1200% increase (American Medical Association, 2002).

This paper reports on a collaboration between American and African researchers in Ghana and Nigeria to review the causes and consequences of physician migration from Africa, based largely on the views of faculty and students in medical schools.

Physician migration generates three areas of concern. The first is a loss of health services available to the populace. Health ministry representatives in Ghana reported, for example, there are no more than 22 pediatricians licensed in the entire country of Ghana, and there are no more than 10 specialists of any kind practicing in the primarily rural region north of the capital city, Accra.

The second effect of physician migration from Ghana and Nigeria is that it diminishes the health sector's ability to organize and expand. Health sector institutions rely heavily on physicians to lead, develop and promote them as they work to advance the public's health. As in the US, physicians are well positioned to serve their organizations by competing for resources, articulating priorities and attracting staff. We speculate that as the number of physicians shrinks, the health system itself contracts, contributing to a vicious circle of factors leading to health institution contraction and implosion.

The third problem is that physician migration depletes an important element of the middle class in West Africa. As in the US and UK, African physicians comprise an important segment in the social and economic make up of the middle class. They are generally respected as being above corruption, they advocate for quality public schools, they provide a market for consumer goods, and they contribute to political, social and economic stability. In Ghana, 44.8% of the population lives on less than $1 per day, and in Nigeria, 70.2% (World Bank Development Data Group (n.d.), 2004). As the loss of physicians reduces the middle class, it can increase the proportion of the population living in poverty.

Background and context

The history of Ghana positions its citizens well for migration. The first African country to achieve independence from European colonization on the subcontinent (1957), Ghana has distinguished itself in the region with relative political stability and fairly universal availability of primary and even secondary education. To this day, Kwame Nkrumah, Ghana's independence movement leader, remains a pan-Africanist hero.

The British first came to Ghana in 1829 to take control of Portugal's Elmina slave castle in the town of Cape Coast, west of the capital city of Accra on the Atlantic ocean. The castle was built in 1482 as a staging area for slaves captured from throughout West Africa.

The first attempt to provide organized western health services came in 1878, when the British established a civil hospital for Europeans in what is now the capital city of Accra (Addae, 1997). A scholarship scheme in the 1930s was established to train African medical doctors in the UK—thus planting the seeds for the first physician migration. Nigeria was able to establish a medical school before independence (at Ibadan, in 1952), but Ghana did not form a medical school until 1957. For at least 20 years, medical schools in both Nigeria and Ghana officially included a UK study abroad component. The non-indigenous nature of African medical school training programs has equipped its graduates for global migration from the very beginning.

The 1200–1600 Ghanaian physicians practicing in their home country (numbers vary by source) serve a population of 20 million, for a ratio of about 8 per 100,000. Nigeria (the most populous country in Africa) has 23,000 physicians for its population of 124 million people, a ratio of 18.5 physicians per 100,000. These numbers compare to ratios of 164 physicians per 100,000 in the UK, and 279 per 100,000 in the US (see Table 1). In all countries, however, the ratios mask maldistribution, with far fewer physicians practicing in rural areas and inner city locations than in sub-urban and higher-income locations.

The Ghana Health Ministry says its goal is to produce and retain sufficient physicians to create a ratio of 20 doctors for every 100,000 people by 2006 (Ministry of Health, 2002). However, the number of additional physicians required to meet the goal (1865) is greater than the current supply of physicians in the country.

The importance of medical practitioners to Africa is further underscored by the notoriously low-population health status on the continent, particularly in sub-Saharan Africa. While health improvements in Africa will require a broad agenda of development activities, access to an educated workforce of health professionals is also essential (Eckhert, 2002).

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