Brain Drain: Why are Cameroonian Medical Doctors Leaving?

By Dibussi Tande

The news from the Ministry of health was quite gloomy. In a special report that appeared in the Cameroon Tribune last week, it was announced that Cameroon’s medical system was in crisis due to a severe shortage of medical doctors resulting from the massive exodus of Cameroonian MDs to countries in the developed world.

According to the report, about 5000 Cameroonian medical doctors are currently plying their trade abroad (with about 500-600 in the US alone, according to the Minister of Health). In an interview with Cameroon Tribune, Pr. Tetanye Ekoe, the Vice President of the National Order of Medical Doctors in Cameroon, reveals that some 4200 MDs reside in Cameroon. However, this is only half of the story; of the 4200 listed on the rolls of the Order, only about half are actually practicing MDs. About 1000 are on secondment to the Ministry of Health where perform a variety of tasks, including purely administrative ones. The rest are either with the Faculty of Medicine and Biomedical Sciences, of University of Yaoundé I, with NGOs, or with the private sector. The nearly 1500 MDs in the private sector handle less that 10-15% of patients.

Pr. Ekoe points out that the limited number of practicing MDs in the country makes the official national doctor-patient ratio of 1 doctor per 10,000 inhabitants largely meaningless. He reveals that the real ratio is closer to 1 doctor per 40,000 inhabitants, and that in remote areas such as the Far North and Eastern Provinces, the ratio closer to 1 doctor per 50,000 inhabitants.

Unfortunately, the country’s lone faculty of medicine is unable to meet internal demand because it produces only about 100 MDs annually. To make the already bleak situation worse, the IMF and World Bank have imposed hiring quotas (which do not take retirements and death into account) that limit the number of MDs who can be integrated into the public service each year. The result is that some foreign-trained MDs actually return home to find out to their horror that they cannot be employed…
So the internal pool of MDs continues to shrink as more Cameroon-trained MDs move on to greener pastures in the West, while Western-trained MDs don’t return home.

**The Brain Drain at a Glance**

In its 2006 World Health Report, the World Health Organization (WHO) uses data from the 30-member Organisation for Economic Co-operation and Development (OECD) to shed light on the medical brain drain phenomenon in sub-Saharan Africa:

It appears that doctors trained in sub-Saharan Africa and working in OECD countries represent close to one quarter (23%) of the current doctor workforce in those source countries, ranging from as low as 3% in Cameroon to as high as 37% in South Africa. Nurses and midwives trained in sub-Saharan Africa and working in OECD countries represent one twentieth (5%) of the current workforce but with an extremely wide range from as low as 0.1% in Uganda to as high as 34% in Zimbabwe (p. 99)

According to the report, 109 doctors trained in Cameroon are currently working in OECD countries (p. 100)

The effects of this migration are disastrous according to the WHO report:

“… when large numbers of doctors and nurses leave, the countries that financed their education lose a return on their investment and end up unwillingly providing the wealthy countries to which their health personnel have migrated with a kind of “perverse subsidy” (23). Financial loss is not the most damaging outcome, however. When a country has a fragile health system, the loss of its workforce can bring the whole system close to collapse and the consequences can be measured in lives lost. In these circumstances, the calculus of international migration shifts from brain drain or gain to “fatal flows”. (p. 101).

If the statistics above are to be trusted (and there is no reason not to trust them), then the situation in Cameroon and most of sub-Saharan Africa, has shifted from simple brain drain to that of “fatal flows” with a wide scale system collapse a potential reality.
To begin to adequately address the problem, we must start by clearly understanding the reasons that push MDs to leave and why others are not returning home after their training in foreign countries.

**Why they are leaving**

Although the *Cameroon Tribune* special report touches on some of the factors that contribute to the prevailing situation, it tries too hard to sell the patriotism angle, i.e., in spite of the hardship, Cameroonian MDs should be more patriotic and be willing make sacrifices for their country. This, in my opinion, is a rather simplistic analysis of the problem, which can only lead to equally simplistic solutions that will resolve nothing.

In its analysis of the reasons that cause the brain drain, The WHO report states that:

Classically this is provoked by a (growing) discontent or dissatisfaction with existing working/living conditions – so-called push factors, as well as by awareness of the existence of (and desire to find) better jobs elsewhere – so-called pull factors. A recent study from sub-Saharan Africa points to both push and pull factors being significant. Workers’ concerns about lack of promotion prospects, poor management, heavy workload, lack of facilities, a declining health service, inadequate living conditions and high levels of violence and crime are among the push factors for migration. Prospects for better remuneration, upgrading qualifications, gaining experience, a safer environment and family-related matters are among the pull factors.

In Zimbabwe, for example, a startling 77% of final university students were being encouraged to migrate by their families (13). Beyond the individual and the family, accelerated globalization of the service sector in the last two decades has helped drive migration in the health field (14–18). In addition, there is a growing unmet demand for health workers in high income countries due in part to rapidly ageing populations. Two important responses in the global market are occurring. First, a growing number of middle income countries are training health workers for international export and second, professional agencies are more actively sourcing workers internationally, raising questions about the ethics of recruitment. (p. 99).
The first step
Understanding and accepting these reasons – which have little or nothing to do with patriotism or a lack thereof -- gives Cameroonian policy makers a better chance of tackling the brain drain issue head-on.

In a paper presented at the international seminar on International Dialogue on Migration, Jorge de Regil & Mel Lambert have a word of advice for countries such as Cameroon which are suffering from the migration of indispensable health resources:

Governments have to be more open and honest about the reality of migration of human resources for health in the country…Given the choice most people would prefer, all things being equal, to remain in their home country. Consequently, in devising policy solutions to migration, making a country a good place to work and to live in must be the starting point: developing a culture where advancement (in education or professional life) depends on quality, not on political affiliation, race, religion, national origin, etc.

Cameroon must therefore go beyond the blame game and look at effective and viable internal solutions to the problem. For example, the Government can seek a moratorium on current Bretton Woods hiring quotas for medical doctors on national security grounds. Or simply go against IMF and World Bank recommendations. There is a precedent here. In 1991, for example, the Government created five new universities in the country, against the specific which the Bretton Woods institutions which argued that the country could ill afford such an expensive venture. 15 years later, there is hardly anyone in Washington who still believes that the creation of these universities was a bad idea.

Without doubt, the medical profession in Cameroon has lost its erstwhile glory and part of the effort to stem the tide of migration must include making it attractive once more in terms of salary, career growth, and social mobility. As long as the situation where a Policeman with a high school diploma earns as much, if not more than an MD persists, the brain drain will continue. According to the e-Africa online journal (Sept. 2003), the government of South Africa set aside R500 million in 2003 and R750 million in 2004 “to adjust the salaries of public-sector doctors and expand the number of rural medical jobs”.

There are a plethora of possible solutions such as this one proposed by Regil and Lambert:

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Developing countries need to try harder to entice their high skilled healthcare professionals back. This could be done, for instance, through schemes where top public officials in countries have their public sector pay ‘topped up’ through aid assistance schemes so as to encourage them to stay. Schemes could be developed were medical expatriates are brought back for a period of time to impart skills on the home population. However, any such schemes need to be sustainable in their own right and not create artificial situations that could dry up as soon as any funding ends.

In search of global solutions
Beyond what could be termed the “classical solutions” to the brain drain, African governments must craft global, bold, innovate and effective policies that go beyond the case of MDs. Even though theirs is the most visible case, the situation is equally critical across the board. In Cameroon, for example, about 25%-30% of professionals trained in the country are working abroad while 70-80% of Cameroonians trained abroad do not return home after their education.

Creativity is in order. Hence, asking the Diaspora community to visit Cameroonian embassies abroad or the website of the Prime Ministry for possible job opportunities in the country, as Prime Minister Inoni did during his July 2005 visit to the United States, shows a lack of vision and innovation.

In the long run, Cameroon may probably have to turn for inspiration to countries such as Nigeria, Ghana, South Africa and the Philippines which are tackling the brain drain crisis in the most innovative manner possible.

“Nigeria has a special assistant to the president for the diaspora. Senegal created a ministry of foreign and diaspora affairs. Ghana changed its laws to allow dual citizenship to make it easier for the diaspora to return… One lesson from Ghana’s effort is that if Africa wants émigrés to return, the process must be easier. In particular, spouses and children born abroad should have the opportunity to claim citizenship easily and be allowed to maintain dual citizenship to make it easier for émigrés to continue to conduct business. The Ghanaian embassy in Washington maintains a computer skills bank on its nationals working in the US.” (e-Africa, September 2003).
In 1995, the Filipino government established the Philippine Overseas Employment Administration charged with promoting the return and facilitating the reintegration of migrants. The Employment Administration offers privileges to returning Filipinos such as loans for business capital at preferential rates and eligibility for subsidized scholarships. (101).

There are dozens, if not hundreds of solutions that have been tested around the world. If Cameroon is serious about the brain drain issue, it knows where to start rather than trying to reinvent the wheel…

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