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InternationalLaborMobility

PAPER TRAILS...

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The migration of MENA health workers: Current understandings, data gaps, and considerations for moving forward

CONTENTS

ABOUT PAPER TRAILS

The International Labor Mobility (ILM) discussion note series, *Paper Trails*, provides an opportunity to highlight ongoing work, discuss emerging findings, and share ideas to build stronger migration systems. The series is intended to spur debate and discussion. To share your thoughts, please refer to contacts on the last page.

The migration of healthcare workers from poor to rich countries is a highly controversial topic within the migration and development discourse. Conventional wisdom has often stressed the negative effects of these movements, noting that they not only pose the threat of substantial human capital and financial losses to sending countries (so-called "brain" and "fiscal" drain), but also risk crippling the delivery of healthcare services to areas with severe public health concerns. Recently, a growing literature has placed these conclusions into question, illustrating that the migration of health workers may not always be as one sided and deterministic as commonly imagined. Indeed, the effects of these movements depend largely on the individual circumstances of migration. Determining who really "wins" and "loses" (so to speak) demands the collection of robust data on who migrates, at what moments during their lives, where/how they are trained, and where they seek employment, in addition to the conditions at the origin and destinations.

Following this line of thinking, this discussion note assesses the current understandings of health worker migration affecting the Middle East/North Africa region (MENA). It particularly aims to draw attention to knowledge gaps that inhibit a more informed and comprehensive understanding of the impacts of these skilled movements. Two sections divide this note. They highlight the minimal information available on MENA health worker movements, their destinations, as well as their training circumstances and sources of training funding. They also point to the critical data gaps that exist in these areas, and discuss how filling these gaps is a precondition for fully understanding how the human capital and financial benefits and burdens of MENA health worker migration fall across sending and receiving countries. This note concludes by stressing that effective policymaking in this area requires more comprehensive and nuanced information about who moves, where/when they go, under what conditions they are trained, and whether they return. Failing to do this risks perpetuating suboptimal contexts where policy decisions do not accurately reflect the realities of migration and its impacts.

Size and direction of MENA health worker migration

Compared to the relatively abundant literature available on skilled migration within MENA, data offerings on the region's health worker movements specifically are sparse. All the same, three studies (OECD, 2007; Bhargava et al, 2010; and Clemens and Pettersson, 2006) provide an adequate collection of indicators to draw three initial conclusions about the size and directions of these movements.

Size and direction of MENA health worker migration, cont'd.

First, when paired with Docquier and Marchiori (2010), findings from the OECD studies suggest that the migration of MENA health workers tends to follow similar movement patterns to those of skilled MENA workers more generally. Based on country-of-birth data from 2000, Docquier and Marchiori indicate that the region's most populous countries (namely Egypt, Iran, Algeria and Morocco) tend to be among the primary exporters of skilled labor abroad. The OECD estimates, which also look at country-of-birth figures but around the year 2000, observe similar patterns with all four countries consistently ranking among the region's top five migrant-sending countries across multiple healthcare professions: physicians, nurses, pharmacists and dentists.

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Second, when paired with the OECD studies, findings from Bhargava et al suggest that health workers migrating from MENA do not necessarily receive their training from their countries of origin. As an example, the top five MENA countries responsible for training physicians who ultimately migrate abroad include only three of the region's more populous countries (Egypt, Iran and Iraq). The remaining two are Lebanon (a relatively small country by regional comparisons) and Syria (a mid-sized country). Even within the top five lists, country size does not seem to correlate as strongly to stock sizes in the case of Bhargava et al's country-of-training data, as it does with the OECD's country-of-birth figures. While Algeria, Iran, Egypt, Morocco and Syria (in descending order) had the greatest stocks of their nationals working abroad as physicians around the year 2000, it was Egypt, Iran, Syria, Iraq and Lebanon that had the greatest stocks abroad of locally trained workers in 2004.

Third, Clemens and Pettersson, Bhargava et al, and the OECD studies all suggest that health workers trained or born in MENA tend to cluster in a small number of destination countries: primarily France, Belgium, the US, and the UK. These workers also seem to move along a few primary migration corridors. Those trained or born in the Maghreb consistently move to France and occasionally to Belgium, with language ties and geography appearing to be of strong importance. Meanwhile, those trained or born in Egypt and several Middle Eastern countries tend to go to the US, and those with connections to Iraq seem to gravitate toward the UK.

Although these three conclusions help relieve some of the obscurity that surrounds MENA health worker migration, several significant information gaps still exist. It is important to note that no data is available on the movement of health workers within MENA, particularly toward labor magnets like the Gulf countries. Such information is crucial for determining the extent of migration-induced regional-level human capital losses – i.e. whether workers who leave their countries of training and/or birth tend more to pursue careers elsewhere in MENA or beyond it. It also can have implications on determining who bears the brunt of financing the medical training for these professionals.

More micro-level indicators also need to be collected to document the age, skill levels, and gender of migrants. Age indicators can help paint a clearer picture of the timing of migration, and more generally about who faces the fiscal costs of training and the human capital burdens of migrating professionals. Younger migrants may very well have their training funded by sources beyond the birth country, while older migrants (particularly past age 30) may likely have the opportunity to practice at home before the moment of departure. More nuanced indicators that distinguish country of origin, from country of training, from country of employment would be essential for fully capturing these effects, and the next section will explore the value of such analyses in a bit more detail. Data on skill level also can help deepen understandings of whether the professionals who migrate actually are qualified to work in fields that are needed at the origin, and whether their departure really inflicts a loss to health service delivery. Information about gender can have a similar effect, particularly for getting a better idea of the impacts on the nursing profession – of course, assuming that more women in MENA countries work in this field than men.

Sources of and funding for MENA health worker training

Similar to the case of MENA health worker movements, only a limited amount of information exists to assess the training options and sources of funding that are available in the region. Documented information on this subject includes the following:

First, MENA countries spend a relatively high percentage of their GDP on education. Saudi Arabia, Tunisia, and Morocco spend 5.6%, 6.9% and 5.6% of their GDP in this area, respectively, compared with a global average of 4.4%. Only a small number of MENA countries, such as Qatar, the UAE, Libya and Lebanon, spend significantly less – no more than 2.7% of GDP (World Bank, 2009 data, via Avato, 2012).

Second, most students in MENA are enrolled in public institutions. In Libya, Egypt and Saudi Arabia, public education covers over 90% of overall education provision. In contrast, the UK has 66% of its students enrolled in public institutions (Avato, 2012).

Third, a large number of students study abroad. Statistics on the number of international students from MENA show that 14% (152,000) of tertiary educated migrants are students from MENA, mainly residing in the US or in such European countries as France, Germany, the UK, and Spain. Student mobility (i.e. the number of students abroad relative to those who stay at home) is well above the world average of 2% in most MENA countries (Avato, 2012).

Fourth, private financing options for education do not exist in all MENA countries, though this has started to change. As an example, the IFC has launched several projects promoting student loans for undergraduate and graduate education, which are to be paid back after graduation. These activities were started in Egypt, Saudi Arabia, Jordan, the West Bank and Gaza. Private banks in Egypt, Lebanon, the UAE, Bahrain and Iran also have started offering education loans. More generally, efforts are underway to increase the private sector's involvement in education. AMCML (2011) finds that private equity firms have invested a total of US$ 275.1 million (disclosed value) through 13 deals in the MENA education sector since 2005. Saudi Arabia is at the forefront having announced the establishment of seven new colleges – including two medical colleges at Shaqra and Dawadmi. The UAE also has invested substantially in its universities, creating regional centers of excellence like the Zayed University and the Higher Colleges of Technology.[1]

At the moment, no comprehensive studies have been conducted to collect specific data on medical training in MENA. It is likely that many of the general trends mentioned above would apply to the training of health workers, and perhaps it is fair to assume that many of the region's health students receive a large portion of their training through public funding. Still, significantly more work needs to be done to explore this subject further. More crucially, additional information needs to be collected on how many medical students study abroad (i.e. outside their origin countries and/or the region), who finances their studies, and whether they return for work at home. The availability of these indicators would allow sending and receiving countries to better understand the financial, human capital, and public health consequences of these movements.

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A recent study by Ozden and Phillips (2013) illustrates the importance of capturing these nuances, and points toward possible methodologies for plugging these gaps. Using propensity score matching techniques to match data from the American Medical Association and the American Community Survey, they attempt to determine the actual loss inflicted on African sending countries by the decision of doctors born and/or trained in Africa to pursue careers in the US. Their study importantly makes the distinction between the locations of birth and training to arrive at a more comprehensive understanding of what constitutes an "African" doctor – a subtlety that existing datasets fail to capture. It also takes into account the age that doctors migrated, so as to better understand who bears the real human capital and financial costs of these movements.

Their findings estimate that only about 45% of the some 20,000 "African" doctors in the US in 2011 were both born and trained in Africa, with 95% of this group trained in the birth coun-

Sources of and funding for MENA health worker training, cont'd.

try. Another 45% of the 20,000 were born in but trained outside of Africa, mainly in the US but also across other countries, while a final 10% were born outside but trained in Africa. A large number of African-born doctors with US training were observed to have arrived in the US as children or students, depending on the origin country. Those trained and born in Africa were estimated to leave at various ages (some as late as their mid-40s), again depending on the origin country.

These results suggest that the global market for skills and labor is highly complex. While in many cases a rich country (e.g. the US) does indeed employ foreign doctors from poor countries who were trained in their countries of birth, this is far from the norm. In many cases these doctors pursue careers in their countries of training abroad, in other cases they export the human capital they earned abroad to another foreign country, and in still other cases they receive training from foreign lower-income countries only to employ these skills in higher income ones. The collection of targeted data is necessary for understanding how these dynamics play out, and it would be very useful to do exercises like this one for the study of MENA healthcare migrants.

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Conclusions

While the migration of health workers remains highly controversial, it is important to remember that the actual human capital and fiscal impacts of these movements are not fatalistic. Rather, they depend on the circumstances surrounding individual migrations, and rigorously-collected targeted data on the movement of these skilled workers is the only way to measure these outcomes adequately. This discussion note highlighted the importance of applying these understandings to the study of MENA health worker migrations, particularly because such little information exists on the subject. It identified key data gaps present in two sub-areas of this discourse: migrant movements and training. Filling these gaps can help overcome critical knowledge gaps, whose existence only risks pushing the policymaking process dangerously into the realm of misinformation and myth.

Contacts:
For more information on this topic or the International Labor Mobility Program, please visit our website (cmimarseille.org/migration) or email us at ilmprogram@worldbank.org.

Note:

[1] The UAE also offers increasing options for education in the private sector, and has begun establishing partnerships with such institutions as the American University in the Emirates, the London Business School, Cass Business School, the University of Wollongong, Rochester Institute of Technology, and Heriot Watt University.

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