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STAFF WELFARE AND MIGRATION OF HEALTH WORKERS IN NIGERIA: A CASE OF SOUTH EAST, 2015 - 2022

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Abstract

The migration of health workers in Nigeriahas been a progressively sensitive and controversial policy issue from time immemorial.Various theories have been put forward to explain the concept of human capital flight in the health sector, all of which revolve around the push and pull factors of migration.The nation'shealth sector is fraught with dearth of skilled medical personnel at the primary, secondary and tertiary health care levels, thus hampering efficient healthcare services. South East however, is not immune from the trend; hencethe current degeneration of healthcare delivery in the region. Therefore, the paper aims at exploring the nexus between staff welfare and migration of health workers in South East;and proffering solutions to brain drain in the sector.Primary and Secondary data were utilised.Data were analysed with Analysis of Variance. A sample of 400 out of the total population of 9,988 was used for the study. The findingsshowed that, there is a strong connection between staff welfare and migration syndrome in the South East health sector.Consequently, we recommended that, there is need to provide solution to the push factors through adequate funding of the health sector and motivation for health workers.

Key Words: Healthcare, Staff Welfare, Labour Migration, Brain Drain, Motivation, Push and Pull Factors, Health practitioners.

Introduction

The migration of health workers is not a new phenomenon but it has been a progressively sensitive and controversial policy issue in the past three decades. The adverse effects of health workforce migration became more visible when developing countries publicly voiced their concerns over the loss of

qualified health workers to richer countries and its impact on their public health systems. The significant increase of health professional migration to developed countries is seen as one of the major reasons for the mal-functioning health systems in developing countries (World Health Organisation -WHO, 2006; Clemens & Petterson, 2008).

Various theories have been put forward to explain this phenomenon of a 'human capital flight', in the health sector, all of which point to the complexity of the problem from source countries. Regrettably, solutions have been elusive. The management of brain drain is difficult for several reasons: first, there continue to exist strong reasons for health workers to migrate (the pull factors) to recipient countries and equally strong reasons to emigrate (the push factors) from source countries (Pang et al., 2002; Kirby & Siplon, 2012). Second, as Dwyer (2007) pointed out, when health workers decide to emigrate, they are only exercising their human rights, so the management of the problem will require balancing the need for social justice with people's right to emigrate with the intention of having a sustainable and better living condition. Third, data on migration are often limited, and where they exist, they are mostly not comprehensive (Diallo, 2004), thus creating further challenges for the management of the brain drain. The reasons for the phenomenon of brain drain among health practitioners in developing countries revolve around the push and pull factors. Pull factors include better remunerations, better standards of living, gaining experience, and upgrading qualifications. The push factors include lack of facilities, lack of promotion, ineffective management, excessive work stress, lack of training, and absence of career development, etc. (WHO Report, 2006).

The importance of staff welfare cannot be overemphasised in any system. Welfare packages are instruments used by all organizations to motivate and increase productivity level of their employees. A defect in this regard is a precursor to labour migration. When an employee cannot meet his basic social responsibilities like rent, tuition fees of children/ward(s), good provision of meal intake for the family, medical care and many other obligations, the effect of such will amount to dissatisfaction and exit from the job hence hampering organisational efficiency and productivity (Adetunji, et al, 2007).

South Eastern Nigeria (Abia State, Anambra State, Ebonyi State, Enugu State and Imo State) is currently plagued by incessant

migration of health practitioners to countries with better conditions of service to the detriment of health sector in the region (Devex, 2018). The above is linked to welfare related issues which border on salaries and allowances, work environment and career development, etc. for health practitioners in the region. They are ill-equipped, highly demoralised and demotivated with little or no career prospects. Ironically, the area is abundantly blessed with both human and material resources especially in the health sector but harnessing the resources had posed serious threat not only to the region but also Nigeria at large; hence the recurrent exodus of health workers upon graduation from schools and from the primary, secondary, tertiary and private health intuitions in the region to developed climes for greener pastures. Dearth of trained and skilled health workers, high mortality and morbidity rate are the precarious consequences of the trend especially during the period (2015 - 2022) under review.

Interestingly, the term, staff welfare "entails all activities of the employers, which are directed towards providing the employees with certain facilities and services in addition to wages and salaries" (Budd, 2004). According to Venugopal et al. (2011), "labour welfare includes both social and economic content of welfare. Social welfare is primarily concerned with the solution of various problems of the weaker section of society like prevention of destitution and poverty. It aims at social development by such means as social legislation, social reform, social service, social work and social action. On the other hand, the object of economic welfare is to promote economic production and productivity and through development by increasing equitable distribution. Labour welfare is an area of social welfare conceptually and operationally. It covers a broad field and connotes a state of well-being, happiness, satisfaction, conservation and development of human resources."

Staff welfare entails all those activities of the employer which are directed towards providing the employees with certain facilities and services in addition to wages or salaries (Patro, 2017; Patro & Raghunath, 2017; Talan et al., 2017).

Staff welfare and personal development are valuable assets in an organization since an organization's primary aims are productivity and profitability. Every organization primarily needs committed and dedicated staff that will help the organization to meet its tactical and strategic objectives (Owusu-Acheaw, 2007). McGuire and McDonnel (2008) explain that, welfare facilities help to promote employee

self-confidence and develop the intellectual level of employees. Matthew (2011) advocates that employee welfare measures are the oxygen of employee motivation and employee productivity. However, inadequate welfare mechanism in the workplace breeds dissatisfaction among workers which ultimately snowballs into brain drain syndrome.

The term, brain drain also known as human capital flight is a large scale movement or migration of top-flight manpower from various developing countries (predominantly African countries) to more developed countries notably the United States of America, Canada, the United Kingdom, Germany, France, Italy, Holland, Newzland and Australia. As earlier stated, the chief reason for this movement is the quest for better opportunities. Similarly, the Longman Dictionary of Contemporary English (2008) 7th edition, defines brain drain as "a movement of highly skilled or professional people from their own country to a country where they can earn more money". With particular reference to the healthcare sector, Utile (2008) conceptualized brain drain as "the mass exodus of highly trained and well experienced health workers from countries with poor conditions of service to those with better work conditions in search of greener pasture".

Furthermore, brain drain in the healthcare sector is equally defined as the movement of health personnel in search of a better standard of living and quality life, higher salaries, access to advanced technologies and more stable political and better working conditions in different places worldwide (Kadel & Bhandari, 2018). Brain drain is regarded as international transfer of resources in the form of human capital which mainly involves migration of relatively highly educated and skilled individuals from developing countries to developed nations (Chimenya & Qi, 2015).As noted earlier, the health sector in Nigeria is not immune from the trend, as health workers at the various levels of government including those at the private sector indulge in the act.

It is noteworthy that, thehealthcare system in Nigeria consists of public and private sectors. The public healthcare system provides about 20% of the population with healthcare, and it is structured along the lines of government (Nigeria operates a three-tier federal system of government, consisting of Federal, State, and Local Governments, with the State and Local governments being semi-autonomous), with each being operated as determined by the

government level, and with considerable overlap among them (Awire, 2017; Oyemakinde, 2009).

At the local government level, primary healthcare is operated by various primary health centres and clinics, run by healthcare workers employed by local governments, and mostly located in rural communities. Most of these centres and clinics are run by nurses and midwives, and are overseen or supervised by community health doctors.

At the state level, government builds hospitals/clinics, which are managed and run by hospital boards. These hospitals are mostly located in urban and semi-urban centres, and include various general and specialist hospitals. In states where the state governments have established medical schools, healthcare at the state level also includes tertiary healthcare services, with the establishment of university teaching hospitals and medical research centres.

The Federal Government is primarily concerned with tertiary healthcare in Nigeria; this involves the teaching hospitals and health research centres, but also includes various Federal Medical Centres scattered across all the states. The Federal Government also supports the various primary health centres in the states and local governments as part of its healthcare service delivery (Awire, 2017; Asuzu, 2004).

There is a growing and thriving private (non-governmental) healthcare sector in Nigeria. This sector is very diverse; it is made up of private for-profit (individual or family) organisations, voluntary organisations such as Non-Governmental Organisations (NGOs), Faith-Based Organisations (FBOs), Community-Based Healthcare Organisations (CBHOs) and Traditional African Healthcare Providers (Kombe et al., 2009). These private organisations together provide healthcare services for approximately 80% of the Nigerian population (Awire, 2017; Kombe et al., 2009).

Finally, a cursory look at the above theoretical expose reveals that, scholars concentrated their views on international migrationof labour vis-a-vis the pull and push factors of migration. An infinitesimal emphasis was made by them on internal or local migrationsystem of labour from rural to urban areas and/or from Local to State, to Federal Institutions or even from private sector to public sector and vice versa for greener pastures. Evidently, labour migration among health practitioners in Nigeria takes place internally in high proportion due to financial constraints to travel abroad, personal

values and other extraneous factors. The foregoing deserves academic attention, hence this study.

Research Objectives

The study was guided by the following objectives:

1. To find out the relationship between staff welfare and migration of health workers in South Eastern Nigeria from 2015 through 20202.
2. To ascertain how welfare packages exacerbate local and international migration of health workers in the region.
3. To suggest strategies for mitigating brain drain syndrome of health workers in the South Eastern Nigeria.

Research Methodology

The study adopted descriptiveresearch design. Primary and secondary data were used for the study. Primary data were sourced from interview and questionnaire. These instruments were administered to a cross section of doctors, nurses, pharmacists and medical laboratory scientists at selected public and private health facilities in the region. The secondary data were generated from the internet, academic journals, textbooks, edited books, etc. The population of the study is 9,988 and the sample size is 400. The sampling technique used is simple random sampling. The data generated were analysed with the aid of Statistical Package for the Social Sciences 20th version- Analysis of Variance (ANOVA).

Hypotheses

This study was guided by the following hypotheses:

H01. There is a correlation between staff welfare and migration of health workers in South Eastern Nigeria

H02. The quality of welfare packages in the region's health sector exacerbates local and international migration

H03. Brain drain syndrome in the South East health sector can be mitigated through competitive welfare scheme for health workers

Data Presentation and Analyses

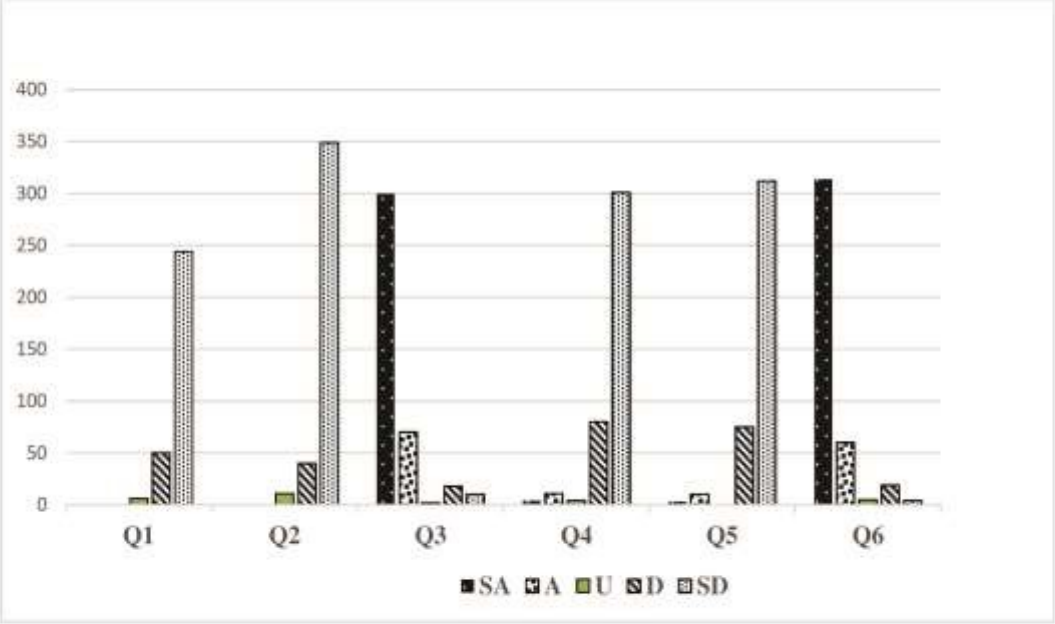

Figure 1.1 Graphic Representation of Field Data From H01
Source: Field Survey, (2022).

Hypothesis Testing

Hypothesis 1: There is a correlation between staff welfare and migration of health workers in South Eastern Nigeria.

Tests of Between-Subjects Effects

Dependent Variable: Responses

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	140551.375[a]	10	14055.138	1.042	.448
Intercept	173868.642	1	173868.642	12.894	.002
Opinions	134426.375	4	33606.594	2.492	.078
Questions	11223.375	6	1870.562	.139	.989
Error	256202.625	19	13484.349		
Total	588754.000	30			
Corrected Total	396754.000	29			

a. R Squared = .354 (Adjusted R Squared = .014)

Discussion

According to the South East Caucus of the Nigerian Medical Association (NMA), the state of medical and paramedical care in the South Eastern Nigeria is worrisome. In a communiqué issued in Awka, Anambra State on 15thAugust, 2021 after its general meeting, appealed to the states in the region to do more to improve the systems for the common good of the people. The communiqué commended the Anambra and Enugu state governments for prompt and regular payment of doctors' salaries, but frowned at the remunerations that were below the Consolidated Medical Salary Scale (CONMESS) (Nzeagwu, 2021).

The NMA caucus further criticized the 'very poor' condition of health workers in Imo State, while describing the arrears of their Abia counterparts as unpalatable and unacceptable. The communiqué reads: "Healthcare workers in Imo are still being owed several months. We hope for a turnaround in the state's health sector. The outrageous salary arrears owed Abia State-employed doctors remain unpalatable and unacceptable. This has worsened healthcare delivery in the state." The caucus urged the Abia government to urgently pay the arrears to the doctors and make efforts to revamp healthcare in the state. "Anambra State government has continued to pay salaries regularly. However, it is yet to upgrade doctors' pay to the adjusted 2019 CONMESS, as it is obtainable with their federal

counterparts. "We commend Governor David Umahi of Ebonyi state for his giant strides in the state's health sector. The construction and equipping of a virology centre and an accident and emergency complex at Alex Ekwueme Federal University Teaching Hospital, as well as other projects stand Ebonyi state out in the region"(Nzeagwu, 2021).

Generally speaking, Nigerian doctors, nurses, pharmacists and medical laboratory scientists, etc. are among the least paid worldwide. Health workers in other African countries are better paid than their Nigerian counterparts. The Guardian investigation revealed that, of all 55 African countries, Nigerian doctors (lowest salary of $320) are better paid than their counterparts only in Sudan ($66), Cameroon ($300), Egypt ($157), Guinea Conakry ($102), Zimbabwe ($83), Uganda ($300), Algeria ($265), Burundi ($100), Ethiopia ($300) (Nzeagwu, 2021).

The immediate past president of the National Association of Resident Doctors (NARD), Dr. Segun Olaopa, noted recently that the comparison might not be fairly contextualized in absolute terms, because "a very senior doctor who gets about $1,200 cannot, for instance be compared with another who perhaps, trained in Nigeria and earns more than $10,000 monthly or whose currency devaluation of equal pay puts him at a cataclysmic disadvantage. For instance, $500 dollars in Nigeria earned by doctors cannot be equivalent in pay to the same amount in a country like Ghana. Even when we look in absolute terms, the Nigerian doctor's pay is very terrible, irrespective of the calculating index."

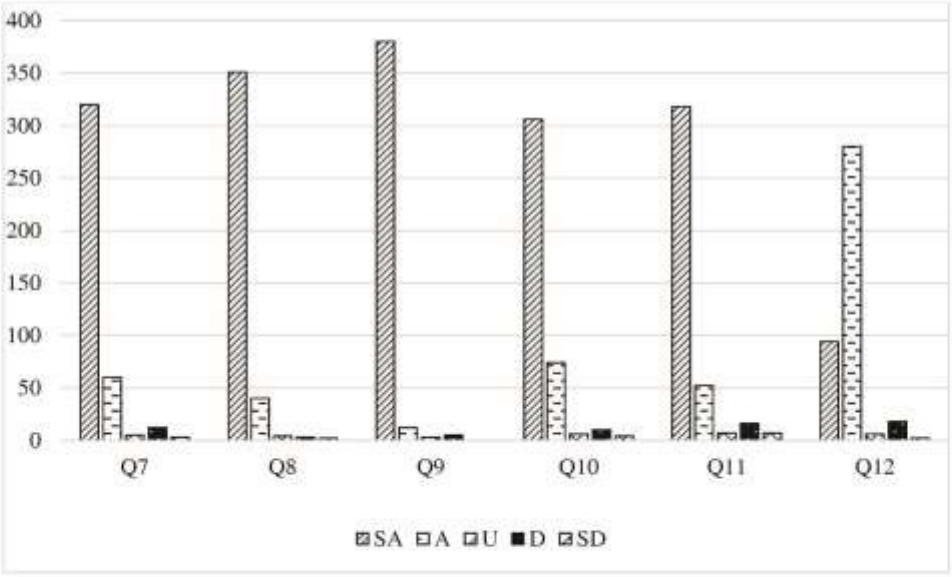

Figure 1.2 Graphic Representation of Field Data From H02
Source: Field Survey, (2022).

Hypothesis Testing

Hypothesis 2: The quality of welfare packages in the region's health sector exacerbates local and international migration.

Univariate Analysis of Variance

Tests of Between-Subjects Effects

Dependent Variable: Responses

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	376677.135[a]	10	37667.713	7.264	.000
Intercept	144619.570	1	144619.570	27.888	.000
Opinions	304674.468	4	76168.617	14.688	.000
Questions	942.668	6	157.111	.030	1.000
Error	98530.332	19	5185.807		
Total	666568.000	30			
Corrected Total	475207.467	29			

a. R Squared = .793 (Adjusted R Squared = .684)

Discussion

Among the numerous problems bedeviling the health sector in South East and Nigeria at large, is high shortage of skilled healthcare providers. Due to work unfriendly amenities and extremely poor reward system in the health sector, a good number of health workers upon graduation, migrate to developed countries in search of greener pastures In fact, some of these countries have established recruiting agencies and examination protocols targeting the best and brightest medical minds in Nigeria, prompting the government to mandate these agencies register with the Federal Ministry of Health and operate within an established framework.

According to Uneke et al. (2007), Nigeria is key exporter of healthcare providers in Africa accounting for 347 (recently revised upward to 432) out of a total of 2000 nurses that emigrated out of Africa between April 2000 and March 2001.

This figure appears to be underreported as it fails to take into account the vast number of nurses who migrate abroad under different pretexts. The mass exodus has resulted in high shortages of healthcare givers especially in local health facilities and drastically impacted access.

According to Uzochukwu (2021), there are 80,000 doctors registered with the Medical

and Dental Council of Nigeria as of June, 2021 out of which only about 35,000 are practising in the country. In 2018, it was equally revealed that 88% of doctors in Nigeria were seeking employment abroad. Between 2015 and 2021, about 4,528 Nigerian-trained doctors have migrated to the UK. In the USA, the number of practising Nigerian doctors is greater than 4,000. The average number of doctors trained in Nigeria and currently practising in the United Kingdom increased significantly between July, 2020 and May, 2021 ranking Nigerian Doctors the third highest in the UK. According to Nursing and Midwifery Council of Nigeria, in 2021 alone more than 7,000 nurses left the country for greener pastures abroad and other specialised health workers such as pharmacists, laboratory technologists/scientists, physiotherapists, etc. are not left out.

In the words of Udom (2016), the healthcare system in Nigeria has the highest number of labour migration. The World Health Organisation (WHO, 2006) asserted that currently, there is high shortage of 4.25 million healthcare practitioners in the world. This shortage is fuelled in part, by labour migration of healthcare workers mainly, doctors, and nurses. Researches have shown that healthcare personnel in Nigeria migrate to developed nations such as United States, United Kingdom, Canada, Australia, Germany, etc. thus, denying their nation the benefit of their training (Kaba, 2011). Dodani & LaPorte (2005) defined healthcare brain drain as the migration of healthcare workers in search of educational and professional advancement, higher remuneration and a better quality or standard of life, often in a more stable socio-political environment.

According to Connell & Brown (2004) and Ikenwilo (2007), brain drain among health workers is pervasive in sub-Saharan African countries. The World Health Organization maintained that sub-Saharan Africa has an estimated 145,000 physicians to serve a population of 821 million and the major cause of this is the brain drain. Tucho (2009) in his study of brain drain in the health system of Tanzania maintained that, the country with a population of about 40 million had only 1,264 doctors working in the country, and 1,356 doctors working abroad. In Zimbabwe, because of the political instability, 51 percent of the nation's doctors and 24 percent of its nurses are estimated to be working elsewhere in the world (Clemens & Petterson, 2008).

Similarly, the Nigerian health sector has suffered labour migration of her medical personnel to countries perceived to have

better working conditions. The brain drain of health workers, especially, doctors, pharmacist, laboratory scientists and nurses, is attributed to several factors. These factors include unreasonable low wage paid to health care practitioners, political instability, the poor socio-economic condition of the home nation, regional and international conflicts, unfriendly government policy, employment of health workers in field other than theirs, low level of development and the frustration of practising in an uncongenial work environment (Keba, 2009).

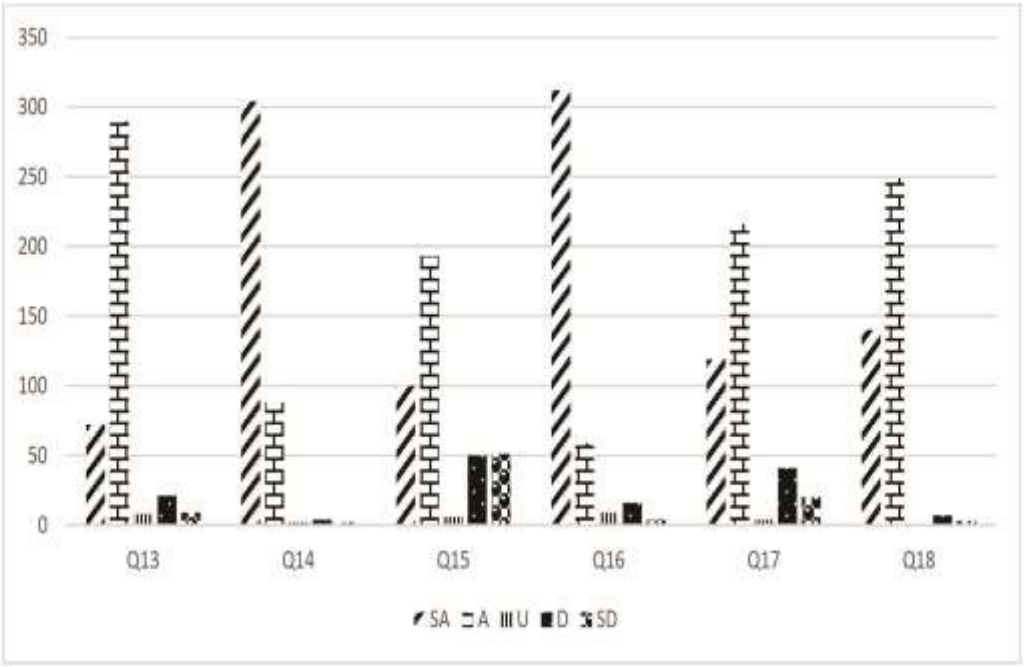

Figure 1.3 Graphic Representation of Field Data from H03
Source: Field Survey, (2022).