MEDICAL MIGRATIONS, COVID-19, AND THE HEALTH IMPLICATIONS IN NIGERIA BEYOND THE PANDEMIC

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Abstract

Medical migrations from Nigeria occasioned by the need for medical professionals abroad due to the loss of frontline workers to the Covid-19 pandemic brings to the fore again some pertinent issues. These issues include the challenges of brain drain, global treasure hunt, imminent African health disaster(s), opportunities or threats to mention a few. No doubt one of the most hit sectors during the Covid-19 pandemic is the health sector. Frontline workers helplessly watched their patients die just as a lot of them paid the supreme price in the line of duty. As the situation eased, there arose the need for some badly affected countries to replace some of their lost medical practitioners. This replacement becomes necessary on the one hand to manage the re-surging waves of the pandemic and on the other hand to re-stabilize their medical sector for a sustainable health industry. In response, the spate of medical migrations from Nigeria is on the increase. This paper attempts an evaluation of the implications of these migrations on the immediate management of the Covid-19 pandemic and the long-term effect(s) on the Nigerian health system. I try to look beyond the basic submissions that each individual has the right to seek better opportunities anywhere since successive administrations have relegated the health sector. I contend that Africa (specifically Nigeria) faces a challenge of survival if our best brains do not find the continent a place worthy of their sacrifices.

***Keywords**: Covid-19, Medical Migration, Health Sector, Medical Challenges Nigeria*

Introduction

Migration of Nigerian professionals to other climes is a saddening occurrence that several sectors in the country face. It's been tagged 'brain drain' and has been depriving us of some of our best brains and hands. From the health sector to the education sector, to technology, to technical and even economic sectors, some of our best are outside the country and several others are on the verge of leaving. Just as established professionals are leaving, potential professionals in persons of prospective doctoral candidates are equally leaving no thanks to scholarships offered to these promising generations. In all, the country is at a loss. On the one hand, losing these professionals deprives the citizens of the benefits services they would have offered. Meanwhile, the lack of these services is detrimental to every sector in the *being* of the country. On the other hand, the loss of these professionals is a loss to the country on the cost of training them.

A little illustration will drive home these points. The health sector is one of the most important sectors in any country. A healthy citizenry depicts the health of the family, the health of the economic sector, the health of the educational sector, the health of the agricultural sector, the health of country to put it in one word. The potentialities of a healthy country are numerous and essential. But when the health sector is in crises (as seen in Nigeria), then the country is in crises as evident in Nigeria. A sick teacher cannot teach and a sick student cannot learn; a sick farmer cannot farm and a hungry citizenry cannot

be productive; an unproductive country cannot meet its need which places it at a precipice. Beyond these physical loses there is also the financial loss to the country. The cost of training a medical doctor is one of the cheapest in the world (the stats on this will be analysed in a later section of the paper). The quality of the doctors (though dropping) is still good enough when compared. This good quality is mostly due to the fact that medical schools are stringent in admitting the best candidates because of the delicacy of the profession. Sadly, after training our best at the least cost we let them off for others to benefit.

Reasons for wanting to leave include: lack of conducive working environment; lack of appropriate equipment for practice; terrible welfare and remuneration packages; lack of relevant incentives for personal and professional development. On the contrary, the immigrating country is providing the environment, equipment, and good remuneration. The exchange rate makes the pay enormous when converted thereby enticing others take the next trip out. To discuss these issues this paper is divided into three parts. The first part attempts an overview of the impact of the COVID-19 on the medical profession, the second part examines some studies on medical migration in Nigeria and the third part analyses the implications of these migrations for both the country's health sector and finance used for training emigrating healthcare workers.

COVID-19 and First Responders

Health-care providers are vital resources for every country. Their health and safety are crucial not only for continuous and safe patient care, but also for control of any outbreak (Liu, *et al*, 2020). One of

the most affected groups during the COVID-19 pandemic was the healthcare workers. They were the front liners, the first responders, the ones who were looked upon for succor from the beginning till date of the pandemic. From the ambulance drivers to the EMT, to the lab technicians, the pharmacists, the nurses, the medical students, the doctors, consultants and other staffs in the health sector, everyone was stretched beyond limits during the peak of the pandemic. They put in their best to manage the situation while seeking ways to prevent others from getting infected and joining the patient lists. Sadly, they equally get infected and join the fatality list.

Razu *et al* (2021) rightly note that although social distancing is the most effective way to contain the outspread of this virus, this is not easy to implement for healthcare professionals who require direct contact with COVID-19 patients and puts them under a high risk of being infected themselves. Thus while we were all keeping the two meters gap our healthcare professionals could not. According to Alshamrani *et al* (2021), Healthcare Workers (HCWs) being at the frontline of treating patients with confirmed COVID-19 are at higher risk of exposure than the general population. The global average health worker infection rate has been estimated to be 10% (Adeniyi et al, 2021). Bandyopadhyay *et al* (2020) equally write that as of 8 May 2020, a total of 152 888 HCWs had been reported to have been infected with COVID-19 with a total of 1413 deaths. Covid 19 created multiple forms of negative effect on the economy trade, education and other sectors of the Nigerian economy (Odii, Ani & Ojakorotu, 2021; Uwizeyimana, Anyika,& Ani, 2021).

The greater threat of having infected HCWs is that their infection is not limited to them. Infected HCWs represent a risk for their families, their fellow HCWs, and hospitalized patients (Alshamrani et al, 2021). The risk of exposure risk of introducing infection to others, long working hours, and perceived stigma from family members and society can be manifested with a number of psychological morbidities including poor sleep quality, stress, post-traumatic stress symptoms, anxiety, and depression. HCWs at the heart of the unparalleled crisis of COVID-19, face challenges treating patients with COVID-19: reducing the spread of infection; developing suitable short-term strategies; and formulating long-term plans. HCWs must also continue to successfully treat non-COVID patients and maintain personal responsibilities, including taking care of their families and themselves (Shreffler, Petrey, and Huecke, 2020).

Doctors and nurses have been spotted weeping in the hospital lobby over the adverse situation they had to face and the pain of watching patients die. They are feeling helpless to save the COVID-19 patients (Shrestha and Kunwar, 2020). The situation is that of losing someone whom you have put so much efforts in helping (even at the detriment to your own health). They experience emotional exhaustion, which may lead to medical errors, lack of empathy in treating patients, lower productivity, and higher turnover rates. The ability of HCWs to adequately cope with stressors is important for their patients, their families, and themselves (Shreffler, Petrey, and Huecke, 2020).

Medical Migrations in Nigeria

The exodus of professionals from Nigeria in search for greener pastures is not a new phenomenon. Challenges during military era

and economic woes of the country motivate several professionals to leave the country in search for security and better opportunities. Healthcare workers are one of the most emigrated professionals from Nigeria. The neglect of the health sector by successive administrations (both military and civilian) has brought untold hardship to practitioners in the sector. Lack of adequate funding has reduced Nigeria from being a choice destination for effective healthcare by non-Nigerians to Nigerians being one of the highest clients of medical tourism. Nigerians now spend millions of dollars annually to different parts of the world in search for healthcare. The unfortunate Nigerians who cannot afford medical trips abroad are left to scramble for the little available resources. This puts untold hardship on the few healthcare workers who struggle to serve the multitude with little resources. In the end, these HCWs who do not have facilities to work with, who are not enough or well remunerated seek the next available opportunity to leave the country.

Medical migration was initially a passive driven by economic, professional, social or political considerations on the part of the migrant, but it is now largely due to over-reliance on imported skilled labour by developed countries (Monye *et al*, 2021). A World Health Organisation (WHO) report (2017) estimates that from 2010–2016, an average of 600 GPs emigrates annually from Nigeria; nearly 50% of emigration was to Europe, followed by North America and Africa… In 2016, letters of verification, a proxy for intention to emigrate, were processed for 13% of the nurses and midwives registered that year. Okafor and Chimereze (2020) cite an estimate that 12, 579 nurses trained in Nigeria or 12% of the total number of nurses in the country, had emigrated as at the year 2000. The top

destinations for emigrant nurses and midwives were the United States of America, Canada, United Kingdom, United Arab Emirates, Australia, and Ghana. While decrying this spate of emigration Ihua and Nsofor succinctly state that:

> Unfortunately, it is this workforce that we so direly need that we lose to these countries, as our medical workforce to population ratio is much lower than the recommended standard. In many instances it is our best and brightest hands that we lose as the application process in these countries is usually very competitive. Interestingly, some of these emigrated professionals end up treating the elite of our society who seek medical attention abroad, because they do not believe they can get the care needed for their recuperation locally in Nigeria. In all of this it is the average Nigerian who bears the brunt of the ailing healthcare system in Nigeria, as he lacks the resources to travel abroad for medical care (Ihua and Nsofor, 2019).

If it is bad enough that we are losing some of our best brains and professional health workers to more developed countries where working conditions and remuneration are better, then it should be more worrisome that a greater proportion of the next generation of medical professionals already have the intention of leaving upon completion of their training. In a study carried out by Adebayo and Akinyemi (2021) at one of the foremost institutions where healthcare workers are trained, the University College Hospital (UCH) of the University of Ibadan they realised that: more than half of the respondents (who were residents) had emigration intentions and about a third of those with emigration intentions had made various

attempts at emigrating ranging from taking tests of English language to writing licensing exams. The most depressing part of this fact of emigration of healthcare workers for me is that beyond the effect of this emigration on our manpower, there is the financial loss because we train these professionals for other country's benefit. This is the focus of our concluding section.

COVID-19, Medical Migrations and the Costs

The COVID-10 pandemic affected more developed countries than developing ones. This has no doubt depleted the number of healthcare workers in the developed countries **(Etodike, Ekeghalu, & Ani, 2021)).** Another point to be pointed out here is that due to the effects of the pandemic the economy of these developed countries was badly hit hence there is lesser fund to train the needed manpower. Coupled with the reduction in resources is the immediacy of need of these medical professionals. The best bet is to tap from already available manpower in developing countries that were already willing to leave for better conditions.

The recent open interview of doctors in Nigeria by agents claimed to be from Saudi Arabia is a clear indication of this challenge. Also, during the pandemic the *Punch Newspaper* reported that some 58 doctors were stopped at the airport from leaving the country for the United Kingdom. This follows an earlier reported concern that the United States government had asked medical professionals seeking to work in America to apply for a work visa at the nearest US embassies as part of measures to strengthen the health system to contain the coronavirus pandemic in America.

These incidents point to the fact that there is a global increase in the need for healthcare workers. Bidwell *et al.* (2013) had earlier noted that both developed and developing countries have a pressing shortage of nurses and doctors, and quite unfortunately, staff shortages, the lack of specialist training in low-and-middle-income (LMIC) countries and the economic downturn in the West have remained some of the reasons for the migration of doctors who are sourced from the most developing countries to the more developed countries. Unmitigated, rising infection and mortality rates in HCWs will paralyse a country's response to COVID-19, and it is bound to have a significant, long-term impact on healthcare delivery, particularly in health systems already grappling with workforce shortage due to lack of trained personnel, skilled labour migration and geographical maldistribution, even prior to pandemic times (Bandyopadhyay et al, 2020). The International Council of Nurses (ICN) also report that Nurses accounted for 60% of the health professional workforce around the world and due to the effects of the pandemic there is the projection for the need of about 10 million nurses by 2030 and there could be a gap of close to 14 million nurses in the future. Our nurses are gladly seeking such future.

Another important point that is less emphasized in the analysis of medical migration is the cost of training. Medical education around the world is an expensive venture. It requires a student who is committed financially, and who is willing to invest his or her time and energy in order to successfully complete their medical education. It costs a society a lot of money to have such highly skilled staff. This applies more in Nigeria where Teaching hospitals are funded by government, and the tuition fees for medical students at federal

universities is low compared with the cost at private universities or in other countries (Ihua and Nsofor, 2019).

The unit cost of training a doctor working in the British National Health Service (NHS) was estimated in a 2012 study commissioned by the UK Department for Health (DH) as £269,527 for a Foundation Officer 1 and £564,112 for a Consultant. These costs are not borne solely by the NHS, but also by the doctors and their families as school fees and loans. It is obvious therefore to understand why these societies are willing to accept qualified medical professionals from developing countries, because of the huge cost-savings to them (Ihua and Nsofor, 2019).

To train a medical doctor in Nigeria, government subsidizes the training to the tune of N3, 860,100. Countries that African doctors emigrate to do not provide medical school training to doctors who successfully pass licensing examinations. As such, these countries essentially make savings on training of medical doctors. Estimates of these savings are as follows: "at least $621m for Australia, $384m for Canada, $2.7bn for the United Kingdom, and $846m for the United States; $4.55bn in total (Ihua and Nsofor, 2019). In other words we are losing our money while training these doctors and losing them after training them. This fact calls for greater reasoning on the part of the state, scholars, healthcare workers.

Conclusion

My intention in this paper is to broaden our scope of reason on the issue of emigration of healthcare workers. It is sad to observe that, unlike the United States, United Kingdom and other forward thinking

stets, the Nigerian state does not perceive the danger ahead. There is the triple problem of an ineffective health sector, COVID-19 pandemic on the health sector and the emigration of Nigerian health professionals. The global call for Universal Health Coverage which allows individuals have access to the care they need without suffering financial hardships is not effective just as government is not providing policy and financial resources badly need of the health sector. Now more than ever, as noted by the American Medical Association, it's important for health systems and health care organizations to create and ensure an infrastructure and resources to support physicians, nurses and care team members.

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