

Chapter 14

Perception by Moroccan Physicians of Factors Affecting their Migration Decisions

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ABSTRACT

The variety of factors affecting migration decisions of medical doctors are confronted with the opinions of medical doctors operating in Morocco. The major objective of this exercise is to see how individual and environmental factors are perceived by each medical doctor who has selected to stay or to return to the country of origin after his or her medical studies. The method used in this research is based on the analysis of the information and data from a survey of physicians. This survey is based on the inputs from 117 medical doctors operating in different cities of Morocco. The results reveal that those with lower age and higher difficulties in medical practice constitute most of the medical doctors to relocate overseas. The migration conditions are also found to have a significant negative effect on respondents' intention to migrate. The study reveals as well that labor wages, gender, the status of the hospital (private or public), and the situations prevailing in hospitals do not significantly affect the attitude of respondents about migration. These results confirm that the surveyed doctors have selected to not migrate but to operate in Morocco while those that migrate could have opposite assessments for the same factors. All the surveyed doctors have confirmed the importance of intensifying cooperation between hospitals and medical schools on both sides of the Mediterranean region. This cooperative framework creates new incentives for the promotion of exchanges of medical doctors, knowledge, and experiences between the South and the North. The intensification of this collaboration allows medical doctors to be more mobile, creating a new win-win process that is far from the brain-drain type of vision.

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INTRODUCTION

The problem of human capital flight, more commonly referred to as “brain drain”, has been widely discussed all over the world in recent decades. The reasons for such phenomenon usually include two aspects which come from both source and host countries. With regard to source countries, the reasons may include lack of opportunities, political instability, economic depression, health risks, ambition for an improved career, and others. In host countries, the reasons are mainly better opportunities, political stability and freedom, developed economy, better living conditions besides the shortage of human resources. Brain drain is usually regarded as an economic cost, since emigrants usually take with them the portion of value of their training sponsored by governments or other organizations (Linacre, 2007). Developing countries are most suffering from the migration of skilled individuals. Brain drain is often associated with de-skilling of emigrants in their country of destination, while their country of emigration experiences the draining of skilled individuals. One very common aspect of brain drain is the migration of health personnel in search of a better quality of life, higher salaries, access to advanced technology and more comfortable conditions. This migration of health professionals is of growing concern all over the world because of the international competition for skilled labor in general and the deficits in health workforce in particular. But, this emigration of health workers and mainly of doctors has negative impacts on health systems in the source countries and in developing economies. These countries lose huge investments in the education and training of young health professionals as a result of migration. But, the most important loss related to the difficulty of not responding to the needs of their population in term of healthcare.

Shortages and imbalances of medical personal have been recently regarded as an international problem (Marchal & Kegels, 2003). Data from

OECD (Organization For Economic Cooperation and Development) countries show that medical doctors trained abroad make up a significant percentage of the medical core in most of these countries: 21% in Australia, 23% in Canada and 9% in Finland (Kumar and Simi, 2007). In 1972, about 6% of the world’s health professionals (about 140 000) settled down outside their countries of origin. Over three-quarters were found in only the USA, UK and Canada. The main exporting countries included: India, Pakistan and Sri Lanka (Dodani & LaPorte, 2005). Dodani and LaPorte (2005) convey also that the countries that produced more physicians than they had the capacity to absorb were identified as Egypt, India, Pakistan, Philippines and South Korea. Even though, the lack of reliable data and difficulties in defining whether a migrant is ‘permanent’ or ‘temporary’ still exist.

All these issues are addressed in the previous chapters of the present book. Furthermore, the model related to the new economics of migration of medical doctors is tested and validated using aggregate data on ECE and MENA economies and their mobility to EU. These empirical tests have shown the importance of economic, social and behavioral incentives in migration decisions. In addition, a cooperative framework is introduced as in chapter 11 of the current book. This model is based on collaboration between Northern and Southern countries of the Mediterranean region. It is suggested to be producing win-win effects through new incentives centered on medical education and research in both sending and receiving countries.

As many countries in the MENA region, Morocco as well suffers from the migration of medical professionals. The previous chapter of this book has extensively shown the existence of deficits in medical doctors over the coming years. OECD statistics (2000) show that Morocco has the second highest expatriation rate in the MENA region, after Lebanon. Algeria, Iraq, Syria, and Egypt have also high expatriation rates according

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