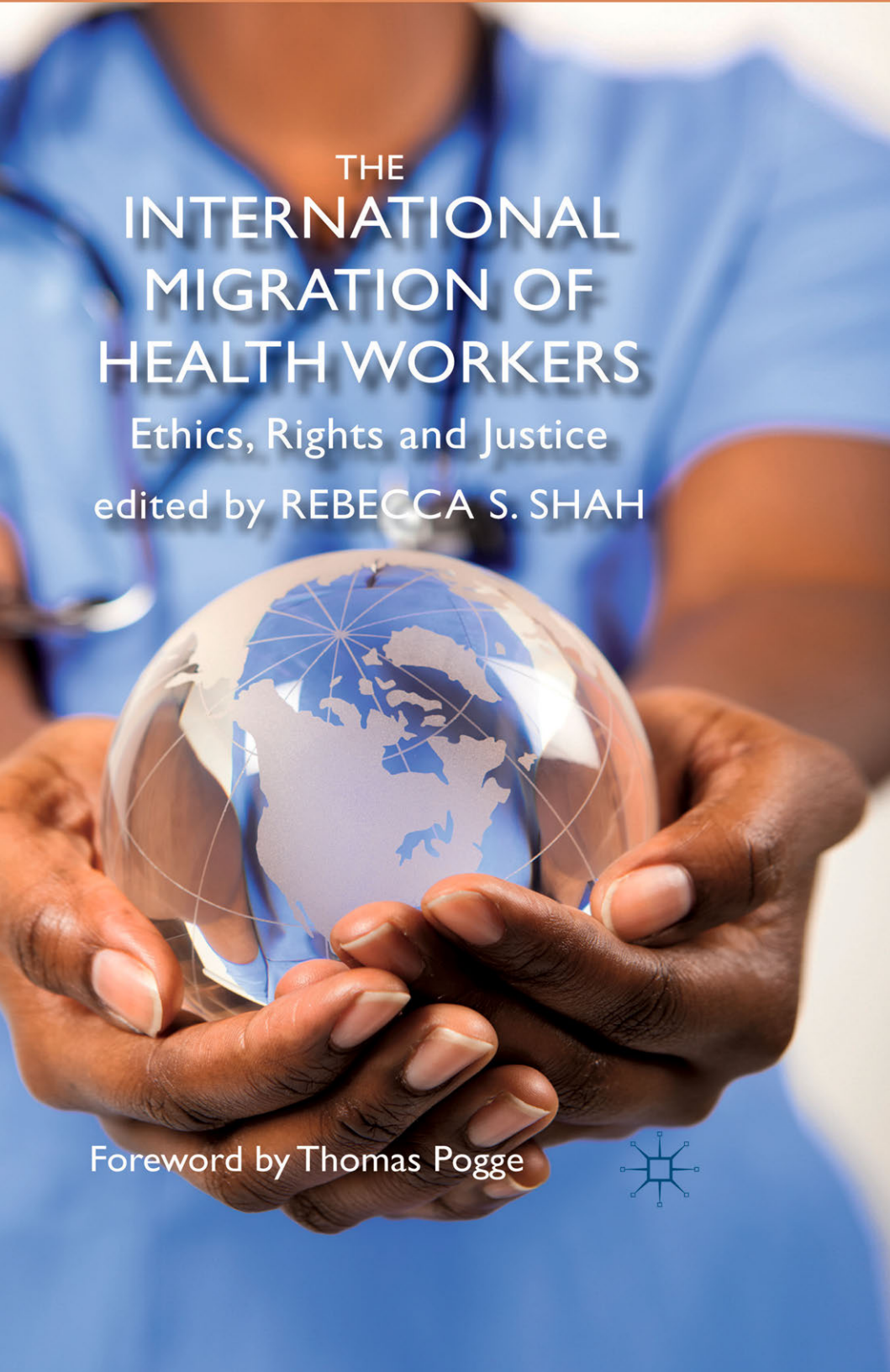
THE
INTERNATIONAL MIGRATION OF HEALTH WORKERS
Ethics, Rights and Justice
edited by REBECCA S. SHAH
Foreword by Thomas Pogge

The International Migration of Health Workers

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Ethics, Rights and Justice

Edited by

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for Joe

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Foreword

The poorer half of the world's population is still very poor: unable securely to meet their most basic needs. They have not benefited much from rising global average income; their share of global household income has reduced to below 3 per cent. On average, these people have about $200 per person per year, or a little over $500 at purchasing power parities.

Poverty contributes greatly to ill health. Each year, some 18 million people, including nine million children under the age of five, are dying from poverty-related causes, constituting about one-third of all human deaths. Life expectancy in the poorest sub-Saharan region is 49 years, more than 30 years lower than life expectancy in the richest North Atlantic region. Hundreds of millions of poor households are burdened or threatened by serious health problems that endanger their survival or livelihood.

Poverty contributes to ill health in three main ways. First, many poor people lack access to private goods that are essential to maintaining good health. For the first time in human history, over a billion human beings are now chronically undernourished, and similar numbers of people lack access to safe drinking water or minimally adequate shelter. Second, poor people must work and live under more hazardous conditions. Over 200 million children (aged 5–17) do wage work outside their household, often under slavery-like and hazardous conditions, 2.5 billion people lack adequate sanitation, and 1.6 billion people lack electricity which would enable safe and pollution-free cooking. Third, although poor people are far more likely to be struck by diseases and accidents, they have far less access to health-care resources such as doctors, nurses, medicines, and medical equipment. Poor people cannot afford such facilities. And their governments are not providing it: in most sub-Saharan countries, for instance, government health spending is below $15 per person per year. While total health expenditure per person per year exceeds $7000 in the US, it is below $50 in many poor countries, including India and most of Africa. As a result, some two billion people lack access even to essential medicines.

This collection examines closely one important aspect of the health crisis among the global poor: the migration of many health-care professionals from poor to more affluent countries. Such migration wastes

some of the scarce resources that poor countries devote to medical training and it further hurts poor populations by reducing the numbers of doctors and nurses available to them. While most affluent countries have over 300 physicians per 100,000 people, for example, most African countries, with their vastly greater disease burdens, have fewer than 12.

It may seem obvious that a health professional should be legally and morally free to move across national borders, that the country she wants to leave should let her go, and that other countries should be free to admit her and, if they do, should afford her the same opportunities that are available to other health professionals already there. Conformity to these reasonable prescriptions would work fine in a just world. But in our world, marred as it is by vast social and economic inequalities, these reasonable prescriptions aggravate the unjust exclusion of the poor. We should make the world just and then stick to the reasonable prescriptions, you may say. I agree. But we are unlikely to achieve a just world any time soon and hence face the question of what is to be done in the meantime.

It is this difficult question that the authors of this book are wrestling with. Taken together, these chapters comprehensively illuminate the phenomenon: offering rich descriptions of it, careful analysis of the relevant causal factors, moral assessments of the conduct of migrants and their employers as well as of the policies of the source and recipient countries, and original and realistic reform proposals geared to the world as it is. This volume is an excellent introduction to a very important topic. It also affords a new perspective on how the choices and policies of the world's more affluent populations are involved in the catastrophic health situation of the global poor.

Thomas Pogge
New Haven, 20 December 2009

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List of Abbreviations

CARICOM	Caribbean Community
DCW	Direct Care Worker
DFID	Department for International Development (UK)
ENAHPA	Ethiopian North American Health Professionals Association
EU	European Union
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GHWA	Global Health Workforce Alliance
G8	Group of 8
HHR	Health Human Resources
HIV	Human Immunodeficiency Virus
HTA	Home Town Associations
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
ITUC	International Trade Union Confederation
LTC	Long Term Care
MDG	Millennium Development Goals
MIDA	Migration for Development in Africa
NHS	National Health Service (UK)
NMC	UK Nursing and Midwifery Council
OECD	Organisation for Economic Cooperation and Development
POEA	Philippine Overseas Employment Administration
RQAN	Return of Qualified African Nationals Program
SANC	South African Nursing Council
SSA	Sub-Saharan Africa
TUC	Trades Union Congress
UN	United Nations
UN CESCR	United Nations Committee on Economic, Social and Cultural Rights
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UN OHCHR	United Nations Office of the High Commissioner for Human Rights
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System

Notes on Contributors

Staffan Bergström has been professor and chair of International Health at the Division of Global Health (IHCAR) at the Karolinska Institutet in Stockholm, Sweden, since 1996. He is also senior consultant (obstetrics and gynaecology) and senior advisor to the Averting Maternal Death and Disability (AMDD) programme, Columbia University, New York. He has devoted more than 35 years to maternal and newborn health in impoverished countries. He was director of the Department of Obstetrics, Maputo Central Hospital, Mozambique, in the 1980s. Over the last 20 years he has been involved particularly in the crisis of human resources for maternal and newborn survival with emphasis on research on task-shifting of comprehensive emergency obstetric care to 'non-physician clinicians'.

Phillip Cole is Professor of Applied Philosophy at the University of Wales, Newport. His publications include *The Free, the Unfree and the Excluded: A Treatise on the Conditions of Liberty* (Ashgate, 1998), *Philosophies of Exclusion: Liberal Political Theory and Immigration* (Edinburgh University, 2000), and *The Myth of Evil* (Edinburgh University Press, 2006). He is co-editor of *Citizenship Acquisition and National Belonging: Migration, Membership and the Liberal Democratic State* (Palgrave Macmillan, 2010) with Gideon Calder and Jonathan Seglow. He is presently writing a book on the ethics of emigration.

Lisa A. Eckenwiler is Associate Professor of Philosophy in the Department of Philosophy and in the Department of Health Administration and Policy at George Mason University. She also serves as the director of Health Care Ethics at the Center for Health Policy Research and Ethics. Professor Eckenwiler has published widely on research ethics, especially on issues concerning vulnerability. She also has written on access to AIDS care, policy for pregnant addicts, the ethical implications of initiatives in biodefense and emergency preparedness and ethics of the international recruitment of health workers. Her first book, *The Ethics of Bioethics: Mapping the Moral Landscape* (co-edited with Felicia Cohn), was published by the Johns Hopkins University Press in 2007.

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Giulia Greco is a Ph.D. candidate in Health Economics at the London School of Hygiene and Tropical Medicine. Her chapter is part of her MSc dissertation that she wrote as a student at the London School of Economics. She is currently working on her doctoral dissertation in which she explores the use of Sen's capability approach for developing an outcome measure to assess women's quality of life in rural Malawi. Her research interests include maternal health, feminist economics, and welfare economics.

Samia A. Hurst is Assistant Professor of Bioethics at Geneva University's medical school in Switzerland, ethics consultant to the Geneva University Hospitals' clinical ethics committee, editor of the Swiss bioethics journal *Bioethica Forum*, and president of the Swiss Society for Biomedical Ethics. Her research focuses on fairness in clinical practice and the protection of vulnerable persons.

Ronald Labonté is a professor in the Faculty of Medicine and Canada Research Chair in Globalization and Health Equity at the Institute of Population Health, University of Ottawa. From 2005 to 2008 he chaired the Globalization Knowledge Network for the World Health Organization's Commission on the Social Determinants of Health. His recent books (co-authored or co-edited) include *Globalization and Health: Pathways, Evidence and Policy* (Routledge, 2009); *Health Promotion in Action: From Local to Global Empowerment* (Palgrave Macmillan, 2008); *Critical Perspectives in Public Health* (Routledge, 2007); *Health for Some: Death, Disease and Disparity in a Globalizing Era* (Centre for Social Justice, 2005), and *Fatal Indifference: The G8, Africa and Global Health* (University of Cape Town Press/IDRC Books, 2004).

Harry Lesser is a retired senior lecturer in Philosophy at Manchester University, where he spent most of his career. He is the author of a number of articles on applied ethics and especially medical ethics, and has recently edited a collection of papers titled *Justice for Older People* (to be published by Rhodopi) and thoroughly revised his article on ageism in the Encyclopedia of Applied Ethics, as well as writing an article on assisted suicide.

Colleen McNeil-Walsh is a senior lecturer in Sociology at the University of Northampton and a Ph.D. student at the University of Birmingham. Her research is on nurse migration, specifically from South Africa to the UK. Her work explores the migration experiences of nurses in relation to skill, relations in the workplace, and return migration.

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Vivien Runnels is a Ph.D. student in Population Health and a research associate of the Globalization and Health Equity Research Unit, Institute of Population Health, University of Ottawa, Ontario, Canada. With Labonté, Schrecker and Packer, she co-edited *Globalization and Health: Pathways, Evidence and Policy* (Routledge, 2009). His other co-authored publications include work on homelessness and food insecurity and a bibliometric analysis of population health. Her current research studies and interests focus on health human resources migration, medical travel, sex and gender-based analysis, and governance of community–university research collaborations.

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Rebecca S. Shah is a Ph.D. student at the Centre for Professional Ethics, Keele University. Her thesis focuses on public health ethics and social justice at the global level and is funded by an AHRC/Royal Pharmaceutical Society of Great Britain collaborative award. She has held academic posts in international development, human rights, and

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Nick Sigler is currently Head of International Relations for UNISON, Britain's largest public service trade union. Previously he worked in various positions for the Labour Party and has also worked in Israel, Brussels, and Belgrade. He has contributed to and edited a large number of publications on subjects ranging from agriculture, the environment, and animal welfare to international relations, development, and migration.

Jeremy Snyder is Assistant Professor in the Faculty of Health Sciences at Simon Fraser University in British Columbia, Canada. He has written articles on sweatshop labour, health worker migration, and organ transplantation. He is currently part of a team exploring the values at play in the decision-making processes of medical tourists and writing more generally on ethical issues in medical tourism.

Introduction
The International Migration of Health Workers: Ethics, Rights and Justice

Rebecca S. Shah

Skilled workers have consistently migrated to seek out new and better personal and professional opportunities abroad. Patterns of migration are constantly changing and are greatly facilitated by the ease of international travel, access to information and communications borne of globalisation as well as the increased harmonisation and interdependence of different countries' economic and employment systems. Globalisation and the prospects of international migration bring both opportunities and challenges. The freedom to pursue migration can prove emancipatory for individuals, culturally enriching for societies, it can stimulate and accelerate progress in professional disciplines and encourage solidarity across borders. Migration is also induced by and serves to reinforce gross global inequalities in health and wealth. In recent decades the particular directional movement of health workers taking their skills from poorer to richer countries has increased apace. Health systems in some of the world's poorest countries are desperately understaffed and under-resourced and fail to meet even the most basic health needs of their populations. Under these conditions it is unsurprising that migration is an attractive option for health workers, but the loss of their valuable skills further threatens the health, human rights and development goals for the populations they leave behind.

Although this represents only a small part of total migration, which takes many forms, this is clearly a system out of balance; the financial, human, intellectual and health benefits seem to systematically and perversely accrue to the richer countries at devastating expense to the poorer countries. Given the vast inequalities in health outcomes between poor and rich populations, harmful health worker migration quite rightly provokes an intense moral reaction. It seems deeply unethical. It seems unfair. It seems unjust. The phenomenon of the medical 'brain drain'

and its harmful consequences has been recognised and lamented for some time, but ethical analysis and responses to it remain relatively scarce or underdeveloped. This is partly because closer inspection of the normative issues reveals that identifying exactly what is wrong here and why, who is morally responsible and for what and how it may be addressed in an ethical manner are far from simple matters.

The magnitude of the causal harm of health worker migration on already understaffed health systems is contested. The balance of benefits and burdens to health workers and sending and receiving countries are disputed. There are apparent conflicts between the human rights of different parties. There is ambiguity about the moral obligations of governments, individuals and health systems and the roles that global institutions should play. Proposed responses can themselves appear discriminatory, rights violating or imperialistic. Well-intentioned actions have negative and unforeseen effects. Some practical solutions seem morally suspect and some ethical solutions are practically implausible to implement. As the World Health Organization (WHO) consultation on an ethical code for the international migration of health workers reveals,[1] opinions diverge considerably about what an 'ethical' response to the international migration of health workers should look like (WHO, 2008). Serious ethical analysis of these issues has been limited to date, but it is essential to ensure ethical responses to the problems raised by the international migration of health workers.

This book provides, for the first time, a collection of works aimed specifically at sorting through this moral quagmire and bringing ethical discussion into unison with real world policy options. The chapters in this volume have been developed out of the presentations made at the conference 'Global Health, Justice and the "Brain Drain"' held at Keele University in 2007. I am delighted and impressed at the depth, breadth, originality and quality of the content developed out of such a modest beginning. My only regret is that the meagre conference budget was unable to fund participants from overseas, and as such contributors from poor countries are under-represented in this volume. Each chapter focuses on a distinctive aspect of the 'brain drain' debate, approaching it from different angles and disciplines. The chapters flow from analysis and conceptualisation of the phenomenon itself to normative considerations of the obligations of states and global institutions before narrowing down to the moral roles of individuals. Particular attention is paid throughout to human rights claims, to infusing theoretical debates with practical and applied perspectives and to considerations of what, if anything, justice requires. The book is distinctive among applied ethics

volumes for embracing the diverse disciplinary perspectives necessary to gain a full understanding of the challenges. As such the book does not aim at, nor does it achieve, ethical consensus. As a whole the volume furnishes the reader with a richer, more nuanced understanding of the moral issues at stake and how they interact with policy options, and as such aims to contribute to ongoing debates about the international migration of health workers.

Chapters

In Chapter 1 Giulia Greco provides a fine introduction to the phenomenon of health worker migration and its context. Looking at the interaction between theory and policy she notes that the different analytical frameworks used to understand migration can generate different policy responses. Greco uses three major competing analytical frameworks – the neoclassical framework, the historical–structural approach and migration systems theory – to classify a range of leading policy responses to health worker migration. She uses this classification to illustrate the limitations of analytical frameworks that focus either exclusively on micro or macro levels and endorses a modified version of systems theory which allows an understanding of how macro and micro structures interact in migration with meso-level influences. This means working with forces that are often beyond the means of policymakers to control, but Greco sees this as somewhat liberating; we must accept migration as inevitable and seek policy options that operate with, as opposed to against, this knowledge, especially in promoting temporary migration.

Lisa A. Eckenwiler also acknowledges the limitations of existing analytical models for the migration of health workers in Chapter 2. Her chapter complements Greco's analysis by proposing a new conceptual framework for analysing and responding to the migration of health workers: ecological epistemology. Ecological perspectives allow attention to patterns, processes, power relationships and systems as well as particularities and can therefore reflect the true complexity of health worker migration unlike other models which tend towards reductionism. Focusing particularly on care workers in the world's largest importing country, the US, Eckenwiler shows how ecological epistemology can provide a uniquely rich framework for analysis and the generation of sustainable ethical solutions.

Corinne Packer, Vivien Runnels and Ronald Labonté, in Chapter 3, also investigate the accuracy of analytical frameworks for health worker migration but to a more specific end. There are claims that the moral

concerns about the international migration of health workers are misleading and potentially even damaging to poor countries. The main bases of this moral counterclaim are usually that migration can provide an enormous net benefit to sending communities, primarily in terms of financial remittances and knowledge transfer. Packer, Runnels and Labonté use their wealth of professional experience to carefully examine the evidence supporting this claim. They extract data from a wide range of sources to establish whether remittances can really compensate for the loss of a country's investment in educating its health professionals and, more specifically, impact positively on their health systems. They conclude that the purported benefits of migration do indeed exist, but that they are unlikely to be sufficient to compensate for the costs.

The fact that remittances fail to adequately compensate for the costs of international health worker migration is one concrete reason to support the moral intuition that there is something morally troubling about the international migration of health workers; something that requires action to remedy in the form of 'ethical' health worker migration. Jeremy Snyder, in Chapter 4, interrogates this moral intuition more closely to ask exactly what the different moral wrongs of the 'brain drain' are. Snyder analyses the set of harms most commonly identified, that is, those to source communities, committed both by destination communities and by the leaving health workers themselves, but he also notes potential harms to migrant health workers in their host countries and harms to domestic health workers in destination countries. Crucially, reforms to the current system that aim to address particular sets of moral wrongs may work at cross purposes with each other, potentially compounding or creating new harms. Snyder argues that reformers therefore need to be aware of the multiple potential harms, to work to avoid conflicts and, when absolutely necessary, to balance competing ethical claims.

Weaving together considerations of ethics, rights and global justice, Rebecca S. Shah looks more closely at the harm to source communities in terms of harms to the human right to health in Chapter 5. While endorsing the human rights approach and its universal aspirations, Shah nevertheless presents a vigorous and incisive ethical critique of the state-limited mechanisms for human rights realisation and claims that they fail to properly address the underlying global inequality that both drives and is a consequence of health worker migration. She establishes that sending states have primary human rights responsibilities but that these are often compromised by a weakness in ability to effect change and degraded by caveats to the right to health. The rights-based responsibilities of receiving states for the right to health of citizens in

foreign countries are often disparaged for being weak and amorphous, but Shah critically analyses what different types of responsibility – to assist, to desist from causing harm and to provide remedy for rights violations – might look like and what they might mean for addressing the current crisis. In each case there are ethical contentions and practical obstacles that limit these as satisfactory responses to the problem of harmful health worker migration. Shah argues, however, that theories of global justice might enrich understandings of real-world human rights responsibilities by building in implicit concern for global inequality and demonstrates how one such theory may do so.

Picking up the mantle of global justice where Shah leaves off, Alex Sager, in Chapter 6, challenges our intuitions of why the brain drain and potential strategies to ameliorate it based on migration policy are morally troubling. Perhaps contrary to expectation given that it would likely increase international migration, Sager constructs the compelling argument that the brain drain gives us reason to support a policy of more open borders. Sager examines potential restrictive migration policies which might stem the brain drain and finds them practically, but moreover morally, wanting. In asking why active recruitment of health workers by rich countries from poor countries is morally wrong and whether policies to avoid it are morally right, he identifies the negative duties not to undermine institutions that provide the human right to basic health care. Sager uses this Poggean concept of international and negative duties to draw our attention away from the phenomenon of migration itself to what he identifies as the core issue – the global structural and institutional context of injustice which created the problem and causes patterns of global inequality to replicate themselves over time. Ultimately, he concludes, it is an error to contemplate the brain drain in isolation from the global context, and doing so leads him to advocate more open borders and an agenda of international institutional change.

Developing this focus on migration theory and applying it to particular policy solutions in Chapter 7, Phillip Cole speaks directly of an historic and enduring proclivity of political theory to focus on controls to immigration, which are deemed morally acceptable, to the exclusion of addressing emigration and the right to leave, control over which is considered morally unacceptable. The case of the migration of health workers is interesting in this context given that it is emigration which appears to be causing the greatest problems. In fact, given that health worker emigration contributes to inadequately functioning health systems, health workers' right to leave seems to clash with their compatriots' right to health. Cole asks whether this clash can justify policies restricting

the right to leave, such as in-kind bonding, or whether health workers have a moral duty to remain. He fails to identify a theoretical framework which can satisfactorily justify this in the context of the brain drain and endorses instead a radical cosmopolitanism where restrictions on individual health workers would not be acceptable but global health governance would enable the distribution of health-care resources according to global questions of distributive justice, not just national ones.

Cole finds that, with the suspension of the human right to leave, albeit temporary, bonding policies may be considered coercive. Nevertheless he asks whether such bonding may be justified as it practically expresses a duty to remain which trumps the right to leave. Anthony H. Lesser takes us further into this debate on apparent conflicts between rights and duties in Chapter 8, and arrives at considerably different conclusions from Cole. Lesser approaches the issue as a question of whether, and on what grounds, it can ever be acceptable to interfere with the free movement of labour. Lesser first establishes the grounds on which we might contend that a right to the free movement of labour exists and why we might claim that it should be free from interference. Utilitarian grounds for defending the free movement of labour from interference appear to fail as the brain drain amply demonstrates the potential negative consequences this freedom can bring. Lesser finds claims that one's labour is analogous to one's property and so one may be entitled to similar rights over it more compelling, but nevertheless makes it clear that such rights are far from absolute; there may be good reasons to limit these rights should demonstrable harm or rights violation result from the exercise of them. As a result it seems that there may be reasons to limit the rights of health workers from developing countries to use their labour wherever they please. These implicit requirements, however, are so indistinct and potentially onerous that it is preferable by far to make any obligations of health workers explicitly contractual ones. For example, for people to have to sign a contract at the time of their training agreeing to remain in the country and the profession for a determined number of years.

In Chapter 9, Nir Eyal and Samia A. Hurst look not at bonding or contractual policies but at the equally ethically contentious policy of training doctors in poor countries to specialise in local health problems and working in the context of local health infrastructure, particularly in rural areas. These policies are also open to the kinds of challenges that were of concern to Cole; that because they limit certain freedoms of health workers (for example to seek employment in more favourable settings) they are coercive. Advancing a raft of legitimising factors, the

authors contest that there is strong enough reason to think that even (seemingly) coercive actions may, at times, be justified and that this applies to the policy of locally specialised medical training. Indeed, by analogy to other commonly accepted but nonetheless coercive practices, they find that locally specialised medical training is either less coercive or coercive in a less troubling way.

Locally specialised training is closely allied to an area of Staffan Bergström's expertise – the training of non-physician surgeons in the fight against staggeringly high maternal mortality in poor countries with health workforce crises. Bergström draws on his years of experience in obstetrics and gynaecology to explore the relationship between maternal mortality and the human resources for health crisis in Chapter 10. Despite the repeated affirmation of laudable targets in the high-level forums of recent decades, progress to reduce maternal mortality in the developing world has been woeful. Bergström analyses the 'price tags' – moral, financial and organisational – of reducing maternal mortality and proposes a shift in thinking from 'endoscopic' (inward-looking, hospital-based) to 'ectoscopic' (outward-looking, community-based) approaches to maternal mortality. He explores how the conceptual lens of ectoscopy might help us to see the challenges of maternal mortality more clearly and to establish creative human resource based solutions, such as the training of non-physician surgeons, or *técnicos de cirurgia*. Given the failure of years of rhetoric on maternal health, Bergström challenges frontline professionals not to wait for the politicians to lead but to show them the way forward.

In Chapter 11, Anne Raustøl picks up on Bergström's challenge to health workers. Much debate on policies to ameliorate the effects of the brain drain focuses on what it is morally acceptable to expect, require or oblige of individual health workers. Anne Raustøl approaches this issue from a different direction and asks what, if any, moral responsibility health workers have when they face the decision to stay or migrate and what the philosophical bases for any duties may be. Raustøl systematically addresses the question drawing on several major schools of moral philosophical thought and the obligations on individual health workers they may give rise to. Her succinct and insightful analysis leads her to the conclusion that despite the compelling moral pressures on health workers from poor countries, the sacrifice involved in staying rather than migrating is of a significant magnitude to render any moral duty to stay supererogatory.

In sympathy with previous chapters' calls to focus on the roles of health workers, Colleen McNeil-Walsh's analysis, in Chapter 12, is refreshing

as she gives voice to the often-neglected perspectives of migrant health workers themselves. In particular she explores the experiences of South African nurses in the UK and how they understand their professional roles alongside their decisions to migrate and against the complex political, economic and historical backdrop that is South Africa. The idea of nursing as a calling driven by an ethics of care emerges from their narratives and suggests an alternative ethical framework to that of impartial rights and freedoms which should be acknowledged and engaged with, including at the level of policymaking. In exploring nurses' attitudes to return migration, McNeil-Walsh shows how embodied experiences of nurses as real people, not just economic units, can have an impact on the success of policies to mitigate the effects of the brain drain.

Finally, as head of International Relations at the trade union UNISON Nick Sigler has to walk the finely balanced path between the competing interests alluded to in other chapters. In Chapter 13, he reflects on UNSION's commitment to protect the rights of health workers in the UK, particularly migrant workers who contribute enormously but may be subject to exploitation, while also supporting health systems and the rights of workers in developing countries. It is not an easy path to tread but Sigler feels that the roles may be mutually reinforcing. Informing workers of their rights and promoting trade unionism can be empowering and drive improvements in working conditions, which might ultimately reduce the number of health workers wanting to migrate abroad. Solidarity alone, however, is not enough, and Sigler highlights the powerful role of trade unions in critiquing weak or inappropriate legislation, including migration policies and ethical codes, and strengthening the implementation of good legislation both at national and international levels.

Note

1. As this book was being written the WHO process to approve the draft ethical code for the international recruitment of health personnel was still underway. At the time of publication the code had just been adopted by the 63rd World Health Assembly in May 2010.

Reference

WHO (2008), *EB124/INF.DOC./2: International Recruitment of Health Personnel: A Draft Code of Practice, Summary of the Public Hearing*, Geneva: WHO.

1

International Migration of Health Professionals: Towards a Multidimensional Framework for Analysis and Policy Response

Giulia Greco

Introduction

This chapter provides some clarity on the key issues surrounding the international migration of health professionals as one of the critical factors that is provoking the global health workforce crisis. It aims to show that different analytical frameworks for explaining the movement of people across borders give rise to different policy responses which are more or less useful and appropriate to address the phenomenon of health worker migration. Three leading analytic frameworks will be analysed: the neoclassical approach, the historical–structural approach and migration systems theory. The proposed models function at different levels of analysis. Even though the assumptions, hypotheses and arguments resulting from each theory are not intrinsically clashing, they have different implications for policymaking. Depending on which theory is used, and under what conditions, different policies are put forward to cope with the challenges generated by the migration of health professionals. It is argued that traditional theories are too narrowly focused; a full understanding of contemporary migratory flows will not be comprehensive if only focused on one discipline; hence a multidimensional approach based on migration systems theory but with the individual at the centre of the analysis is recommended as it engages with different levels, assumptions and perspectives.

Patterns and trends of health professional migration

In recent years, concerns about the impacts of skilled migration from poorer to richer countries have put the flows of health professionals at the forefront of the policy agenda (WHO, 2006). There are not enough

health workers in the world, and they are not equally distributed among countries: the imbalance of the global distribution of health workers is expressed as an inverse relationship between the supply of health care and health needs (Bueno de Mesquita and Gordon, 2005). The World Health Report (WHO, 2006) shows that a considerable proportion of the total health workforce in Organisation for Economic Cooperation and Development (OECD) countries is composed of doctors and nurses who were trained abroad. Doctors trained in sub-Saharan Africa (SSA) and working in OECD countries represent 23 per cent of the actual health workforce in those source countries, ranging from as low as 3 per cent in Cameroon to as high as 37 per cent in South Africa. Nurses and midwives trained in SSA and working in OECD countries represent 5 per cent of the source countries' current workforce but with an extremely wide range from 0.1 per cent in Uganda to 34 per cent in Zimbabwe (World Health Report, 2006). In Jamaica, the brain drain has caused a reduction in the nursing workforce from 3000 to 1000, forcing the Jamaican government to recruit professionals from their neighbouring country, Cuba (Wickramasekara, 2002). Indeed, Cuba is an exceptional case: every year it sends thousands of health professionals overseas, mainly to African and Caribbean countries (WHO, 2006).

The UK has traditionally been a major destination for health professional migrants (Bach, 2003). According to the General Medical Council, over one-third of doctors registered in the UK were trained overseas, and more than 9000 of them come from SSA (GMC, 2004). In 2004, 40 per cent of nurses registering in the UK were from overseas, the majority of whom were trained in low–middle-income countries, particularly the Philippines, India and South Africa (NMC, 2004). The trend in the US is similar, where 23 per cent of practising non-federal doctors are trained overseas, of whom 64 per cent qualified in developing countries (Hagopian et al., 2004). A peculiar case is South Africa that loses up to half of its doctors and nurses overseas (Pang et al., 2002) and yet recruits up to three quarters of its rural physicians from overseas (Martineau et al., 2002).

In May 2003, health ministers from Commonwealth countries approved a document that drew attention to the fact that the international migration of health professionals 'has grown to such proportions that is affecting the sustainability of health systems in some countries' (Commonwealth Secretariat, 2003: 1). The impacts of health worker flows across the world are highly variable. In the short term, wealthier countries are relieved of labour shortages, fill vacancies in less desirable areas or sectors (Bach, 2003), increase skilled human capital and save

on the costs of education and training. Protests against this form of 'free riding' (Martineau et al., 2004) have been voiced by several non-governmental organisations including AMREF and VSO that are seeing doctors and nurses trained in their programmes migrating overseas (VSO, 2006; AMREF, 2006).

The potential benefits to sending countries include transfer of expertise and skills, if health workers return to their countries (the so-called brain gain or brain circulation, Findlay, 2002), and financial gains through remittances. Much debate has arisen over the controversial topic of remittances – whether they are associated with a decline in poverty or an increase in inequality in low-income countries (Özden and Schiff, 2006). Moreover, little is known about the actual amounts of remittance money and how that money is used within the sending community.

The most pernicious consequence of the outflow of health professionals from Southern countries is a sharp decrease in the quality of healthcare services in developing countries (Marchal and Kegels, 2003; Martineau et al., 2002). Chronic understaffing of health facilities will automatically cause a reduction in the availability of healthcare service provision (Buchan et al., 2004). In extreme cases, the worsening of health conditions can provoke a reduction in productivity, a loss of economic investment and slower economic growth in developing countries (Mejia et al., 1979; Ahmad, 2005). When large numbers of health workers emigrate, the countries that financed their education suffer a loss in intellectual capital and the return on their educational investment, and end up providing rich countries, which receive their trained doctors and nurses, with a 'perverse subsidy' (Mensah et al., 2005). Another implication suggested by Bach (2003) concerns those health workers who are left behind. The emigration of their colleagues can generate frustration and increase stress and work overload. Furthermore, these professionals are among the highest taxpayers in the country, and therefore their emigration provokes fiscal losses (*Economist*, 2002). Finally, labour migration can result in 'brain waste' when highly skilled migrants are employed in receiving countries in jobs below their level of qualification (Bundred and Lewitt, 2000; Özden and Schiff, 2006). However, although international migration is viewed as aggravating a shortfall in source countries, it cannot be assumed that health workers would have been retained in the public healthcare systems had they not emigrated (Bach, 2003).

The migration of health professionals is a central component of a wider crisis of human resources for health that is considered as a

major obstacle to the achievement of the health-related Millennium Development Goals. As the World Health Organization (WHO) states, 'when a country has a fragile health system, the loss of its workforce can bring the whole system close to collapse' (WHO, 2006: 101).

In order to minimise the harmful effects that international migration has on sending countries, it is essential to investigate the critical factors that can influence the patterns and trends of these flows.

Analytical frameworks and policy responses

Three conceptual frameworks for investigating the root causes of migration are analysed here: the neoclassical framework, the historical–structural framework and the migration systems theory. Each model differs in its conceptualisation of migration and adopting any one of the specific analytical approaches will lead to the formulation of different policy responses, such as retention strategies, two-tier training schemes or recruitment codes of practice. Widening the perspective through different levels of analysis will create a multidimensional framework that can be employed for policy analysis and ad hoc response.

Neoclassical framework

The neoclassical framework assumes that the migrant is a rational actor who maximises utility searching for the 'best' place to live and work in (Borjas, 1989), where she or he can be more productive, given her or his skills (Massey et al., 1993). According to Todaro (1969), a worker decides to migrate because, in the analysis of the costs (including material cost of travelling as well as social and psychological costs) that are incurred on leaving the country of origin and the benefits (including increased wages and acquisition of higher skills) that may be gained at the destination, there is an expected net positive return.

Variations of this model see international migration as a strategy to diversify the household's livelihood and lower the risks of market failures even in the absence of wage differentials (Stark and Levhari, 1982). Piore (1979), one of the most influential advocates of the 'dual labour market theory', stands apart from the previous theories and argues that labour migration is mainly caused not by factors that drive the worker out of the home country, but by factors that attract her or him to those countries with a 'chronic and unavoidable need for foreign workers' (Massey et al., 1993: 440).

Derived from the earlier models is the 'push and pull factors' theory. It looks at the origins of international migration as a result of balanced

forces: 'push factors' operate in source countries that motivate the worker to leave (including low wages, unsafe environment, unemployment as well as political repression) and 'pull factors' operate in destination countries that attract the migrant (such as higher salary, technology, better employment conditions, political freedom and increased security) (Massey et al., 1993; Castles and Miller, 2003). The issue is whether the 'push factors' outweigh the 'pull factors'.

A recent report based on interviews of doctors from Malawi, Ghana and Nigeria, who are currently working in the UK, points to both push and pull factors being significant. In particular, low salaries, political instability and inadequate living conditions are among the pushing forces (Boseley, 2005). According to the WHO (2006), workers' concerns about poor management, insecurity and oppression, high levels of violence and crime, reduced availability of employment opportunities, poor working environments and chronic shortages of supplies leads to lower levels of morale, professional frustration and increased workloads.

In many developing countries the opportunities for continued education and professional training are limited and career development is very slow, hence health workers seek professional fulfilment in the private sector or in 'greener pastures' overseas (Hongoro and McPake, 2004). The pull factors have been identified by Boseley (2005) as prospects for better remuneration, upgrading qualifications, gaining experience and availability of learning opportunities.

Neoclassical policy responses

Policy responses, according to this approach, largely unable to influence pull factors must work to address push factors either by tackling the causes of migration, for example by lessening wage differential (topping up salaries) and improving local conditions or through bonding systems that retain the worker in their country of training.

Eichler et al. (2001) illustrate that staff retention can be increased through monetary incentives, such as the bonus scheme that was recently introduced in Haiti. The Peruvian government has developed a Focal Health Spending Programme for motivating physicians and nurses to operate in remote areas. This strategy has successfully increased health staff availability and has consequently contributed to reduced inequalities between urban and rural areas, although the financial sustainability of the scheme has not been proved (Martinez and Collini, 1999). However, evidence from Namibia demonstrates that financial incentives should be used in tandem with other kinds of benefits such as a

subsidised housing scheme, car ownership, adequate pension systems and merit-based career development (Martineau et al., 2002, 2004). Otherwise, considering health worker motivation as exclusively financial can threaten the development of the public mission itself. Countries like Mozambique cannot compete with the financial incentives of overseas employers; however doctors are given significant social status and professional esteem (Martineau et al., 2004).

Bonding systems that enforce public service have been employed to ensure that the government gets a return on its investment in training and education. However, the effectiveness of this policy is dubious. As Mensah et al. (2005) describe, coercive measures may be counterproductive and can fail badly by generating more pressure to leave. According to Martineau et al. (2004), bonding schemes only work in those countries with efficient administrative systems and where inflation is not too high, otherwise the bond repayment needs to be readjusted. In the public sector, the human resource management system often has weak administrative efficiency and migrants are able to find a way of evading the system, such as buying out the bond (Dovlo, 2004). Alternatives are withholding academic certificates or establishing a form of compulsory community service that can guarantee some repayments to the system as employed in the scheme successfully introduced in South Africa for every medical graduate (Martineau et al., 2004).

There has been a tendency for policymakers to focus only on the 'push and pull' theory within the neoclassical framework, although more recently there has been a greater appreciation of the need for broader understandings of the dynamics of migration. By focusing on the individual or household level, neoclassical models neglect the critical role of the state and the penetration of the global market (Massey et al., 1993; Boyle et al., 1998) and they fail to address political influences, trade and historical issues such as the colonial legacy, as discussed in the next framework (Sassen, 2001; Portes and Rumbaut, 1990). Castles and Miller (2003) consider it absurd and unrealistic to assume that worker migrants are 'market-players' who can rely on comprehensive information for making rational and free decisions. Migrants usually have partial or incongruous information and do not enjoy complete freedom of choice because of lack of negotiating power with future employers as well as legal, economic and cultural barriers. Migrants overcome these constraints by building social networks that support them in different ways, from the process of decision making to the arrival in the destination countries. An analysis of social networks is discussed in the third framework.

Historical–structural framework

A different framework of analysis stems from Marxist political economy and is called world system theory. The main concept is that migration is caused by an uneven distribution of economic and political power in the global economy. In the tradition of Marxist analysis, academics see international migration as a natural consequence of the transition to capitalism and the migrant as a factor of capitalist production (Shrestha, 1988). The causes and driving forces behind migratory movements are to be found in the logic of capitalist demand for labour.

According to Harvey (1982), labour migration is a necessary condition for the accumulation of capital and, as Sassen (2001) explains, it causes unequal development, depleting the resources of poor countries with the result that wealthy countries become even richer. Migration flows 'follow the political and economic organization of an expanding global market' (Massey et al., 1993: 447), in particular they tend to be directed towards certain 'global cities' where capitalist production is concentrated (Sassen, 2001). As labour within peripheral areas comes under the influence and power of global markets, the displacement of people is inevitably generated.

Since international migration is generated by the dynamics of the global market, policies should follow the patterns dictated by the integrating trends of labour market. Labour supply needs to be adapted to fit the demand in the pursuit of market equilibrium rather than aiming at regulating wage differentials or unemployment rates among countries. Labour market changes are cumulative and self-reinforcing, and, as Mensah et al. (2005) argue, policies that do not follow their patterns are unlikely to succeed.

Historical–structural policy responses

As the global market in healthcare is expanding in several countries, different responses are occurring. First, it is not only national health service providers but also private sector agencies that are more actively recruiting workers internationally, raising concerns about the ethics of recruitment and therefore raising pressure for adopting a *code of practice* to guide recruitment procedures. Second, an increasing number of middle-income countries are adjusting the training of health workers to local needs (community health workers, substitute health workers) and to global demand (for international export) including two-tier training systems.

In 2001 the UK Department of Health issued a code of practice stating that developing countries should not be targeted for recruitment unless

there is a formal agreement with the country. Recruiting agencies were also invited to sign up to the code; however, only 68 out of about 115 private sector agencies have done so (Bach, 2003). Whether these guidelines have been a useful tool is not without doubt.

As indicated in Bach's study, there was a significant decrease in the number of nurses registered in UK from the Caribbean and South Africa in the year prior to April 2003, but the number of nurses from sub-Saharan countries including Zimbabwe, Nigeria, Zambia and Ghana increased (Buchan et al., 2003). The main difficulties with codes of practice are enforcement and monitoring and the inclusion of private sector agencies (Bach, 2003). In fact Martineau et al. (2004) examined several codes of practice and found none of them to be legally binding. There are mainly two responses to the ineffectiveness of the UK code. The first one is to strengthen the code with more coercive measures; but, as Mensah et al. (2005) argue, this is discriminatory towards health professionals from the most disadvantaged countries. The freedom of the better off to move, for example nurses from Eastern Europe, is implicitly privileged. The second strategy is that the code should ensure equal employment rights to all migrant workers (Mensah et al., 2005). It is therefore crucial that public and private sectors agree on a code of practice and that in accordance with employment laws, the code should protect all health professionals, to prevent acts of racism, discrimination and abuse.

Some nations are beginning to modify the composition of their health workforce in order to make it less vulnerable to market penetration, for example promoting the employment of substitute health workers. Paramedical staff and medical auxiliaries are gradually becoming the main service providers in several African countries, such as Tanzania, Mozambique and Malawi (Dovlo, 2004). One of the major advantages of focusing on mid-level health workers is that they are less employable overseas, and hence less likely to emigrate (Buchan et al., 2005). Furthermore, the cost and time of education is smaller; they need only three years of post-school education plus one year for training (Hongoro and McPake, 2004). The main concern is that quality and safety of health services may decrease. However, the existing evidence (although limited) suggests that, at least in some circumstances, well-trained clinical officers can safely substitute for physicians in the provision of some services (Hongoro and Normand, 2004). Research carried out in South Africa by Dickson-Tetteh and Billings (2002) reported that mid-level midwives could be as safe and effective as doctors in delivering surgical services such as abortion.

Another strategy is to reorientate current medical education towards local needs and contexts, for example developing a training programme mainly based in rural communities and involving traditional healers and community leaders in the process of educating, recruiting and retaining health workers (Dovlo, 2003; Chen et al., 2004; AMREF, 2006). In Uganda, AMREF is training 'comprehensive nurses' who can undertake different tasks even with shortages in equipment, personnel and medicines. They are considered 'unemployable in Europe, indispensable in Uganda' (AMREF, 2006). Evidence shows that community-based schemes have worked well in Thailand, increasing the number of physicians working in deprived areas. The emigration of doctors and nurses from Thailand significantly reduced once training was conducted in Thai. Nurses, midwives and paramedical staff are recruited and trained locally, and then assigned to posts in their home villages (Wibulpolprasert and Pengpaibon, 2003).

Another response is adapting training to labour demand. The Development Research Centre on Migration, Globalisation and Poverty (2006) suggests a two-tier system of medical training: the first in which doctors and nurses are trained to international standards with the acknowledgement that some will migrate and the second tier in which others are trained to more basic levels of healthcare provision in response to local needs. Such a policy response calls for a level of capacity that is beyond many countries, which struggle to provide only one form of training.

The case of the Filipino nurses is an example of training for international export and effective state-managed migration (Abella, 1997). Private nursing schools decided to train a surplus of nurses with the aim of supplying countries that are facing a shortage. The Philippine Overseas Employment Administration (POEA) has been established in order to formulate and manage migration policies (e.g. marketing Filipino workers, countering illegal migration, regulating private recruiting agencies and providing an advisory service). The effective protection that the POEA can offer to migrant workers has been well documented; however, some commentators have argued that the loss of nursing professionals will at some stage be detrimental to the sustainability of the health system (Stilwell et al., 2004).

The historical–structural approach clearly generates many potentially effective policy responses to problematic labour migration. A significant drawback of this approach, however, is that, contrary to the neoclassical approach, in considering the logic of capital and the interest of wealthy nations as the driving forces behind migratory movements, it ignores the actions of individuals and their communities.

A multidimensional framework – migration systems theory

By focusing on the individual, or the household, the neoclassical framework neglects the role of institutions including governments as well as cultural, political and economic influences. On the other hand, the historical–structural approach does not consider personal decisions. Although wage differentials, minimisation of risk and maximisation of income, push and pull factors and market penetration may continue to provoke people to move, new causes are rising: migrants' networks are spreading and institutions supporting international movements are growing. There is a need to extend the analytical framework beyond the confines of macro or micro economic theory.

The 'migration systems theory' stems from a broader range of disciplines, covers more diverse dimensions of migratory movements and includes different perspectives, such as network theory, institutional theory and the cumulative causation model.

The decision-making process starts as an individual's or household's choice but is strongly influenced by social and kinship chains that bond countries of origin and destination and by formal and informal institutions that shape the global context. Migratory movements develop a structure over space and time 'allowing for the identification of stable international migration systems' (Massey et al., 1993: 454). Migration is a system of networks linking sending and receiving countries (Castles and Miller, 2003). As such, a migration system is composed of two or more countries that exchange migrants. Usually, it is considered as the base for an analysis of specific regional systems that are interlinked, such as South Asia with the UK, Northern and Western Africa with France or the Caribbean with Western Europe and North America. This framework allows the linkages between countries to be analysed as 'state-to-state relations and comparisons, mass culture connections, and family and social networks' (Fawcett and Arnold, 1987: 456–7).

Any migratory movement can be explained as the result of interacting macro and microstructures. *Macrostructures* are large scale institutions: the international political economy, global market forces (Castles and Miller, 2003), international relations, migration laws and regulatory policies of both sending and receiving countries (Brettell and Hollifield, 2000).

Microstructures are those informal connections, practices and attitudes, including kinship patterns and community ties that are built by the migrants themselves (Castles and Miller, 2003). Studies on international migration have increasingly drawn our attention to the importance of social networks in structuring and shaping patterns of migration flows (Boyle et al., 1998). Migrants are tied to those left behind in their

countries of origin and they themselves create new networks in their destination countries. Social networks are critical for reducing risks and the costs of migrating and increasing the expected net benefits (Massey et al., 1993); moreover, they make the migratory process safer and more reliable for both the migrant and their family. When a migratory movement has started and migration pathways are set up by the first pioneers, the social process of migrating becomes self-sustaining because each movement builds the social structure necessary to support it (Massey et al., 1993; Castles and Miller, 2003). Once the number of migrants reaches a critical threshold such that social networks have developed sufficiently to reduce costs and risks and facilitate further opportunities, the processes of migration modify the context in which future decisions will be taken, increasing the probability that other people will choose to leave their countries (Massey et al., 1993).

The macro and microstructures are interlinked by various intermediary dimensions called *meso-structures*. An imbalance between the large number of people who want to move to wealthier countries and the limited number of available visas create a space for action for agents and organisations dedicated to supporting and fostering migration, both legally and illegally (Massey et al., 1993). Lawyers, recruiting agencies, humanitarian organisations as well as human smugglers are part of these meso-structures. As Castles and Miller (2003) explain, they function as a liaison between the migrant and formal institutions and can provide different kinds of services including legal advice concerning immigration policies, labour contracting, clandestine transport, counterfeit documents, arranged marriages between migrants and citizens of receiving countries as well as counselling and social services. Massey et al. (1993) consider the networks built in the meso levels as another form of social capital on which migrants can rely to gain access to the international labour market.

Controlling migration at the micro and meso levels results in difficulties for governments because the process of building networks and promoting or inhibiting flows is beyond their influence. Moreover, social, economic and cultural changes generated by international movements give migration a 'powerful internal momentum' (Massey et al., 1993: 453) difficult to regulate and manage through government policies, since the feedback mechanisms of cumulative causation are not controllable by external interventions.

Potential migrants will always find a means to migrate. First they will seek to profit from any bilateral agreements that may exist between the two countries. Failing this and taking into consideration that restricting

immigration policies will lead to a black market, they will try to use their micro level networks and kinship ties. If these are not forthcoming they will resort to meso-structures, including recruiting agencies and informal organisations.

Migration systems policy responses

Policy responses developed with systems theory in mind are based on the awareness that migratory movements are unavoidable and therefore should be orientated at promoting controlled temporary mobility wherever possible. The UK Department of Health has concluded a range of agreements with certain countries, which include international recruitment as well as cooperation on health systems development.

Egyptian doctors can participate in a fellowship programme for working in England and as a result gain additional experience (Bach, 2003). The Caribbean Community (CARICOM) has designed a scheme that promotes health professionals' short-term migration: they are encouraged to work overseas for three years and then return. These agreements have many advantages: first, they reduce the use of private sector agencies, ensuring a more transparent recruiting process and reallocating the costs of migration to the final client and not onto the migrant. Second, they are more flexible than codes of practice and can be implemented in different ways. For example, they can vary from a simple training programme to a comprehensive partnership which involves exchange, as is the case between Cuba and Venezuela where health professionals are exchanged for oil.

A critical component of this response is the return of the migrants. The International Organization for Migration (IOM) has developed a programme to facilitate the return of professional migrants; however, according to Martineau et al. (2004), of the 250 Ghanaian returnees assisted from 1986 to 1999 only 15 per cent were doctors, and they have reported several difficulties and frustrations on their return home (Mensah et al., 2005). Governments ought to provide flexible terms of employment to enable health professionals to work abroad and return to their home country, where their skills gained overseas can be valued and welcomed.

A compensation mechanism has been advocated by various academics and policymakers as one of the most ethical responses to the crisis (Mensah et al., 2005; Stilwell et al., 2004). Receiving countries have to pay for the 'perverse subsidy' they are gaining from sending countries, for the education of health professionals. Though it is not easy to evaluate the amount to pay back, this can be negotiated through

bilateral agreements. It is recommended that the compensation be then reinvested in health sector training and education.

Conclusion

It is important to recognise the inevitability of international migration and that the integration of global labour market is irreversible. Policy responses should operate within rather than against this force, promoting controlled temporary mobility wherever possible. Policy responses that attempt to force immobility are unlikely to succeed and are both discriminatory and a violation of the right for the free movement of people. The decision to migrate, although essentially personal, is inevitably conditioned by different influences that in some cases are beyond the control of policymakers but in other cases are manageable with appropriate interventions.

The neoclassical framework, the historical–structural framework and migration systems theory differ in the conceptualisation of migration and thus in the policies that can be derived from each. Migration systems theory is an improvement on the first two frameworks as it is more comprehensive in its understanding of migratory flows by taking into account micro, meso and macro dimensions of migration. But it puts too much emphasis on the role of networks and ultimately neglects the critical role that the individual plays in the decision over whether or not to migrate.

No single approach can adequately address the challenges created by migration, in fact when policy responses are taken in isolation, they have been proven to be ineffective. The understanding of migration needs to be multidimensional, and making the individual the centre of analysis within migration systems theory may generate the most useful approach to date. It is not that the networks ought to be the subject of the analysis but rather how the individuals themselves interact within and between these networks and only then are the chances of deriving holistic policy responses improved.

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2

Care Worker Migration and Global Health Equity: Thinking Ecologically

Lisa A. Eckenwiler

We read throughout the literature on health worker migration of 'channels', 'flows', a 'cascade'. We hear calls for 'sustainability'. These concepts, drawn from the discourse of ecology, entice with their imagery and vision of a better future. Yet the resources of ecological thinking call for closer attention. I intend to show that *ecological epistemology* provides rich conceptual resources for analysing and understanding this transnational flow of people and its implications, and in turn, generating more potent and ethically sound policy remedies.

In making the case for embracing ecological thinking here, I concentrate for the most part on what I will refer to as 'care workers', by whom I mean nurses and direct care workers (DCWs), such as nurse aides, home care aides, and personal care assistants. These workers may be the most essential members of the health workforce, serving as the principal providers of basic health services as well as long-term and palliative care, the need for which is burgeoning and helping to fuel mobilities (Fleming, Evans, and Chutka, 2003; Priester and Reinhardy, 2003; WHO, 2003). I focus on the US and its growing needs in long term care (LTC) because although care workers migrate to many affluent countries, the US is the largest importer (Aiken, 2007; Dumont and Zurn, 2007).

My plan is, first, to identify the limitations of the frameworks so far embraced for discussing health worker mobility. Next I describe ecological thinking and highlight its key elements. From there I offer four compelling reasons why we ought to embrace ecological epistemology for thinking about care worker migration.

Metaphors and models for understanding health worker migration

The carousel, the conveyor belt, and the cascade

We are invited to imagine carousels and conveyor belts carrying workers from one place to the next (Ncayiyana, 1999; Packer, Labonte, and Spitzer, 2007). And with a wave of downward-flowing arrows, with the US as the bottom-most point, the Organisation for Economic Cooperation and Development (OECD) offers a 'cascading migration model' for depicting migration between OECD countries (OECD, 2008).

These metaphors, importantly, identify that there is some process, indeed *processes*, at work. But by focusing merely on the movement of individuals, they divert attention from the social, economic, and political environment in which the flows occur. The carousel and conveyor belt also obscure relevant features of the movement. First, it tends not to be circular. People typically do not return to their countries of origin as the images of a carousel or a belt suggest but instead may move permanently to work in a second or even a third country (Buchan, Parkin, and Sochalski, 2003; Kingma, 2006). The metaphors also suggest that the pattern is always identical. Yet the mobilities at issue here are more varied and complex. The cascade image, while capturing that current rates of migration are unprecedented (so the flow is not a mere trickle) and that many migrants do not return, focuses our attention mostly on the direction of health worker flows.

Global care chains

Developed to describe the transnational caregiving relations that arise as a result of women's migration to serve as nannies (for example, while a sister or parent cares for her children, a migrant care worker cares for another, more affluent woman's children) (Hochschild, 2000), 'global care chains' is now sometimes used to describe the global flow of nurses (Yeates, 2009).

Notably, the concept of global care chains captures the gendered nature of labour migration, and of care worker migration in particular (Sassen, 2002; Dumont, Martin, and Spielvogel, 2007; Reichenbach, 2007). It also focuses its attention on the transnational relationships that support and sustain migration, revealing the full extent of the division of labour structured by gender, race and ethnicity, and class. Third, the image of a chain can make clear the significance of connection as well as constraint in the lives of globally mobile care workers.

Cost-benefit calculations

The earliest accounts of *why* health workers migrate framed mobilities as a matter of cost-benefit calculations, suggesting that migration occurs when the perceived cost of moving is less than the perceived cost of staying (Lowell and Findlay, 2002). People move, in other words, when the value of wages in a destination country exceeds the value of wages in a source country, the costs of migration, and the desire to remain at home.

This approach, grounded in neoclassical economic theories of wage differentials fails, however, to account for migration that takes place in the absence of wage incentives. While people do hope for better pay, even when they do not stand to gain it, many migrate seeking prospects for better working conditions, a better quality of life, and sometimes greater safety and security (Crush, Pendleton, and Tevera, 2005; INSTRAW, 2007; Packer, Labonte, and Spitzer, 2007). An even greater liability of this model is that it frames decisions as being made by rational, self-interested, acquisitive individuals who are fundamentally 'counters in a mathematical game' (Nussbaum, 1995: 24) and, on the whole, free to determine their actions and the conditions of their actions. This liberal individualist framework offers a crude analysis for it rests on a narrow (and some would say distorted) conception of persons and ignores the ways in which people are embedded in broader social, economic, and political contexts that can shape and constrain choice. While more sophisticated cost-benefit models have emerged, they still suffer from the same liabilities.

'Push-pull' factors

Most current work on the migration of health workers explains it in terms of 'push-pull' factors (Bach, 2003; Chen, Evans, Anand et al., 2004; Commission of the European Communities, 2005; ICN, 2006; WHO, 2006). This model aims to capture the conditions in so-called source countries that 'push' health workers to migrate and the factors that 'pull' them to work in other countries. It moves beyond the reductionist cost-benefit calculation approach in identifying many of the social and economic structures and processes that facilitate migration among health-care workers.

This framework and the metaphor of the 'coveyor belt' are compelling for their industrial imagery. Both seem to suggest that in the global economy, labour migrants are little more than widgets or, in this case, vessels of caring capacity of merely instrumental value, being transferred from one place to another. The push-pull framework also

effectively captures the extent to which choices to migrate, particularly from low-income countries, are made under conditions that might be characterised, if not as coercive, as at least constraining. Like the 'global care chains' concept, then, it acknowledges the troubling implications for the autonomy of labour migrants.

Nevertheless this framework lacks the capacity to make clear the complexity of the global structures, processes, and relations within which these flows emerge and evolve, and the implications that unfold overtime. While it captures many salient factors that contribute to migration, this still crude, mechanistic model is not well suited for highlighting how factors may work together, synergistically, to generate flows. It is not particularly adept at revealing the ways in which migrations are patterned – moving, for example, from south to north, rural to urban – but also particularistic, subject to variation across countries, regions, and populations. Moreover, because its scope is restricted to the factors facilitating health worker migration, the 'push-pull' framework cannot – and is not designed to – capture future (short- and long-term) implications for health equity.

Despite their important contributions, existing models for describing and explaining health worker migration highlight important issues but also limit understanding. Ecological epistemology allows for a more nuanced and detailed understanding of health worker migration and what it means for migrants and those who need care.

Defining ecological thinking

As typically understood, ecology describes 'the study of patterns in nature, of how those patterns came to be, how they change in space in time, why some are more fragile than others' (Kingsland, 1995: 1). Yet ecology, as a discipline, is 'stunningly diverse' (Pickett, Kolasa, and Jones, 2007: 4). Most influential in shaping ideas here is work in population and ecosystem ecology, ecosocial epidemiology, and ecophilosophy.

Population ecology describes the study of 'the interrelationships between organisms and their surroundings' (Pickett, Kolasa, and Jones, 2007: 12), 'the processes influencing the distribution and abundance of organisms, the interactions among organisms, and the interactions between organisms and the transformation and flux of energy and matter' (IES, n.d). Ecosystem ecology involves 'the study of ecological systems, and their relationship with each other and with their environment' (Pickett, Kolasa, and Jones, 2007: 12). Ecosocial theories in epidemiology 'seek to integrate social and biological reasoning … to develop

new insights into determinants of population distributions of disease and social inequalities in health'. They investigate 'who and what is responsible for population patterns of health, disease, and well-being, as manifested in present, past, and changing social inequalities in health' (Krieger, 2001). Finally, philosophers who embrace ecological thinking explore the interrelationships between the environment, social and political relations, technoinformatic structures, and our embodied subjectivities (Genosko, 2009). In other words, ecophilosophical inquiries focus on how environments 'constitute corporeality' and shape the way people experience 'lived spatiality', exercise agency, and strive to endure. How, they ask, do we as embodied beings in need of 'support and sustenance' navigate particular terrains from day to day and flourish (or not) (Grosz, 1995: 103)?

Ecological thinking is distinctive in four ways. First, it is critical of and aspires to replace reductionist models that 'isolate parts of nature [and/or social life] so as to obscure the constitutive functions of multiple and complex interconnections' in generating effects (Code, 2006: 42). Second, thinking ecologically highlights broad patterns as well as particularities. '[I]n its commitment to complexity, [this approach to knowing] urges attention to detail, to minutia, to what precisely – however apparently small – distinguishes this patient … from that, this practice, this locality from that, as Rachel Carson would distinguish this plant, this species, from that … all the while acknowledging and respecting their commonalities, where pertinent' (Code, 2006: 280). Third, it is especially attuned to power relations. It situates its fine-tuned investigations 'within wider patterns of power and privilege, oppression and victimization, scarcity and plenty' (Code, 2006: 280). Finally, it invokes a 'longer, temporal and spatial view, across terrains and timeframes' and thus allows for identifying effects and their sources that may not be readily apparent, and for envisioning interventions that can be sustained over time.

As I understand it here, then, ecological thinking can help to generate a detailed mapping of health worker migration and its meanings. It can examine the confluence of factors contributing to care worker mobility and distribution in different regions and explore how this adversely affects particular health systems and populations. With a commitment to finding fragility, it can trace the complex, social, and economic structures that shape health systems in different parts of the world, relations among these systems, and in turn, the health and identities of particular people. It can also help to ground and assign responsibilities for global justice, aiming for interventions sensitive to particular places and persons.

Now I shall turn to four reasons that recommend ecological epistemology for thinking about the mobility of care workers migrating from the global South to the US and other sites in the more affluent North.

Four reasons to embrace ecological epistemology

Ecological epistemology highlights the multiple and complex relationships among policies, programmes, and people

Social values and health policies

Around the world, care work suffers from a poor public image and a lack of social respect (Folbre, 1999; Kittay, 2001). Those who care for pay also face difficult working conditions attributable to policy choices. Nurses in the US point to frustration with underinvestment in the health sector, staffing that is insufficient to support quality patient care, increasing hours on the job, rotation between units, centralised decision making that denies them participation (including participation in decision making regarding patient care), inadequate opportunity for continuing education and professional development, and poor compensation (Berliner and Ginzberg, 2002; Steinbrook, 2002; IOM, 2004).

These problems are greater for DCWs, many of whom also lack benefits, including retirement benefits, health insurance, and sick leave (National Clearinghouse on the Direct Care Workforce, 2006; Lipson and Regan, 2004).

Such conditions have contributed to what some call a 'care crisis' (Berliner and Ginzberg, 2002; WHO, 2006). Nursing and direct care work is now characterised by unprecedented vacancies and turnover rates, with a declining number of people entering the field, retention problems, and a growing trend towards early retirement. Estimates are that between 3.8 million and 4.6 million nurses, nurse aides, home health, and personal care workers will be needed in the US by 2050 in order to meet the demands of a growing elderly population, a 100–140 per cent increase over 2000 levels (US DHHS HRSA, 2004a, b; US Census Bureau, 2008).

The reasons for the rising need for care workers, though, go beyond the projected growth in sheer numbers of elderly people in need of care. Increase in the age and disability levels of care recipients may create a greater demand for paid care workers given that the care needed may be more complex and call for a higher level of skill than many family caregivers, historically the first line of care for the elderly, can provide (Wolff and Kasper, 2006; Kramarow, Lubitz, Lentzner et al., 2007; Seavey, 2007).

While these conditions might be addressed by any number of strategies, an increasingly popular one involves the employment – in both hospitals and LTC settings – of women from the global South in nursing and direct care positions (Brush, Sochalski, and Berger, 2004; AARP, 2005; May, Bazzoli, and Gerland, 2006; Leutz, 2007). These care workers are increasingly likely to come from low-income countries with a low supply of nurses and, in some cases, a high burden of disease (Dumont and Zurn, 2007; Polsky, Ross, Brush et al., 2007).

Global economic and trade policies

Underdevelopment in the global South and the emergence of neoliberal economic policies may be the greatest contributor to the transnational flow of care workers. Structural adjustment policies have led to reductions in wages and employment, including health sector employment, underresourced health systems, and difficult living and working conditions, causing many to seek work in richer nations (Bach, 2003; Buchan, Parkin, and Sochalski, 2003; Stillwell, Diallo, Zurn et al., 2004). Although many care workers migrate for their sake and that of their families given the economic conditions they confront, their governments are also dependent upon them for economic survival (World Bank, 2005; UNFPA, 2006). Some, like the Philippines, India, and China, have taken to recruiting their own citizens for care work abroad as part of their economic development plans (Fang, 2007; Khadria, 2007; Lorenzo, Galvez-Tan, Icamina et al., 2007).

Free trade agreements, as well, have reduced trade barriers and contributed to job losses in the global South, thereby facilitating the mobility of people (Narasimhan et al., 2004). Free trade blocs also aim at encouraging the 'free movement of labor' through mutual recognition of qualifications or the easing of visa or permit requirements (Bach, 2003: 27).

Immigration and labour policy

Selective immigration is a strategy increasingly used as an 'instrument of industrial policy' under globalisation (Ahmad, 2005: 44). Lobbying for an easing of immigration requirements in order to gain access to nurses are employers and industry organisations like the American Hospital Association, the American Health Care Association, and the National Center for Assisted Living who have come to regard international recruitment as a way to keep hiring costs down and improve retention (Buchan, Parkin, and Sochalski, 2003; Pittman et al., 2007). DCWs confront more challenges when it comes to immigration to the US. No temporary visas

are available for them, as the number of immigrant visas set aside for all less-skilled workers was, at the time of writing, capped at 5000 per year (Leutz, 2007). The increasing demand and scarcity of legal avenues likely contribute to the illegal immigration of many women who end up working in LTC (International Organization for Migration, 2005), especially in the informal or 'grey' economy in home care (Redfoot and Houser, 2005).

The recruitment industry

While informal recruitment through family members, former colleagues, and friends is common, the growing demand for care workers, especially nurses, has contributed to the dramatic growth of a 'for-profit' international recruitment industry, involved in a range of activities related to recruitment, testing, credentialing, and immigration (Pittman et al., 2007). In the late 1990s in the US, there were roughly 30–40 companies engaged in international nurse recruitment, often operating on behalf of the health-care industry. As of 2007, there were at least 270. Estimates are that 41 per cent of foreign-born nurses working in US hospitals and LTC settings have been recruited from abroad.

Not only has the number of companies surged but so too has the number of countries in which recruiters operate (Pittman et al., 2007). In the early days of international nurse recruitment there were roughly half a dozen countries. Now there are over 70, many with high burdens of disease and low nurse-to-population ratios.

Labour policy and workplace practices

The overwhelming majority of family caregivers in high-income countries are employed in the paid labour force (International Longevity Center and Schmieding Foundation, 2006). Yet their employers tend to offer scant support. Estimates are that roughly six per cent of employers in the US have written policies about elder care. One survey found that 39 per cent said that elder care benefits were 'too costly to be feasible' (Gross, 2006). Beyond what employers make available, the Family and Medical Leave Act provides some assistance. Yet this leaves many workers uncovered, and studies show that even for those who are eligible, it does not offer adequate support (Williams, 2006). This problem plays out in many countries (WHO, 2003), especially with the surge in demand for high-level professionals, including women, under economic globalisation. This demand has, in turn, created a demand for low-paid service workers, including women who serve as care workers for children and the elderly (Sassen, 2002).

Care worker migration, thus, is generated, shaped, and sustained by a complex configuration of norms, rules, and structures that operate across national boundaries. An ecological approach can not only point out the factors that facilitate migration but can also highlight and trace the complexity of processes at work across policy sectors and institutions and the interactions among them, and their implications for care workers – paid, unpaid, native, and migrant, highly skilled and 'unskilled' – and ultimately, populations in need of care.

Ecological thinking helps to conceptualise how particular patterns come to be and change over time

Ecological epistemology possesses the conceptual resources to chart the flow of health workers and map the patterns that emerge. Well-established 'channels' lead many care workers to places with a shared language and culture (often tied to the history of colonialism), a large diaspora, or where immigration and licensure are less problematic (Kingma, 2006). Canadian nurses, for example, often migrate to the US, South African nurses migrate to Canada, and nurses from other parts of Africa fill vacant posts in South Africa (Dumont and Zurn, 2007). Caribbean nurses travel to the US, while their vacancies are filled by women from poorer countries like Cuba and Guyana, Ghana, and Nigeria (Salmon et al., 2007). Filipino nurses are educated and trained for export to the US and Middle East (Go, 2003).

Mapping migrant flows gives us tools to describe the resulting distribution and maldistribution of health workers between and within countries, for instance between urban and rural regions, the public and private sector, and between specialties (Martineau, Decker and Bundred, 2002; Dubois and McKee, 2006). Indeed, ecological thinking can chart fragile habitats, populations, and particular organisms. The World Health Organization (WHO) estimates that while approximately 55 per cent of the population lies in urban areas, 75 per cent of the doctors and 60 per cent of the nurses live in urban areas (WHO, 2006). It also finds that 57 countries face a severe health workforce shortage, most of them in Africa. Such shortages worsen inequalities in areas like child and maternal health, vaccine coverage, and in response capacity for outbreaks, the consequences of conflict, and mental health care. In the Philippines, the major source country for nurses in the US, the skilled nursing workforce is migrating faster than it can be replaced, threatening the viability of the country's health services and the health of its population (Lorenzo et al., 2007). Nurse-to-patient ratios are dangerously low, especially in rural areas. The Caribbean, with the second highest prevalence

rate of HIV/AIDS after sub-Saharan Africa (SSA), is also highly represented in the US nursing and DCW workforce. There, as many as 42 per cent of nursing positions were vacant in 2005 (CARICOM/PAHO, 2005). India, a growing exporter of nurses to the US and other destinations has one of the lowest nurse-to-population ratios of all source countries (Khadria, 2007). Variations in recruitment and migration patterns and in health effects within countries warrant further study. The point to underscore is that ecological thinking allows for a more particularised understanding of the populations of countries and regions losing care workers.

It also enables us to consider the ways in which care workers themselves are a fragile population. While they may earn better wages, it is far from clear that migration improves the lives of care workers. Many experience the adverse effects sometimes described as dislocation. They often get lower-tier jobs, in some cases contrary to the promises of recruiters, and thus lower pay and worse working conditions than expected (Bach, 2003; Buchan, Parkin and Sochalski, 2003; Pittman et al., 2007). As noted earlier, many go without health insurance, which is especially troubling considering that care workers have espcially high rates of job-related injury among all occupations. In the case of DCWs, it is a striking four times the national average (Newcomer and Scherzer, 2006; US BLS, 2007). Undocumented care workers face especially difficult obstacles in accessing health care (Meghani and Eckenwiler, 2009). Due to US immigration and travel laws that control the entry and exit of some nationalities stringently, some care workers are unable to freely and easily travel home to visit. Some do not see their families for years and so suffer from strained filial ties (Parreñas, 2003; Jones, 2008).

Even in the affluent global North, some worry that reliance on care workers educated abroad might erode the already-weak state of LTC and diminish the already-fragile quality of care for much of its patient population, especially where licensing, orientation, and mentorship for migrant care workers are lacking (Wenger et al., 2003; Asch et al. 2006; Castle and Engberg, 2007). Finally, just beyond our scope here but an integral part of the ecology of care work are family members working to provide care for aging or otherwise dependent loved ones. Data reveal serious adverse implications of care work here too, including health inequities (Schulz and Beach, 1999; Stone, 2001; Christakis and Allison, 2006).

Just as rock and soil erode due to the forces of wind and water, health systems and institutions and the health of populations can erode due to a confluence of policies and practices. Ecological knowing can help us

to conceptualise how patterns emerge and evolve over time. It can also attend to particularities – of habitat (whether country, health system, region, institutions, etc.), population, and individual – enabling us to chart health inequities across a range of sites and scales.

Thinking ecologically traces the transnational processes and relationships that generate injustice and helps with the assignment of responsibilities to remedy it

An ecological approach helps to show how the mobility of care workers both reflects and perpetuates structural injustice. By 'structure' I mean 'the confluence of [social norms], institutional rules and interactive routines, [and the] mobilization [and distribution] of resources' (Young, 2006: 111). Structural injustice occurs where social and economic norms and processes serve systematically to undermine or constrain some people's abilities to develop their capacities, to determine their actions and the conditions of their actions, and to threaten their equality while at the same time enhancing and expanding others' prospects. The ethical concern is not merely that structures constrain. 'Rather the injustice consists in the *way* they constrain and enable, and how they expand or contract … opportunities' (Young, 2006: 114), here for care workers and the populations they leave behind.

Appreciating the injustice surrounding care labour migration as structural provides for a more nuanced understanding of how harm can be perpetrated, that is, not necessarily by intentional, malevolent acts of tyrants but rather as unimagined consequences of a multitude of decisions and operations carried out by what are, in some cases, well-meaning actors. Also, it allows for a more inclusive understanding of salient concerns for individuals, populations, and health systems. Much attention focuses on the distribution of health workers, which is, of course, central for it bears on care worker-patient ratios, number of beds and facilities available for use, and worker stress and fatigue. Yet an ecological analysis brings into view more than the distribution (and redistributions) of human health resources; it can trace the structural processes that render some places sites of deprivation where flourishing is all but impossible and survival itself may be a struggle, at the same time that others become more prosperous. It brings into relief the social norms regarding care work, care workers, migrant women, and those in need of care. It highlights the multilayered and often fragmented decision-making structures and processes of governments, international financial institutions, the health-care industry and the for-profit sector whose actions cross borders, and the ways that these function

to perpetuate asymmetries of power. As well, by highlighting structural processes an ecological account can raise questions about how certain identities are shaped and constructed for export, manipulated and categorised for immigration and labour purposes, and how particular bodies are mobilised and located in ways that undermine prospects for flourishing.

Yet the distinctive nature of structural injustice makes responsibilities harder to assign. While 'structural processes that produce injustice result from the actions of many persons and the policies of many organizations [often within accepted rules and norms], in most cases it is not possible to trace which specific actions of which specific agents cause which specific parts of the structural processes or their outcomes' (Young, 2006: 115). Not only is it hard to trace specific harms to particular actions of individual agents but adverse effects also emerge over time and are not necessarily intended. Prevailing conceptions of responsibility, though, tend to emphasise direct harms perpetrated by identifiable agents on particular others and, in temporal terms, near rather than remote effects of action (Young, 2004: 374). This has been a persistent problem in efforts to address the harms wrought on health by globalisation. For '[t]he causal pathways linking globalization with changes in SDH [social determinants of health] are not always linear, do not operate in isolation from one another, and may involve multiple stages and feedback loops' (Marmot, 2000; Labonte and Schrecker, 2006: 10–11). 'Process tracing' to locate sources of harm, in other words, is complicated and takes time.

How, then, should we think about responsibilities for addressing the injustice surrounding care worker migration? Most appealing from an ecological standpoint are theories that somehow ground responsibilities in our relationships, our connections, through the sorts of injustice-generating structural processes identified above, to people who are not our compatriots (O'Neill, 2000, 2004; Pogge, 2004, 2005; Young, 2004, 2006). In being more attuned to how transnational structural injustice operates they can – with the benefit of richer temporal concepts – trace connections between agents and injustices. From an ecological perspective this seems more compelling for it better captures how we are constituted and exist in relation with others than accounts that emphasise our common humanity (Singer, 1993), benevolence (Nussbaum, 2006), or that appeal to mutual advantage as the basis for global justice. These relational accounts vary when it comes to determining who has what kinds of responsibilities, however, discussing this in detail is beyond my scope here.[1]

Thinking ecologically encourages strategizing around sustainability

'Around the world … officials [who advocate for recruiting foreign-born nurses] often have short-term vision. … [Yet they] need to understand the long-term implications of their decisions' (Oulton, 2006). Just as Rachel Carson looked across terrains and timeframes in studying pesticides' effects, thinking ecologically about care worker migration highlights the inadequacy of speedy assessments and short-term solutions, and invites appreciation for sustainable strategies.

Current rates of care worker migration are unsustainable. In the global South, health inequities appear to be deepening. But there are also the losses incurred by source countries in intellectual capital and over time, innovation, national economic investment, and economic development to consider (Bach 2003; Buchan, Parkin and Sochalski, 2003). Educating and then exporting care workers to promote economic development, for instance, costs low-income countries an estimated $500 million annually (Kuehn, 2007). The hope has been that remittances sent home by care workers abroad would help to reduce poverty and contribute to economic development, and reinvigorate struggling economies (World Bank, 2001; Kapur, 2003). In recent years remittances have come to exceed the amount of official development aid, foreign, private investment, and market capital flowing into source countries (Stilwell et al., 2004; Page and Plaza, 2006). Yet in spite of the agreement that migrant workers transfer billions of dollars in money and goods, the evidence regarding the benefits of remittances in reducing poverty and promoting development, and overall, of migration's impact on labour exporting countries is mixed (Page and Plaza, 2006). With respect to health worker migration specifically, the OECD argues that the adverse effects of losing them is not likely to be compensated by remittances, for they tend neither to contribute to the development of health systems specifically nor to compensate for the overall economic consequences of losing educated workers, especially when they are educated in source countries (OECD, 2008). The increasing migration of women – especially tertiary-educated, highly skilled women like nurses – has been shown to have especially adverse implications for social and economic development and the health of countries in the global South (Dumont, Martin, and Spielvogel, 2007). Some suggest that other adverse implications that could surface over time include worsened working conditions for domestic labour forces, costly staff turnover (for both paid care workers and family members who provide care while working in the paid labour force), and as noted

above, increased vulnerability for those who require care (Seavey, 2004; Metlife, 2006). Sustainability is surely among the most crucial organising concepts for global health. It focuses on how to manage and nurture resources responsibly so that they meet existing needs and also regenerate for the future. Young underscores the importance of questioning assumptions about time in prevailing phenomenologies of agency, and in particular, responsibility, namely, the tendency to give 'primacy to near effects rather than remote effects of action' (Young, 2004: 374). Just as the tendency to emphasise near rather than remote effects of action makes it harder to assign responsibiliteis for slow-to-emerge effects, it also undermines effective long-term planning. Indeed, it is crucial to scrutinise the assumptions about time that shape our thinking about human agency and health planning. Ecological thinking invites us to explore new temporal concepts, more appropriate to systems and living organisms that aim to endure over time, and in sum, cultivate, and *sustain* 'livable futures' (Grosz, 1999; Rawlinson, 2010).

Sustainability also demands attention to particularity. With heightened perception to the distinctiveness of terrains (geographic, institutional, and embodied) and the processes that shape them, ecological epistemology can help to formulate durable interventions appropriate to place, population, and individual. While attention to local detail is crucial, ecological thinking strives to take account of how specific sites are situated in a broader context and to formulate strategies that in some cases can be integrated across regions, policy sectors, and institutions.

Conclusion

'A conceptual model, like a map, can simultaneously organise and spur ideas and observations. … [D]ifferent types of images illuminate, or obscure, the relevant … processes' that must be understood and addressed (Krieger, 2008: 1098). I have argued here that an ecological perspective allows for a detailed mapping of health worker migration, an enriched understanding of how it occurs and its implications for justice, and of how we might begin to think about sharing responsibilities.

Note

1. For further discussion see Eckenwiler, 2009.

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3

Does the Migration of Health Workers Bring Benefits to the Countries They Leave Behind?

Corinne Packer, Vivien Runnels and Ronald Labonté

Introduction

Although many people agree that there is something morally troubling in the phenomenon of brain drain, it is also often claimed that the substantial benefits it can bring to source communities may go some way to balance, or even outweigh, its negative consequences. It has been suggested that source countries and remaining family members and communities derive benefits from migrants by way of wealth and knowledge transfers. In this chapter, we examine the empirical details behind the ethical claims. We weigh the two main purported benefits of health human resources (HHR) migration: remittances and the transfer of knowledge, against the losses of knowledge, experience and labour that occur to developing countries. While such benefits do indeed exist, evidence suggests that their impact on source country health systems is indirect, or temporary, and likely to be incommensurate with the permanent losses to source countries.

Remittances

Health professionals migrate from developing to developed countries for a number of reasons. In a synthesis report of migration from six African countries (Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe) Awases et al. list a number of reasons why health professionals emigrate. Foremost among the reasons is to gain better remunerations and experience (Awases et al., 2004). These 'better remunerations' that migrants earn are the basis for remittances that are sent 'home' to support families and communities. Remittances are specifically defined as 'current transfers by migrants who are employed

in new economies and considered residents there. A migrant is a person who comes to an economy and stays there, or is expected to stay, for a year or more' (Reinke, 2007: 2). The nature of these remittances are 'frequent, small flows in cash and kind, through a multitude of channels, mostly by related individuals' (Reinke, 2007: 12). The World Bank characterises these remittances as 'stable sources of foreign exchange for poor countries and [that] may be more likely than other capital flows to reach poor households' (World Bank, 2005: 8).

Remittances represent an increasingly significant proportion of household income in some countries (United Nations Population Fund (UNFPA), 2005). In Ghana, for instance, remittances account for the third largest inflow of foreign funds (Martineau, Decker and Bundred, 2002). Global remittance flows in the aggregate are officially estimated to reach over US$150 billion, 84 per cent of which flows into developing countries (World Bank, 2005). According to the World Bank, in 2004, remittances to poor countries reached US$15.9 billion, averaging 5.1 per cent of Gross Domestic Product (GDP) in 2002–3, compared to 2.8 per cent in 1990–1 (World Bank, 2005). In 2004 workers' remittances contributed US$36.9 billion to Latin America and the Caribbean economies, US$32.7 billion to South Asia and US$6.1 billion to sub-Saharan Africa (SSA). Some studies have shown that health workers in particular account for a large number of the remitters. For example, a study of Tongan and Samoan migrants working in Australia concluded that nurses are more likely to be remitters and to remit larger amounts than other migrants. This propensity of nurses to remit is consistent with other studies that show that there is also a gendered basis for remittances: women migrants remit more frequently and generously than men, which is likely due to women being more responsive to the perceived needs of family (Connell and Brown, 2004). Other authors submit that remittance patterns based on gender and in some cases education level cannot be clearly identified or generalised (Hertlein and Vadean, 2006).

In 2001, the World Bank suggested that developing countries might benefit specifically by sending their health personnel abroad temporarily, as it would increase wealth transfers to these countries (World Bank, 2001). Analysts then and now who espouse internationalist labour market views advance that increases in remittances can reduce poverty, improve social conditions and ultimately become an important source of foreign exchange for developing countries (UNFPA, 2005). Some argue that use of remittances, even when confined to consumer spending, stimulates economic development, particularly when

households spend their remittance income on nationally produced goods and services, which then have multiplier effects on the economy (Ouaked, 2002).

There are four empirical limitations to these assumptions. First, remittances are a personal form of transfer, consisting principally of small altruistic funds sent periodically to family members for private consumption (e.g. school or health-care costs, food, clothing or shelter) or small-scale investment (e.g. farm animals, paying off debts, purchasing land or a house). Harnessing these small-scale personal transfers for broader development purposes distorts their nature. Secondly, more extensive forms of remittances serving as a source of savings or investment are less common than often presumed. There is only recent African evidence suggesting that émigrés are slowly reinvesting some of their earnings into their countries (Collier, Hoeffler and Pattillo, 2004). In the meantime, the numbers of professionals leaving have continued to increase. Similarly, the widely held perception that Indian physician émigrés send considerable amounts of money home and help India with hard-currency accumulation may be more fiction than fact. A recent study found that such émigrés, coming as they do from generally wealthier families, do not actually send a great deal of money home (Mullan, 2006). This view is repeated in other studies of physician émigrés (Astor et al., 2005). Thirdly, Maurice Schiff of the World Bank contends in a recent publication representing that institution's most detailed report on migration and remittances that 'the impact of the brain drain on welfare and growth is likely to be significantly smaller, and the likelihood of a negative impact on welfare and growth significantly greater, than reported in the literature' (Schiff, 2005: 3).

This raises a fourth and more normative consideration. To enhance the effectiveness of remittances for development, a number of analysts are advocating a change in their character from private goods to semi-public goods through a larger intermediating role for banks and non-bank financial institutions in the remittance marketplace (Puri and Ritzema, 1999; Sander, 2003). These analysts anticipate that a heightened positive development impact of remittance receipts in developing countries would result from such change (Robinson, 2007). Doubts remain about the value of remittances for economic development because of uncertainties about how they are utilised within source communities (Bach, 2006). While there are suggestions of tithing remittance taxes for such purposes, this could reduce their flow. Moreover, as other migration analysts contend, remittances are essentially 'poor peoples' money' that international agencies should leave alone, and that any

expectation that they would compensate in some way for the loss of HHR is misguided.[1]

This is an important debate, but it still leaves unanswered two questions of concern to this particular matter. Is there sufficient evidence to contend that, in some fashion, remittances can (a) compensate for the loss of a country's investment in educating its health professionals; and/or (b) impact positively on their health systems?

Are remittances substantial enough to compensate for losses?

It is notoriously difficult to estimate the scale of remittances because of the often-informal manner in which they are returned. In spite of this, a number of analysts have made very convincing arguments that, while financial remittances provide benefits to source countries, they are not in any quantity commensurate with the number of migrants and the losses incurred by the source country as a result of outmigration of their health professionals (Pang, Lansang and Haines, 2002). Generalising, Aluwihare believes the 'cost of what is sent back is much less than the financial effects to the donor country of having lost its physicians' (Aluwihare, 2005: 15–21), meaning that remittances are small in value compared to the amount the source country has invested in training the physician and the loss of that physician's own investment in his/her country. Other research further suggests that remittances to sub-Saharan African countries, the countries hardest hit by the HHR crisis, are comparatively low. As illustrated in Figure 3.1, only two SSA countries – Lesotho and the Gambia – are in the top 20 remittance-receiving countries (expressed as percentage of GDP), neither of which is an HHR exporting country. Only one, the Philippines, of the top 20 remittance-receiving countries is an exporter of HHR.

Research has also shown that remittances have a limited time-value. Anecdotal evidence from Ghana suggests that the longer health professional migrants have been away from Ghana, the less they remit (Mensah, Mackintosh and Henry, 2005). Evidence from the US also shows that foreign workers remit less the longer they remain abroad – each year reduces the likelihood of remitting by three per cent (Ouaked, 2002). The study of Tongan and Samoan nurses in Australia referred to earlier found there was a steep decline in remittance propensity after a five to ten year absence (Connell and Brown, 2004). Remittances reduce in both frequency and magnitude when family members join the migrant in their adopted country (Ouaked, 2002).

There are other factors inhibiting remittances. The transfer costs (fee for sending money, exchange rate) can absorb up to 20 per cent of the

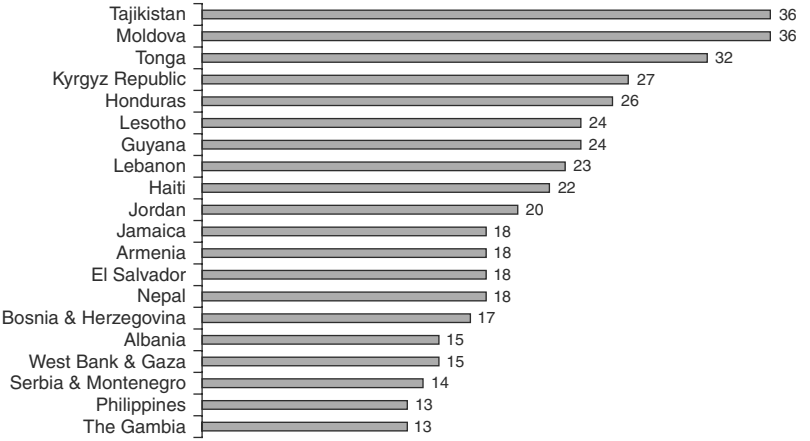

Figure 3.1 Top 20 remittance-receiving countries (as % of GDP), 2006
Source: Adapted from the World Bank *Migration and Remittances Factbook, 2008*.

total amount. If people remitting no longer have children in the country from which they migrate, they are less likely to remit (Ouaked, 2002). It has also been reported that higher skilled workers (as health workers would be categorised) remit proportionately less than their unskilled compatriots despite the fact that their incomes are higher (Martin, 2003). Finally, although remittances have been noted to increase in situations of natural disasters, émigrés stop remitting when there is fear of financial instability in their country of origin (Ouaked, 2002).

Pinning figures on real financial losses to source countries

'Brain drain' is said to occur 'if emigration of tertiary educated persons for permanent or long-stays abroad reaches significant levels and is not offset by the "feedback" effects of remittances, technology transfer, investments or trade' (Lowell and Findlay, 2001: 7). If remittances contribute to the 'gain' side of this economic equation, what is on the other side? A number of analysts have tried, using different methodologies, to estimate the financial losses incurred by countries through the emigration of health workers raised and trained in those countries. We provide the general findings of these studies although we do not assess the methodologies used in the costing exercises.

In a recent publication, Kirigia et al. estimate the cost of health professional brain drain in Kenya. They compounded the cost of educating a medical doctor and nurse (from primary schooling to complete

university training and credentialing) over the period between the average age of emigration (30 years) and the age of retirement (62 years) in recipient countries.[2] The researchers then estimated that the total cost of educating a single medical doctor in Kenya is US$65,997 and that, for every doctor who emigrates, the country loses about US$517,931 worth of returns from investment. The total cost of educating one nurse from primary school to college in Kenya is US$43,180 and, for every nurse who emigrates, a country loses about US$338,868 worth of returns from investment (Kirigia et al., 2006: 89). Applying more simplistic survey methods, Chanda estimates that South Africa lost an estimated US$9 billion in human capital investment in the health sector from the emigration of health workers in the last decade (Chanda, 2002). According to 1999/2000 PAHO estimates, in the Caribbean region the public health sector covering training costs for nurses lost US$16.7 million due to the outmigration of nurses. It is projected that it would take 35 years of remittances from a single nurse for the public investment in his/her education to be repaid (Schmid, 2006).

What would it cost to rebuild a health workforce?

Another way to analyse losses is to look at what it would cost to rebuild a health workforce adequate to serve a population. A simulation exercise using Ethiopia worked out the cost of doubling the health workforce over a period of five years. For simplicity, it was assumed that salaries remained constant over the five years. It found that the health budget would have to increase 5.2 per cent per year to cover the basic salary for the extra work force. It should be noted that this sum would be the bare minimum investment to rebuild the numbers needed in the health workforce and does not include improvements in pay, working conditions, facilities and so on that led to failed retention in the first place. In other words, increased investment in health care in Ethiopia would have to be well above 5.2 per cent per year (Serneels et al., 2005).

Contracted health human resources

Numerous source countries desperate for HHR hire physicians and nurses from other countries on contract bases, such as the case of Jamaica (Martin, 2003), South Africa, Zimbabwe and Ghana hiring Cuban doctors. These replacement expatriate professionals can come at a high cost. In Ghana, as elsewhere, the employment of foreign doctors (who often need support from interpreters) is widely seen as a drain on resources that could be used to train and retain Ghanaian health professionals (Eastwood et al., 2005). While providing only inferential support

for this perception, it was estimated that in the 1990s African countries spent nearly US$4 billion annually to replace professionals lost through migration with expatriates from the West and other countries, a figure which represented nearly 35 per cent of Africa's total overseas development assistance (Oyowe, 1996).

On the other side of the coin is the great savings imported health professionals represent for receiving countries. In the UK, for example, the medical education of each qualifying doctor costs £200,000 to £250,000 (US$370,000 to $460,000) and takes five to six years to train. So every migrating doctor arriving in the UK is in effect importing this sum or, in economic terms, appropriating human capital at zero cost for the use of the UK's health services (assuming no public costs for additional training or registration). Furthermore, the capital realisation is immediate rather than in five or six years' time (Eastwood et al., 2005). Our own estimates suggest that the 619 South African physicians registered for practice in Canada in the ten years after apartheid saved the country almost $300 million in foregone medical undergraduate training costs.

Loss of HHR means more than lost investment and income

The international migration of a physician or a nurse in developing countries represents much more than a financial loss in terms of academic training; states also invest in primary and secondary education, and infrastructure (Aluwihare, 2005). The health worker's family is a tax-paying and employment-generating family. This is lost when physicians migrate (Aluwihare, 2005). When health workers migrate, it means not just the loss of professionals but the loss of a middle class, a class which pays taxes, is responsible for hiring others and whose children would also likely be productive professionals in these countries (Kapur and McHale, 2005a). As Ouaked explains, in summarising the results of an expert roundtable on high-skilled migration, '[b]y reducing human capital in source countries, high-skilled emigration may hinder economic growth. As all economies become more reliant on knowledge, the loss of the best-trained workers poses serious threats to national productivity and output' (Ouaked, 2002: 155).

Do remittances and other migration-related financial schemes help fund health in source countries?

Not only do remittances fail to compensate for the losses sustained by source countries they also do not necessarily fund (at least directly) their health systems (Martineau, Decker and Bundred, 2002). Because remittances typically represent private welfare gains, they do little to

offset the public health investment losses incurred by the emigration of health-care professionals (Stilwell et al., 2003). Extensive literature searches and discussions with analysts closely following health worker migration and shortages have led us to only one study on remittances specifically related to the health sector. The study, now 25 years old, suggests that the volume of remittances made by Filipino physicians practising overseas was sufficient to compensate for the associated economic losses of emigration (Goldfarb and Havrylyshyn, 1984). The study, however, was far from conclusive, weakened by data limitations and formulated on questionable assumptions.

While the evidence of any direct benefit from remittances to health systems is unconvincing, remittances may indirectly benefit home-country health systems to some extent by (a) improving child health through better nutrition, sanitation and health care (Frank and Hummer, 2002; Frank, 2005; Hildebrandt and McKenzie, 2005) and (b) helping to finance out-of-pocket health-care spending. Both effects can improve financing for, or reduce unnecessary use of, home-country health systems (whether public or private), in theory making services more available for others in need.

A few examples exist of countries establishing policies to stimulate remittances. India, which is also the top remittance-receiving country (see Figure 3.2), provides higher interest rates to attract remittances (Orozco, 2003). Some countries reportedly try to use hometown associations

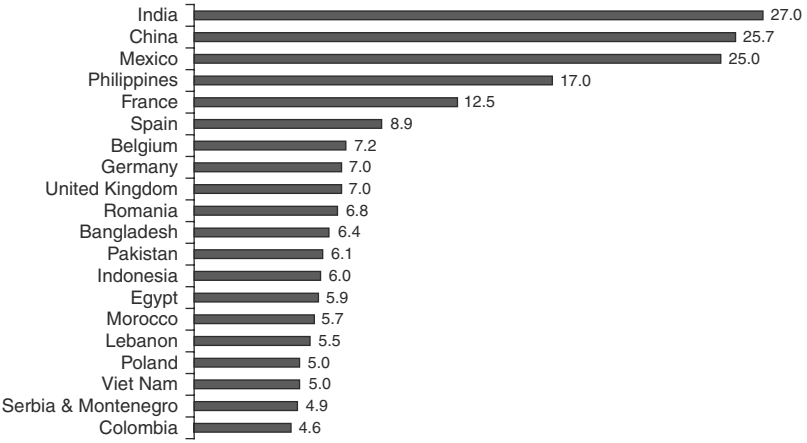

Figure 3.2 Top 20 remittance-receiving countries (in US$ billion), 2007
Source: Adapted from the World Bank *Migration and Remittances Factbook*, 2008.

(HTAs) which are defined as organisations that allow immigrants from the same city or region to maintain ties with and materially support their places of origin, to collect remittances and contribute them to the economic development of their communities (Orozco and Rouse, 2007). The results have been mixed. For instance, HTAs have supported the development of infrastructures, schools and health centres but the experience largely has been that these communities do not necessarily have the resources to maintain what has been built through the contributions of expatriates (Ouaked, 2002).

Depending on expatriates to be altruistic and support their community equally or ahead of their own family members is risky and uncertain. As explained earlier, the remittances are also predicted to decline over the years as migrants remain abroad. So, while this idea of collecting community funds for health through international migrant remittances is intuitively appealing, it needs to be boosted and supported by other funds or innovative strategies. Remitters could be assured, for instance, that their contributions will be matched by contributions by source country governments. One Mexican initiative (*Tres por uno*) channels remittances with peso-matching by the local and national governments into community projects (Orozco and Rouse, 2007). In general, remitters could also be given tax breaks or credits by receiving or source countries. They could also be recompensed for the costs incurred in sending money. This would need formal channels to be arranged through bilateral intergovernmental arrangements or through an agency mechanism established by such organisations as the World Health Organization (WHO) or the International Organization for Migration (IOM).

In summary, it is difficult to assess how and to what extent remittances from migrant health workers benefit the health systems of source countries primarily because of lack of relevant data. Nonetheless a few known facts bring into question the future potential of such remittances to do so. No country to this point in time has set up a centralised filtering system whereby a portion of remittances received from migrant health workers, or any other workers for that matter, might be taxed for reinvestment into its health-care system. While the WHO has suggested devising a system in which remittances could be channelled directly into the health system as a form of compensation, this would likely be riddled with difficulties, not the least of which would be to account for remittances since large amounts take place through informal channels (UNFPA, 2005). Strong incentives schemes would also have to be devised to convince individuals to remit part of their earnings to the state rather than directly to their families (UNFPA, 2005).

Such schemes would also require policy recognition that remittances are personal capital flows. Over-regulating and channelling the use of these capital flows in source countries and tying them to decisions regarding official development assistance in donor countries would likely affect their spontaneous flow and drive them underground or redirect their use. Tax-aided policies promoting public good contributions from the diaspora (quite separate from personal remittances) could overcome this problem.

Knowledge transfer: The role of diasporas in alleviating the HHR crisis

The second main alleged benefit of health worker migration is that migrants return to their home countries bringing with them the knowledge gained while abroad. Indeed, diasporas are often touted as key in resolving the HHR crisis but there is no convincing evidence or even argument for the means by which they would do so. The general expectation is that diasporas will provide relief through financial remittances, knowledge transfers and as returnees (UNFPA, 2005). As explained above, financial remittances – while important for augmenting consumption – cannot address the development (including health-care system) problems in developing countries which led to migration in the first place (Kapur and McHale, 2005a, b). It is similarly too optimistic to believe that skills and knowledge are transferred back to source countries. Typically such knowledge transfer would occur if a migrant returns temporarily or permanently to work in the health-care system in the source country. But two key questions should be asked: (a) are migrants returning? And, if so (b) are they contributing new skills and knowledge?

Are migrants returning?

As with many issues in this crisis of shortage of health human resources, there is an absence of data from which we can draw firm conclusions. Very few studies have been conducted to determine rates of return of migrant health professionals but most analysts fail to see returns to any substantial degree. Obviously, if 'brain recirculation' were happening in sufficient numbers, there would not be an HHR crisis associated with migration. The principal reason why substantial return migration is not occurring is because the conditions which drove physicians and nurses out of their countries in the first place have not improved and in some cases have even worsened. For instance, there must be jobs available with suitable pay. As noted in one report with reference to Ghana, if

the 1500 doctors working abroad were to return, the government would probably only be able to find or financially support jobs for about 200 of them (Martineau, Decker and Bundred, 2002).

There are additional reasons for the lack of return flows. For instance, Davide Mosca of the IOM explains that, while many professionals would like to return home, they fear losing their residence status in the country where they have been working (Nullis-Kapp, 2005). (This portends a possible policy measure that recipient high-income countries could take to remove this barrier.) Another obstacle that prevents the diaspora from returning is the significant number of countries that do not allow dual citizenship. This discourages migrants from remaining for a sufficient length of time in their home countries to assess the economic situation and relocation possibilities, while risking loss of status in countries in which they have become permanent residents. This situation is changing somewhat in attempts to encourage and capture economic benefits of circular migration for sending countries. Some sending countries have recently amended policies to allow dual citizenship or, in the case of India, created forms of citizenship which selectively and effectively extend citizenship to non-residents living in wealthy and developed countries (Newland, Rannveig Agunias and Terrazas, 2008).

Nurses and physicians working in rich countries also develop new sets of skills which would be difficult to transfer to their home countries because of significant differences/discrepancies in health-care facilities and technologies. It would thus be difficult for a Zambian nurse working in an intensive care unit in the US to transfer useful skills if she returned to a district hospital in her country (Martineau, Decker and Bundred, 2002).

Returning is often not easy for health professionals, even for those who are highly motivated. The logistics of resettling are daunting and adjustment to life back in their home countries can be difficult for families, especially those with children. Some young health professionals intend to work overseas for a short time and then return. However, they also tend to start families and then are 'stuck' in their adopted countries, at least until their children have completed their primary, secondary or tertiary education. By that time, many will find it hard to get back into employment at an appropriate level in their home country (Martineau, Decker and Bundred, 2002) and may not return (if at all) until close to, or for the explicit purpose of, retirement.

Professional life also requires readjustment. Stories have accumulated of health professionals' difficulties re-entering the work force, dealing

with civil corruption, coping with the absence of good regulation of hospitals and trying to practise effectively within generally uncontrolled and uncoordinated health-care systems of home countries (Mullan, 2006). Our literature search and anecdotal research[3] demonstrated failed or frustrated attempts by HHR returning to their home countries to work in the public system.

One study of India did report that some physicians expressed an intention to return once they had saved enough money to set themselves up in private business, such as private practice, or by establishing medical equipment firms. India has reportedly latched on to this potential capital investment by returnees and adopted economic policies explicitly to attract émigré capital (Mullan, 2006), although we were unable to locate any published evaluation of the impact of this policy.

There is also some published and anecdotal evidence that some nurses return to home countries either permanently or in a circular migration pattern. One study of 80 Jamaican nurses who emigrated to the US and later returned home found that 24 per cent had travelled abroad to work at least five times. Some 80 per cent of the respondents intended to travel again (Kingma, 2007). This may well be due to the special nature of nursing contracts (typically short term) and to the fact that many nurses are women. Some are single and wish to return to marry in their home countries while others, who have left their families behind, worked with the intention of jump-starting family savings and supporting families back home.[4]

Failure of programmes to encourage return

In 1992–3 the Pretoria, South Africa, office of the IOM ran a small programme called the Return of Talent Program which encouraged migrants to return to their country of origin by offering incentives. The IOM managed to recruit 52 South Africans working abroad, of whom 75 to 80 per cent were reported to have stayed in South Africa since their return. The programme was suspended because it was able to recruit very few numbers (Cohen, 2007).

The IOM also implemented a Return of Qualified African Nationals (RQAN) Program from 1983 to 1999 in ten African countries. The programme encouraged about 100 nationals to return to their countries of origin every year of the programme, about 1600 in total. Professionals who agreed to return under this programme would sign two-year contracts that required them to work in the public sector in exchange for travel and housing assistance and enhanced pay. The programme, however, had several problems. Its success depended on bringing back

sufficiently skilled personnel to make an impact, and this was not always the case. Finding the capital required to ensure the success of the programme was also difficult given the poor economic situations of the countries involved. Many of the factors that drove people out in the first place still persisted in much of the continent. In some cases, returnees eventually moved back to the developed countries, therefore defeating the purpose of the return option. The incentives offered to returnees also served to undermine those who had never left; they felt that their loyalty went unrewarded while returnees were offered lucrative packages. These assisted return programmes proved costly and numerous analysts concluded that there were 'expensive failures' (Black, 2002 cited in Martin, 2003: 21).

Zimbabwe was one of the countries that tried the RQAN Program from 1983 to 1997. In the final three years of the programme, a total of only 27 professionals (11 of whom were doctors) agreed to be relocated. Zimbabwean analyst Chikanda assesses the programme to have had a limited impact at a time when political and economic conditions were less chaotic than they are today and rightly hypothesises that the programme would be even less effective today (Chikanda, 2005). This raises the question that if migrants will not even return when they are paid and facilitated to do so, why do we think they will do so of their own volition and effort?

Gaillard and Gaillard note that when conditions begin to improve in countries of origin, there is evidence of expatriate professionals returning (Gaillard and Gaillard, 2003). This was the experience of Singapore, South Korea, Taiwan, and is beginning now in China and India (Aluwihare, 2005). This lends strong credence to the argument that a major policy thrust must be to decrease push factors. If these attracting conditions also rely upon the strengthening of private health systems accessible only to wealthier groups, however, the issue of equitable allocation of human resources within such countries will remain very problematic.

Are migrants transferring skills and knowledge?

Ideally contact between migrants and their home country's training institutions can lead to new ideas, technology and knowledge transfer. In this spirit, the Ghana-Netherlands Healthcare Project, one of the initiatives of Migration for Development in Africa (MIDA), a project of the IOM, attempted to stimulate the transfer of knowledge, skills and experience. The project supported short-term assignments of Ghanaian expatriates in the Netherlands to Ghana to conduct research and implement

projects, and provided internships for Ghanaians in the Netherlands. A centre for the maintenance of medical equipment in Ghana was also developed. The project has been reported as a success story (Nullis-Kapp, 2005) although details of how or why this conclusion was reached were not provided. Anecdotally, we learnt of an increasing number of *diaspora knowledge networks*, several of which are contributing to health development in their homelands. For example, the Ethiopian North American Health Professionals Association (ENAHPA), in collaboration with US universities and hospitals, mobilises and transfers health-care delivery knowledge-based technologies from the US to train Ethiopian HIV-AIDS workers. Somali migrants worldwide mobilise resources to rebuild, equip and staff two major hospitals in their homelands. Ghanaian and Liberian physicians in the US are currently undertaking major health sector development initiatives in their respective homelands.[5]

Conclusions

With regard to wealth transfers, migration (including HHR professional migration) and remittances are likely to increase in the future. Some countries, such as the Philippines and Ghana, have actively supported and promoted cultures of migration and remittance, and other countries may follow suit. While there are claims by some that losses to a country (such as to their health-care system through the departure of health professionals) are compensated by remittances, we have not found evidence of equalising compensation in our review of the literature. Maximising the benefits of remittances to individuals and the health sector through some sort of financial scheme would be desirable. However, the benefits of personal remittances will continue to be mainly confined to individuals, families and, at most, local communities. For the time being, the impacts of remittances on health systems of source countries can only be claimed to be negligible and indirect.

In terms of knowledge transfers, while there are benefits to be derived from migrants transferring their skills and knowledge back to their home countries, and efforts to support such transfers are important and should not be minimised, our literature review found few examples of diasporas being successfully organised to help transfer their skills and knowledge. For the most part, diaspora network efforts seem to be limited to fund-raising through HTAs or as informal networks encouraging compatriots to emigrate and work (Poros, 2001). It may be unrealistic to believe that skills and knowledge will be voluntarily transferred back to source countries, at least to the scale commensurate with the initial

loss. This would only occur if the migrant returns temporarily or permanently to work in the health-care system in the source country and he/she is given the opportunity to transfer skills. Initiatives such as the Ghana-Netherlands one cited earlier may be admirable but they are also very costly. High cost is the principal reason why IOM's return of talent programmes have failed – this in addition to the fact that migrants do not wish to return to countries with conditions being the same as, or worse than, when they left.

In conclusion, health human resources migration is purported to bring benefits of wealth and knowledge transfers to source countries. Although there are instances of indirect and temporary returns, such benefits are nowhere near commensurate with the permanent losses experienced by source countries.

Notes

1. Rudi Robinson, The North/South Institute, personal communication, 17 November 2006.
2. Much of the literature on health worker flows concentrates on physicians and nurses; this chapter does likewise. However, flows of other health workers, notably pharmacists, are becoming more important, particularly in SSA where a shortage of pharmacists could slow the roll-out of anti-retroviral treatments (see, for example Attaran and Walker, 2008: 265–6).
3. Views shared at expert meeting Promoting Global Solutions to Health Worker Migration: Policy Innovations for Sending and Receiving Nations, 12 September 2006, New York.
4. Presentation of Mpho Letlape at the conference 'A Call to Action: Ensuring Global Human Resources for Health', 22–23 March 2007, Geneva. Agenda available at: http://www.hret.org/hret/publications/ihwm.html.
5. Rudi Robinson, The North/South Institute, Canada, personal communication of 17 November 2006.

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4

Conflicting Obligations in the International Migration of Health Workers

Jeremy Snyder

Many moral wrongs allegedly take place due to the migration of skilled health workers from the developing to the developed world. In many cases, the immorality of this kind of migration is taken to be self-evident, as is the need for reforms aimed at creating an ethical system of health worker migration. While it might be uncontroversial that the 'brain drain' created by the migration of skilled workers out of the developing world is morally troubling, there is a danger in not clarifying and assessing charges of moral wrongdoing.

The moral wrongs created by health worker migration may not only be serious but also many. If so, there is the potential, at least, that reforms aiming to resolve one kind of moral wrong associated with health worker migration might conflict with reforms aiming at other kinds of wrongs. At the very least, a multiplicity of moral wrongs demands clarity and coordination in our responses to these wrongs.

In this chapter, I survey the most plausible, common, and serious forms of moral wrongs resulting from present patterns of health worker migration. I consider whether health worker migration harms members of the source community for migrants, the migrants themselves, and members of the destination community for migrants. I conclude with three lessons derived from these multiple charges of moral wrongdoing.

Wrongs against the source community

In this section, I consider charges of moral wrongdoing against source communities committed by two groups. First, I discuss wrongs committed by the members of the destination community. Second, I consider wrongs committed by the migrants themselves.

Wrongs committed by the destination community

The principal worry surrounding the migration of health workers is that it actively undercuts health services in the developing world.[1] Migration can harm the source communities of these workers by depriving them of the skilled workers needed for a well-functioning health system. Due to this outflow of skilled workers, some developing world communities find themselves unable to improve the health and welfare of their citizens or to fight against the spread of infectious disease. Perversely, substantial support for the education of health workers and health infrastructure by source communities can exacerbate this problem by creating a pool of workers that can readily be incorporated into the health systems of richer countries.

Consider, for example, that there are 24.8 health workers per 1000 people in the Americas, 18.9 per 1000 in Europe, and only 2.3 in Africa (World Health Organization, 2006: 5). The Americas, including the US and Canada, represent ten per cent of the global disease burden, yet retain 37 per cent of the global health workforce and represent over half of global spending on health. At the same time, Africa, a home to many source communities for health worker migrants with 24 per cent of the global disease burden, makes do with three per cent of the global health workforce and one per cent of health expenditures, including external loans and grants (World Health Organization, 2006: 8). The effects of health worker migration are particularly severe for rural populations within poor source communities, which are already underserved relative to urban areas of source communities (Martineau et al., 2004). With so few health resources in many source communities, moral concern should be raised by a system of migration that distributes scarce health workers from desperately poor source communities to relatively rich destination communities.

At first glance, any movement of a worker from one community to another would seem to constitute a morally problematic harm for the community that loses the skills and contributions of the worker. But to see a difficulty with this assessment, consider a similar case. Andy is a highly skilled software engineer working for Smallsoft, a moderately successful Internet startup company. The leader in Smallsoft's field, Megasoft, learns of Andy's talents and offers him a position, salary, and benefits much better than those he currently has and much better than Smallsoft is able to offer. While Megasoft has taken advantage of its greater resources to snare Andy's talents in a manner that will reduce Smallsoft's ability to compete, we would not ordinarily think that

Megasoft has committed a moral wrong. All of the actions in Andy's movement from one job to another were voluntary and above board, despite the fact that Smallsoft is worse off because of them. We might say that Megasoft's actions have made Smallsoft worse off than it had been, but it is more of a stretch to conclude that Megasoft has harmed Smallsoft in a morally relevant way. That is, not every action that results in a loss to another party constitutes a morally significant harm.

If the movement of skilled workers from one community to another is just part of the everyday process of business competition, why should the migration of health workers be treated any differently? The obvious answer is that the kind of loss provoking worries about health worker migration is absent from the Smallsoft case. While Smallsoft might suffer a financial loss from Andy's defection, this loss is very different in size and scope from the damage to the basic health infrastructure faced by some source communities due to health worker migration. Health care is a good necessary for the basic functioning of all persons. While individuals may have a moral claim to a decent minimum of welfare, it is not clear that Smallsoft has a moral claim to Andy's services. Actions by one community that undermine the capacity of another community to provide a necessary good for its members, I would like to argue, raise heightened moral concern.

The moral concern surrounding the brain drain of skilled *health* workers is integrally a concern about others' basic welfare given the impact of migration on the provision of basic services to members of the source community. The ethical concern in the case of health worker migration is not triggered merely by the transfer of skills from one community to another but rather when that redistribution of skills results in one community being unable to develop its health infrastructure to a point where basic health care can be extended to its citizens. Were the skills in question not integral to a basic good like health, then this moral concern would not be triggered. Similarly, were the transfer to take place between two communities, each of which had adequate levels of the critical basic good, then a similar moral concern would not arise.

We can understand this moral wrong committed by members of destination communities against source communities in two ways. First, the moral wrong can take the form of a failure of the general duties of beneficence and non-maleficence. A wide range of moral theories will agree that, in the least, we all have a duty not to damage others' goods and welfare in morally significant ways and to relieve some others' suffering at least some of the time. Actions that make others worse off in terms of their basic goods will often, though not always, count as

morally significant. Given that the duty of non-maleficence is strict and the duty of beneficence allows some discretion, the former is usually understood as having priority over the latter.

Health worker migration schemes can violate the duties of beneficence and non-maleficence either by creating a harm for the source community or by diminishing the positive effects of other beneficent acts such as anti-HIV programmes. While the duty of beneficence is often considered not to give definite answers as to how much should be given to help relieve suffering, in some cases a health worker migration scheme can undermine beneficent acts to the point where the duty of beneficence cannot be said to have been fully discharged, even if destination communities create net benefits for source communities. That is, a migration scheme can so undermine the positive effects of aid programmes to the global poor that a minimum level of beneficence to the poor will not be achieved. As a result, enabling health worker migration may not be inherently wrongful, but through its effects on poor countries it may run counter to rich destination communities' duties of beneficence and non-maleficence. If so, these duties create independent reasons for curtailing health worker migration.

The duties of beneficence and non-maleficence create obligations in virtue of our shared humanity, regardless of our particular relationships with needy persons. A separate duty of justice is created through our interactions with one another, where we create additional resources through social cooperation. When these additional goods are created, a question of justice arises focusing on a fair or just means of distributing the social surplus created through cooperation.[2] Even if all parties benefit from cooperation when compared to their individual welfare under the status quo, one party might yet be wronged in terms of a just distribution of the social surplus of the interaction if it receives less social surplus than it is entitled to under a just distribution.

The ethical concern in the case at hand is that rich nations use their superior bargaining power to set the terms of the global institutional structure in their own favour and contrary to the requirements of fairness and justice (Pogge, 2002a, b). In the case of health worker migration, destination communities might exploit the vulnerabilities of source communities to create a system of skilled worker migration that redistributes wealth and skills from the poorest nations to the richest. Even without providing any detail as to what a just global institutional structure, or even a just global health infrastructure, would look like, there is good reason to doubt whether a system that redistributes wealth and skills from the poorest to the richest is likely to be consistent with a

just system. By allowing, and in many cases encouraging, the continuation and replication of this system, destination communities can be said to treat the poorest communities of the world unjustly.[3]

Wrongs committed by the migrants

Health workers can be thought to have special duties towards their home communities that are violated by migration. James Dwyer (2007: 38) argues that '*when* people choose to acquire professional skills and rely on public resources and institutions to achieve that goal, they also acquire some social responsibilities'. These social responsibilities may be generated simply by a duty to repay those social resources that have been invested in the worker's education, as Dwyer suggests, or through connections between workers and their home communities.[4]

If connections to the needy in one's home community create special responsibilities, this would explain why health workers from poor source communities have social responsibilities to their communities regardless of whether they received their training from public *or* private institutions. These connections also explain why the social responsibilities of health workers, and thus their duty not to migrate, are reduced when they are not connected to a poor community or community with many unmet health needs.[5] Dwyer (2007: 41) is cognisant of the relationship between social responsibility and need when he writes that 'I am troubled by the emigration of 30 percent of Ghana's physicians because life expectancy in Ghana is fifty-seven years. I am less troubled by medical migration out of Ireland. About 40 percent of Irish physicians have emigrated, yet in spite of this high rate, life expectancy in Ireland is about seventy-six years.' If the duties of health workers were merely matters of restitution for public services consumed, then we would need some explanation as to why this duty of restitution is triggered most strongly when the local community is in great need.

Should health workers choose to migrate in violation of a social responsibility to their home communities, then there is a clear sense in which they can rightly be accused of moral wrongdoing. However, there is a substantial danger that in discussing this responsibility we might engage in victim blaming when the migrants are themselves victims of injustice. Health workers may migrate from their home communities for a variety of reasons, including a lack of economic opportunity, physical danger, lack of access to basic necessities, and due to ethnic, sexual, religious, or other forms of discrimination (Crozier, 2009). The migrant's social responsibility may be outweighed by other

moral considerations, then, including duties to oneself. Moreover, some accounts of social responsibility will allow for various means of discharging this responsibility, including by helping the needy in one's new community or by working towards institutional reform from afar (Young, 2006). Therefore, we cannot determine whether a particular migrant is violating her social responsibility to her home community without considering the context in which the migration occurs.[6]

Wrongs against migrants

Migrant health workers typically leave their home communities in search of a better life. Yet because of the cultural and geographical distances involved in migration, as well as the migrants' strong desire for better employment, there are many opportunities for unscrupulous brokers to take advantage of vulnerable migrants. In some cases, these brokers offer misleading terms of service that can deny migrants better opportunities or land them in circumstances worse than those they left behind (Buchan, 2002; Allan and Larsen, 2003; McElmurry et al., 2006). The wrongness of these actions can easily be grasped as forms of lying, coercion, manipulation, and deceit.

Barring deceit or coercion on the part of brokers in the destination community, the conditions of migrants should usually improve following migration. Yet while these migrants might be better off than they would have been had they remained in their home communities, charges of wrongdoing arise when these workers are treated less well than native workers in the same positions and with the same experience. Donna Kline (2003: 110) notes that the 'potential for exploitation of foreign nurses is of great concern' citing as examples lower pay for migrant workers compared to domestic-born workers with similar levels of training (Grimsley, 2000), reduced credit for equal experience (Brubaker, 2001), positions that are geographically distant from urban centres, and poorer working conditions and positions for migrant workers generally (Glaessel-Brown, 1998; Hardill and MacDonald, 2000). If these workers are signed to multi-year contracts as a condition of immigration, they will have little bargaining power with which to protest their treatment or renegotiate their terms of employment (Trossman, 2002).

However, if the migrant benefits by migrating, it is not clear why one might worry that she is wronged. Particularly if the terms of the contract are transparent and the migrant voluntarily – in fact, gratefully and enthusiastically – accepts these terms, why should we think she is

morally wronged? Defenders of the current patterns of health worker migration emphasise the benefits created by voluntary migration:

> Nurses are generally underpaid and overworked globally. Because the majority of nurses are women, many suffer from gender inequities, marginalization, and oppression. Having an opportunity to work in an economically rewarding area such as the US, Saudi Arabia, or Brunei, can be economically liberating. Nurses who come to the US to work, for example, use technologically advanced equipment, adopt evidence-based models of practice, enhance their economic potential, and increase educational opportunities for their children. Their work is affirmed, competencies are enhanced, skills are sharpened, knowledge is advanced, and sense of self is dramatically enhanced.
>
> (Meleis, 2003)

Given the range of benefits created even by a system that treats migrant workers less well than native-born workers, there may seem to be little room for moral outrage at the plight of these workers given how much they would prefer migration to their other, much worse, alternatives.

But instead of comparing benefit and harm against the workers' welfare before migrating, we might look to the benefit migrant workers would receive when treated fairly. While migrant health workers might agree freely and rationally to the employment terms offered to them, these terms may yet be unfair. For a variety of reasons, an employer might come to possess unjustified bargaining power over his employees. This bargaining power, if fully exercised, would allow the employer to retain an unfair portion of the social surplus created through the contract between employer and employee. In these cases, while the worker receives a benefit through her employment when compared to her welfare without the employment offer, it may create a harm for her when compared to the benefit she would receive under fair bargaining conditions.

A good starting point for a standard of fairness references the terms that would be set in a hypothetical fair market inhabited by well informed and unpressured employers and employees in a competitive marketplace. This standard is not successful against all forms of unfairness, as when some parties are disadvantaged by unjust background conditions such as pervasive racism or economic disadvantage. But, as Alan Wertheimer (1996: 232) describes it, 'the competitive market price is a price at which neither party takes *special* unfair advantage of

particular defects in the other party's decision-making capacity or special vulnerabilities in the other party's situation'. Market failures give some parties asymmetrical bargaining powers over others, creating a vulnerability that can be exploited to the advantage of the better-situated party. Appeal to a hypothetical fair market price can rule out some forms of unfairness in employment terms, and the general strategy of eliminating elements of unfairness can be expanded if need be.

Regulations that block or restrict the access of some potential workers to the health employment market tend to disrupt a fully fair and competitive market.[7] When some would-be migrant health workers are restricted in their access to the employment market in the developed world, these restrictions can transfer bargaining power to employers in the destination community. This asymmetry in bargaining power expands when some workers are legally tied to specific employers, restricted in the positions they may hold, or face reduced credit for their experience, education, and skill levels. These restraints have the effect of decreasing the migrant workers' wage levels below that which would be available under a hypothetical fair employment market.[8]

If destination community health sector employers wish to offer fair wages and positions, they must adjust their employment offers in keeping with a hypothetical fair market. This adjustment can be made by approximating the wages and benefits that would be offered in a fair market and then extending employment offers accordingly. As free and equal participants in the labour market, migrant health workers would be free from the constraints that depress their wages below the hypothetical fair price. As a duty of fairness, employers should offer their migrant employees wages higher even than those that are arrived at in the market as it is currently constituted and higher than would be freely agreed to by would-be migrant workers under the status quo. This duty would require adjusting the wages of all migrant workers, no matter their backgrounds.[9] As a result, migrant workers would receive wages similar to those received by domestic workers with comparable levels of training and experience. This step will likely increase the appeal of migration to destination communities by health workers, however, potentially creating a conflict with other moral duties.

Wrongs against the destination community

Some members of the destination community might be harmed if the migration scheme reduces opportunities for employment or worsens working conditions. A frequent criticism of many health systems in

the developed world is that they fail to encourage or allow sufficient domestic workers to enter the health-care field. This shortfall in the production of domestic workers is said to derive from insufficient pay for workers, poor working conditions, and insufficient training opportunities in institutions of higher education for domestic workers (Committee on the Work Environment for Nurses and Patient Safety, 2004).

The bargaining power created by a health worker shortage could be used to create pressure for reductions in mandatory overtime, improved worker to patient ratios, and increased training opportunities. By adding to the supply of workers through migration, particularly when these migrant workers are in a position of vulnerability and are reluctant to demand better working conditions, domestic workers lose some of their power to demand reform (Trossman, 2002; American Federation of Teachers, 2003; McElmurry et al., 2006). For would-be domestic health workers, the opportunity and reward for training in health care is undermined, creating a harm through lost opportunities for entering health professions and the reduced appeal (through continued low wages or poor working conditions) of existing opportunities.

This potential harm to domestic health workers in the destination community is not always a moral concern. Taken in isolation, the response of wages to changes in labour supply and demand is not necessarily of moral concern and domestic workers are not necessarily entitled to the wages that would arise from a more restrictive labour market. Only if health workers are entitled to better working conditions should a loss of bargaining power for better conditions raise moral concern.

Just working conditions for health workers would arguably first include levels of pay, benefits, working hours, and treatment that are consistent with living a minimally flourishing human life in one's community. Long working hours can undermine access to free time and recreation for workers, low levels of pay can fall below the levels of a robust 'living wage' within the local community, and limited paths for advancement can run afoul of conditions of equal respect for all persons. In a variety of ways, the working conditions of health workers even in the developed world can be considered unjust even though they are much better than those available to workers in the developing world. Therefore, increased migration that undermines progress towards improved working conditions will be of moral concern if working conditions are sufficiently unjust in the destination community.

Conflicting reforms

Migration creates the potential for wrongs against a range of parties, including the source communities, migrants, and members of the destination communities. I will now sketch some reforms of the migration system without claiming to develop a list of all available responses. My aim is to highlight the potential for conflict among these reforms and to indicate reforms with the potential for avoiding conflict.

Harms against source communities

Migration potentially stunts or reverses the development of health infrastructure in source communities. In response, destination communities might first choose to recruit health workers only from source communities which agree to be the targets of recruitment.[10] The aim of this reform is to limit migration to source communities that have surplus health workers or can maintain a well-functioning health system despite or even in partnership with the emigration of skilled workers. Second, destination communities can encourage and support source community programmes to limit emigration and to indemnify source communities for the costs of health worker migration (Benatar, 2007). Additionally, destination communities can limit the access of migrants to their communities through the use of temporary work visas. Finally, destination communities can work to reduce poverty and improve working conditions for health workers in source communities. This action would discharge duties of beneficence and justice for destination communities while reducing the factors that drive source community health workers to uproot themselves from their home communities. Taken together, the aims of these reforms are to mitigate the harms to source communities of skilled worker emigration, as well as to reduce the factors encouraging migration in the first place.

Harms against migrants

Migrant health workers face vulnerabilities that often limit them to poor working conditions and wages. These harms can be mitigated, in the first place, by creating and supporting an open, free market for skilled labour.[11] If free market reforms of this kind are politically impossible or only partially implemented, individual employers can make employment offers based on a hypothetical free market for skilled labour. Finally, destination communities can implement and enforce legislation forbidding discrimination against migrant workers based on their country of origin. Collectively, these reforms would aim to insure

that migrant workers receive the same benefits as domestic workers with the same skills and experience. A secondary effect of these reforms would be to encourage migration by giving better working conditions for migrants in destination communities than currently exist, creating a conflict with the efforts taken to reduce migration.

Harms against destination communities

Members of the destination community are harmed when health worker migration reduces their ability to demand just working conditions. This harm could be mitigated by reducing migration into destination communities, either through outright bans or caps, or through limiting immigration to partner source communities. Limits on immigration would conflict with calls for a free labour market for health workers. Alternatively, destination communities can push directly for reform of the working conditions within their health systems and increase opportunities for domestic training within institutions of higher education. This reform would encourage migration given the greater appeal of health sector work in these communities.

This brief and incomplete survey of responses to the moral wrongs surrounding health worker migration demonstrates two important and related lessons. First, despite the frequent call for 'ethical' health worker migration, it is not often clear what ethical violations are purported to have taken place under current conditions. Most commonly, ethical concern is triggered by the negative effects of migration on the already fragile health systems of source communities. But as I have shown, a range of moral wrongs can reasonably be thought to be taking place within current migration patterns. Moreover, these wrongs can be committed against a diverse range of stakeholders, including source communities, migrants, and health workers in the destination community. Merely condemning present practice as unethical ignores the serious distinctions in the kind and weight of these moral wrongs, and avoids assessing the merits of these various claims.

More worryingly, the solutions presented in response to these various moral harms are diverse and, in some cases, work at cross purposes. In particular, proposals to limit the recruitment of workers and their access to destination communities will work counter to proposals to eliminate migrant worker discrimination and increase their free access to destination community labour markets. Without clarifying the moral wrongs being attributed to health worker migration, we cannot be sure what reforms are demanded by these wrongs or when these reforms have the potential to clash with our other duties.

Conclusion

Efforts at the reform of the current system for health worker migration should take the following three steps. First, a clear list of the specific moral wrongs and the groups who are wronged is needed. A full list of the most common and serious moral wrongs created by the current system is important given the potential for conflict among the obligations of relevant agents. This list should also identify the agents who are responsible for rectifying these wrongs in order to direct reform efforts.

Second, reformers should suggest changes to the present system with the aim of avoiding conflict among the relevant ethical obligations when possible. The interests of source communities, migrants, and domestic workers are not necessarily in conflict and reforms to the present system of migration need not represent a zero sum gain for any one party. Of particular interest will be reforms that avoid the conflict between encouraging and discouraging migration. Plans that will remunerate the costs of migration and improve working conditions in source communities do not create a conflict and should be implemented. Destination communities may be unwilling to take these steps, however, in the current climate of health worker shortages even in relatively wealthy destination communities. Therefore, it will be important to encourage help from third parties such as NGOs and wealthy countries that do not rely on migration for health workers.

Other, non-conflicting reforms are within the power of source communities even given destination community recalcitrance. By training community health workers, the brain drain of skilled health workers from the developing to the developed world can be reduced (Eyal and Hurst, 2008). Consider, for example, programmes in Mozambique and Malawi that give non-doctor, assistant medical officers, surgical training (Bergström, 2005). These *técnicos de cirurgia* have been trained to perform surgical operations such as caesarean sections in the absence of fully trained clinicians. A programme of this kind has the advantage of partially filling short-term gaps of skilled health workers in the developing world, particularly in badly underserved rural areas. But because of the relatively narrow training of the *técnicos de cirurgia*, aimed at medical care in resource-poor settings, these workers will typically not have the qualifications necessary for employment in the developed world, meaning that they will be less likely to migrate out of their home communities (da Luz Vaz and Bergström, 1992; Pereira et al., 1996).

The promotion of community health workers, or any single solution to the moral wrongs of health worker migration, will not succeed in

isolation. While community health workers may not be able to migrate to destination communities in the developed world, these workers may migrate to other developing world communities, if working conditions are sufficiently bad in their home communities. Fully successful responses to health worker migration, therefore, must address conditions in source communities including poverty, war, insecurity, and lack of opportunities for advancement.

There is no guarantee, of course, that practical, non-conflicting solutions are possible given the present extent of poverty in source communities, the inertia created by current institutional structures, and political limitations. When these limitations make conflict impossible or impractical to avoid, a third step demands that reformers balance competing ethical claims against one another. The strongest ethical obligation should be given priority when it is not possible to satisfy all obligations. Given the desperate lack of basic health infrastructure faced by many members of source communities, there is good reason to think that our obligation to protect free migration and fair compensation for individual migrants will be outweighed in many cases. Without a clear statement of our obligations, however, the conversation surrounding health worker migration will remain muddled, disrupting a coordinated, effective, and ethically defensible response.

Notes

1. The connection between migration and weakened health-care systems in poor parts of the world is not universally supported. Michael Clemens (2007), for example, argues that migration actually creates a net benefit for poor countries through greater health worker production.
2. This conception of justice is developed by John Rawls (1999b). Rawls is hesitant to extend the two principals of justice internationally (Rawls 1999a). Many have argued that at least one version of the two principals of justice should apply internationally. See Beitz (1999) and Buchanan (2000).
3. A common additional complaint lodged against destination communities is that both public agencies and, more commonly, private groups aggressively recruit or 'poach' workers from source communities. The root concern in these charges is that scarce health resources are lost by the source community through the recruitment process. Unless source communities can be said to have a claim on the free movement of their citizens – a very dubious claim – I believe that the wrongs that give rise to charges of poaching have already been described in this chapter in terms of duties of beneficence and non-maleficence by destination communities and the social responsibilities of workers that I discuss later (Snyder, 2009).
4. There are a variety of arguments for the moral importance of connections between persons. Soran Reader (2003) emphasises presence, biology, history,

practices and shared activities, shared environment, institutions, and shared projects. Similarly, the ethics of care stresses duties to those with whom we stand in specific relations. See, for example, Eva Kittay (1999) and David Miller (2001).

5. Within poor source communities, this social responsibility would also push health workers to care for the poor and underserved in their own countries in addition to relatively well off urban elites.
6. By creating a path for migration, destination communities facilitate the wrongdoing of migrants who owe a duty of social responsibility to their home communities. This facilitation of, or complicity with, wrongdoing might count as an additional wrong in itself, distinct from failures of the duties of beneficence, non-maleficence, and justice.
7. The ethical import of free migration is often expressed as a matter of individual autonomy in guidelines for the ethical recruitment of health workers. Consider the claim that 'no one from developing countries should be barred from moving to pursue their own interests provided that they fulfill any obligations or contracts within their country of origin or do not interfere with the corresponding rights of others, in which case, a fair process for resolving conflicts should be implemented' (McIntosh et al., 2007: 7).
8. Daniel Attas (2000) argues that depressed wages stemming from limits on migration and economic rights are exploitative. For a more detailed argument on the connection to an open immigration policy and the requirements of justice, see Harry Van der Linden and Josh Clark (2005).
9. Many migrants suffer from unjust global social and economic conditions that negatively affect their life prospects and, indirectly, depress the wage levels they can expect to earn in a free global labour market. The strategy of requiring individual employers to adjust wage offers in accordance with a fair labour market could be extended to account also for just global social and economic conditions. I am reluctant to recommend this step given: (1) the immense epistemic burden of determining what wages could be commanded by individuals in a fully just world; and (2) worries about placing the entire burden of rectifying income disparities arising from global injustice on individual employers.
10. This reform has been suggested in the UK (Great Britain Department of Health, 2004).
11. More generally, a moral case can be made for free markets in labour (or a right to free movement) for unskilled labourers as well. As Soloman Benatar (2007) notes, destination communities are often hypocritical in defending freedom of movement to skilled workers while denying it to unskilled workers.

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5
The Right to Health, State Responsibility and Global Justice

Rebecca S. Shah

Introduction

The greatest moral concerns in the international migration of health workers are its harmful effects on health systems and health outcomes in very poor countries. Poor countries face a vastly greater burden of preventable and treatable morbidity and mortality than rich countries. And yet the world's poorest countries have grossly inadequate numbers of health workers to serve the health needs of their populations. Relatively speaking, rich countries have health workers in abundance, although many of them also face shortages of domestically trained health workers. The human resources for health crisis is one of the contributing factors to the enormous and abhorrent inequality in health opportunities and outcomes between the global rich and the global poor. This problem is compounded by the fact that many of the world's poorest countries are failing to see a return on the investment they make in the training of much-needed health workers because many of them migrate to richer countries. The loss of just a few health workers from a critically understaffed health system in a very poor country can have a massive impact on the health services left behind. This is implicitly a question not only of need in poor countries but also of inequality. The substantial financial and health returns are accruing to the health systems, populations and governments of richer countries, which are financially and institutionally equipped to train health workers with far greater ease at the expense of poorer countries.

It is these moral concerns that motivate the search for ethical solutions to the harmful migration of health workers. One impediment to designing and implementing ethical policy responses is ambiguity in establishing who is responsible and for what. Other chapters in this

book examine the special responsibilities of individual health workers and the responsibilities of states to seek solutions that do not violate the freedoms and rights of individuals to migrate. This chapter asks what the responsibilities of sending and other (especially receiving) states are if we conceive of the harms to health systems and health outcomes in poor countries of origin in terms of the right to health.

In what follows I claim that countries of origin have clear responsibilities for the right to health of their populations but that the strength of responsibility is matched by a weakness in capability to achieve the health goals they seek. This is particularly true in the case of health worker migration as the movement of health workers is driven by international inequality which poor countries may aim to mitigate but cannot plausibly eliminate. Best efforts to secure domestic health systems therefore represent only a partial solution to the problem. The rights-based responsibilities of receiving states for the right to health of citizens in foreign countries are far weaker and more amorphous. I explore three potential human rights responsibilities of receiving states: responsibility to assist, to desist from causing harm to human rights and to provide remedy for rights violations. In each case there are ethical contentions and practical obstacles that limit them as satisfactory responses to the problem of harmful health worker migration. In closing, however, I explore how a conception of global justice might enrich our understanding of human rights responsibilities and I claim that specific policies and responsibilities should also be accompanied by a commitment to challenging the systems that perpetuate the gross global inequality of which harmful health worker migration is both a cause and a symptom.

Health worker migration and the right to health

One way of understanding the potentially harmful impact of the international migration of health workers on the health systems (and hence, health outcomes) in poor countries of origin is in terms of its contribution to the violation or under-fulfilment of the right to health. I will call this international migration of health workers, which negatively impacts the right to health in poor countries, 'harmful migration'.

Many rights sceptics object to the way that the language of human rights fudges the boundaries between moral, legal and natural concepts and fails to provide a coherent account of their meta-ethical foundations. I acknowledge these objections but am both unable and unwilling to properly engage with them here. In fact, at the risk of heresy, I think the ability of rights language to fudge these important distinctions is

one of its crowning strengths. The language of human rights has become so universally well spoken, understood and endorsed that it provides an extremely powerful practical tool for analysis, advocacy and policymaking. That it has clearly normative and aspirational content combined with legal enforceability and methodological clarity for identifying responsible parties and holding them to account makes it exceptionally powerful. Moreover that this normative content articulates a set of moral imperatives, things that people are owed as a matter of justice based only on their humanity rather than that which is merely good or otherwise contingent, lends it the strength of a moral trump. Whether you like rights talk or not, I think there are good reasons to engage with the existing human rights regime as an articulation of some of the normative responsibilities of states in the context of harmful migration.

The case of harmful migration has been described as an apparent clash between the employment, opportunity and migratory rights of health workers and the rights to health of all members of the population left behind (e.g. Bueno de Mesquita and Gordon, 2005). It is usually assumed that states have no, or at least extremely limited, grounds for interfering with the rights of individuals to leave their countries of origin, and as other chapters in this volume address these rights they will not be discussed here. I will consider the responsibilities of states to protect the right to health.

The right to health is a somewhat messy and contested concept. Common misinterpretations are that it either means a right to be healthy or that it means a right to a rather narrow conception of health care. The first of these is nonsensical as a human right and the second, though a crucial constituent of the right to health, insufficiently reflects its breadth. Article 12 of the International Covenant on Economic, Social and Cultural Rights defines the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and makes special reference to areas of application including certain health outcomes such as those associated with infant mortality, as well as environmental hygiene, disease prevention and medical services (UN OHCHR, 1966). The UN Special Rapporteur on the Right to Health, Paul Hunt, further describes the right to health 'as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health' (Hunt, 2005). The underlying determinants of health include myriad social, economic and political factors including safe living and working environments, access to adequate safe and nutritious food, freedom from physical violence, freedom from harmful discrimination, access to education, fair pay for

work and time to rest. In other words, these include most other human rights. In drawing attention to the underlying determinants of health as part of the right to health, this definition reaffirms the idea that all human rights are indivisible and interdependent.

This interdependence has resonance for recognising the complexity associated with harmful migration and finding ways to address it. The phenomenon of harmful migration is not solely accountable either for failing health systems in poor countries or for the failure to realise the right to health for poor people, although it may be both a contributory factor to and a symptom of these failures. Health workers often migrate because of the life-constraining lack of choices and under-fulfilment of theirs and others' rights in their home countries relative to destination countries. Inadequate pay and intolerable working conditions, insufficient infrastructure and resources necessary to perform optimally, overwhelming patient load, threats to personal safety and security, poor living conditions including limited educational and work opportunities for their children and other relatives are strongly motivating factors in the decision to migrate. Sufficient numbers of properly trained and resourced health workers are essential to delivering the basic health care and preventative measures necessary for the right to health, but the right to health will not be assured simply by halting harmful migration. Solutions to the problem must be enacted with awareness not only of the right to health but also of the broader rights context, which includes constraints such as respecting the right to freedom of movement.

As the right to health incorporates concern for health outcomes, health systems and the broader determinants of health, it is a useful indicator for the harms caused by the international migration of health workers. Approaching the harms of international health worker migration as a matter of the right to health does not necessarily reduce complexity but it does provide clarity with regard to responsibility: the human rights framework establishes that the right to health, as with other rights, is a right that individuals hold with respect to their state.

Source country governments and the right to health

The founding bases of the human rights regime are distinctly cosmopolitan; human rights are held by individuals, held equally by individuals and held universally by all individuals without exception or distinction.[1] The mechanism for their realisation, however, is distinctly state based. The responsibilities of states for the rights of their populations are unrivalled. States have primary responsibility to respect, protect and

fulfil the human rights of their citizens. This is clearly a useful practical tool in our current global statist system to enable the realisation of the utopian goal of universal human rights. Arguably it also reflects a concern of the emerging human rights regime after World War II that it is against their own states that individuals often need the greatest protection. But reliance on the state as duty-bearer is more than just a practical tool or historical artefact. It also reflects a particular political ideal in which the state acquires unique responsibilities in virtue of its unique relationship with its population. The population cedes responsibility to the state to govern in their name and in return the state assumes responsibility to govern in citizens' interests. State responsibility, unlike the moral responsibilities of individuals or other entities, is not derived from causal responsibility or malign intent. Governments have special responsibilities for their populations in virtue of their existence. The language of human rights gives moral, practical and legal shape to many of these responsibilities of governments.

As the primary protectors of the right to health for their populations, developing country governments have certainly been criticised for taking inadequate steps to ensure this right, including taking inadequate steps to resolve the human resources for health crisis. For example, African heads of state pledged to allocate at least 15 per cent of national budgets to health care in the Abuja Declaration in 2001 (African Union, cited in Action for Global Health, 2007). By 2006, over two-thirds of sub-Saharan countries were still allocating less than ten per cent of national budgets to health (Joint NGO briefing, 2008) and very few countries actually met the 15 per cent target (Goldsbrough et al., 2007).

Even when poor countries assign relatively high proportions of government expenditure and Gross Domestic Product (GDP) to health, the monetary value and purchasing power of that allocation remains low. For example, Switzerland and Rwanda both allocate similarly high proportions of total government spending to health (18.5 and 18.8 per cent respectively; WHOSIS, 2009). In Switzerland this spending amounts to about US$3350 annual per capita spending on health. In Rwanda this amounts to only US$14 annual per capita spending on health, or less than half of one per cent of Switzerland's spending (ibid.). Even in terms of purchasing power this amounts to only 1.5 per cent of that in Switzerland. It is evident that it is simply not feasible for the budgets of poor countries to allocate funding commensurate with values attainable in rich countries. As a result the funding available for training, employing and retaining health workers and for other areas of health service delivery is lower in poor countries than in rich ones. Even if poor countries do

their very best to secure the right to health, the working environments for health professionals, health service provision and health outcomes will likely be lower than those in rich countries.

The inequality in resources and outcomes between rich and poor countries may not matter so much if it were not the inequalities between countries that drive harmful migration. It is precisely because living and working conditions and opportunities are so different between rich and poor countries that the current pattern of international skilled migration from poor to richer countries exists. If these opportunities and conditions were roughly equivalent between countries then health worker migration would likely be lower, far more balanced or circular and certainly less harmful than it is. The comparison between rich and poor countries may also not matter so much if poor countries could nevertheless ensure acceptable domestic working conditions, health services and health outcomes, but they cannot. Angola, for example, has a critical shortage of health-care workers. Government-employed Angolan doctors report that they cannot meet their cost of living on their government salaries which they must supplement with other work (Ferrinho et al., 1998). Angola also has only one hospital bed per 10,000 people; healthy life expectancy at birth is 33 years and under five mortality exceeds one in four (WHOSIS, 2009). Health outcomes are grotesquely low for poor people in poor countries.

Poor sending states have clear responsibilities to protect the right to health of their citizens. The human rights framework and the right to health in particular makes explicit a core range of obligations on the part of states, the implementation of which will form an essential part of approaches to addressing harmful migration. Source country governments have general obligations to prioritise the health (and the right to health) of their populations relative to other goals and specific obligations to take measures to prevent and redress the negative impacts on health caused by harmful migration. Poor country governments can and should strive for excellence in both of these and there are certainly innovative and efficient ways of optimising health outcomes and employment conditions under circumstances of extreme budgetary restriction. Examples particularly relevant to the brain drain include the explicit contracting of health workers, the training of para-health professionals and the incentivising of work placements in high-need areas which are discussed elsewhere in this book.[2] Even in best-case scenarios, however, the strong and clear responsibilities of poor countries of origin are matched by weak capacity to fulfil them especially when core elements of the right to health are determined by a global context which they have limited power to address.

They simply cannot nullify the differences between their own and richer countries that often serve to motivate health workers to migrate.

Caveats in the right to health

This inability of poor countries to currently provide health services and the wider systems necessary to fully realise the right to health to a level comparable to that in richer countries is, however, accommodated in understandings of state responsibility in the human right to health in three main ways. First, the right to the health is considered to be progressive; second, it is considered to be relative; and third, it is to be realised through international assistance and cooperation.

First, being progressive means that, given limited state resources, states are not expected to immediately and fully realise the right to health but rather to 'move as expeditiously and effectively as possible towards the full realization' (UN CESCR, 2000: paragraph 31). The progressive nature of social, economic and cultural rights in general has often been associated with the idea that they are 'positive' rights that require state intervention to be realised and that they are less morally and legally pressing than 'negative' civil and political rights which merely require the state to refrain from intervention. This distinction is often overstated to the point of inaccuracy; even ostensibly negative rights require significant intervention from the state in terms of creating and maintaining an enabling environment, and even ostensibly positive rights include freedoms that are to be protected from undue state interference. The distinction is also often invoked and exploited by those keen to evade their legitimate human rights responsibilities. Nevertheless in practical terms the progressive nature of the right to health does serve to somewhat degrade its moral status. As noted earlier, the strength of rights language is partly the moral imperative it conveys; human rights do not merely denote the good or the desirable but entitlements and corresponding duties. When a human right no longer requires immediate fulfilment or the appropriate duty-bearer is incapable of protecting it, the right is stripped of some normative force.

Second, the right to health, as elucidated in General Comment 14 is implicitly relative, which means that '[t]he notion of "the highest attainable standard of health" … takes into account both the individual's biological and socio-economic preconditions and a *State's available resources*' (UN CESCR, 2000: paragraph 9; emphasis added). Relativity to an individual's biological preconditions makes sense; it may never be possible to raise the health standards of someone with a congenital illness, for example, to those of someone without and it is no rights

violation that this is the case. Relativity to socio-economic preconditions and state resources seems more problematic. Taken literally, the implications are confusing and repellent. It suggests that for poor people in poor countries where poor health circumstances are the norm, poor health outcomes are less of a rights violation, less morally problematic and less legally compelling than for people with richer backgrounds or in rich countries where the local standards are higher. This seems to be saying that people with a poorer socio-economic start in life and fewer state resources, such as those in countries where governments are incapable of resolving the human resources crisis, have or should have *lower entitlements* than well off people or people living in well-resourced states. This perversely appears to justify lower standards for the least well off; a form of double burden which makes a mockery of health as a universal and inalienable right.

It was obviously not the intention of the human rights regime to be read in this manner. Relativity and progressiveness were built into the right to health in order to avoid charges of rights violations being levied against poor states incapable, despite best intentions, of realising the right to health any further. It may sound practically reasonable but it is ethically most bizarre that poverty and inequality could be used to justify lower moral consideration and practical protection for the worse off. This is particularly true in the case of harmful migration which itself serves to increase inequalities between rich and poor countries in terms of socio-economic preconditions, state resources and health outcomes. Every increase in inequality would seem to increase the distance between the human rights entitlements of the worst and better off. The result is to weaken the strength of appeals on human rights grounds for poor countries to ensure the right to health of their populations through addressing the human resources for health crisis.

The third acknowledgement of the limited ability of poor states to secure the right to health is that although states hold primary responsibilities with regard to their populations, all states share some responsibilities to respect and take steps to realise the right to health (and other rights) through international assistance and cooperation (UN CESCR, 2000). It is to these responsibilities of other states, particularly rich states which are receivers of health workers from poor countries, that I now turn.

Receiving country governments and the right to health

The responsibilities of states and non-state parties for human rights in other countries are more obscure and amorphous than those of states for

their own citizens. In many respects human rights instruments reflect the dominant traditions of political philosophy which have tended to be deeply sceptical about any responsibilities of states to citizens of foreign countries, limiting them to duties primarily of non-interference and secondarily of beneficence. More intrusive responsibilities may be seen to conflict with the prominent civil and political human right to self-determination. It is another peculiar twist of 'universal' human rights that (with some limited exceptions) many people believe that states firstly have no clear obligations to stop another government abusing the rights of its own citizens (Donnelly, 1999) and secondly, have no legal obligations to avoid taking actions which violate rights in foreign countries (Gibney et al., 1999). Human rights instruments do stipulate responsibilities of foreign states but these are often interpreted as being undefined, weak, unaccountable or not legally binding. This section explores what some of these potential responsibilities might look like, starting with the most concretely articulated responsibility to assist and moving through responsibilities not to harm, responsibilities to remedy and finally to more expansive responsibilities for justice.

Responsibility to assist

The clearest articulation of international responsibilities with regard to the right to health and harmful migration is that of international assistance and cooperation. The UN special rapporteur notes that this 'includes a responsibility on States to seek appropriate assistance and cooperation, and a responsibility on States in a position to assist to provide appropriate assistance and cooperation' (UNGA, 2008: paragraph 22). There is no clarity, however, about what this duty to assist entails and although global attention to and funding for health, particularly health in poor countries, has never been higher, this assistance is often a double-edged sword when it comes to protecting the right to health in the context of the human resource crisis.

International assistance in its manifold forms often and increasingly makes a massive contribution to health spending in poor countries. Development aid has contributed to enormous health benefits such as the global eradication of smallpox and dramatic reductions of river blindness and guinea worm in some developing world regions (Levine et al., 2004). However, the plethora of current aid mechanisms for health, from direct budget support to global health partnerships, has been seriously criticised for potentially undermining stable funding for public health services in poor countries. Donor funding sources are often uncoordinated, leading to duplications and omissions; lack transparency

and accountability to recipients; are interested in short-term results rather than long-term stability; are concerned with high-tech solutions rather than making existing low-tech solutions more widely available; and may reflect donor values and preferences rather than recipient needs (see, for example, Buse et al., 2006; Bloom, 2007; Brown, 2007; England, 2007; Lorenz, 2007). High levels of external funding, which often exceed public funding for health, can swamp domestic infrastructure, prevent governments from sticking to comprehensive national health and development plans and may have a particular impact on human resources for health. As a long-term ongoing cost, staff training and remuneration requires long-term funding stability, whereas much current aid funding for health is short term, disease specific, unpredictable and uncoordinated (e.g. Dodd et al., 2007). Donors are usually disinclined to commit to the long-term funding necessary to address the human resources for health crisis such as in the form of salary support. At the same time a different form of brain drain may occur where health workers are enticed out of public health systems into the better funded parallel private systems of donor-endorsed organisations (Poore, 2004).

Even in the responsibilities associated with international assistance it is the primary responsibility of states to ensure that external or non-state actors do not act in such a way that undermines the realisation of human rights. The onus, therefore, is on the governments of poor countries, both to seek aid and also to ensure that any aid received does not impede the realisation of the right to health, rather than for donors to ensure that their actions do not impede the realisation of the right to health. In reality this often serves to place responsibility with the parties with the weakest international bargaining power. Rwanda provides a clear example. The Rwandan government has seven strategic objectives for health including human resources, institutional capacity and health services, but donor funding is many times higher just for health services for HIV/AIDS than for all the other strategic objectives combined (Dodd et al., 2007). In fact, international funding for HIV/AIDS dwarfs Rwanda's entire domestic health budget (Shiffman, 2006). The Rwandan government may not be in a position to refuse such generosity, indeed they may be considered negligent on human rights grounds if they did, but with money comes power and they may also struggle to ensure that this generosity is compatible with their sustainable objectives for realising the right to health.

Responsibilities to assist the right to health have sadly often been discharged in a manner that meets the humanitarian, political, economic or ideological interests of donors more than it meets the rights of recipients.

Assistance that fails to attend to potential negative human rights impacts is an insufficient response to harmful migration.

Responsibility to desist

Bueno de Mesquita and Gordon (2005) claim that responsibilities of international assistance and cooperation include duties to respect rights in other countries. The legal grounds for such an obligation are unclear and some would disagree that this was the case (e.g. Gibney et al., 1999). Rich countries, of course, also have responsibilities for the right to health of their populations. They may claim that it is both morally and legally legitimate to prioritise their own obligations and their own citizens' right to health over the right to health of citizens in foreign countries, even if this includes international recruitment which threatens human rights abroad. This may seem reasonable on many readings of human rights responsibilities and it serves to indicate how the human rights regime struggles to accommodate international inequality, especially if the standards for rights fulfilment are considered to be locally relative.

Taking the inequality in both financial and health terms between the world's poorest and richest countries into account, however, gives us reason to try to push for a better reading of the human rights regime in this regard. Receiving countries benefit from the employment and tax contributions of migrant health workers without having to invest in their education and training, the cost of which is borne by health workers themselves or, more often, their home country governments. Receiving countries can therefore deliver improved health services for their populations, and consequently achieve enhanced population health outcomes, with far lower investment than would be necessary to train the workers themselves. Sub-Saharan Africa (SSA) is the world's poorest region, accounting for less than 1.5 per cent of global GDP, whereas the Organisation for Economic Cooperation and Development (OECD) countries account for 74 per cent of global GDP (UNDP, 2009). Average life expectancy at birth is 27.5 years longer in OECD countries than in SSA (ibid.). The World Health Organization (WHO) statistics indicate that 36 countries in SSA have critical shortages of health workers (WHO, 2006) and it is estimated that Kenya loses US$517,931 worth of returns on investment for *every* domestically trained doctor who emigrates (Kirigia et al., 2006). Against this backdrop nearly *one quarter* of doctors trained in SSA now work in OECD countries (WHO, 2006).

It is staggering that the richest nations could be benefiting to this extent at the expense of the poorest nations. Moreover these benefits have been actively solicited by richer countries; they have systematically

pursued the active recruitment of migrant labour from poor countries in order to fill their own domestic staff shortages rather than taking other measures available to them to address domestic problems (e.g. Deeming, 2004; Attaran and Walker, 2008, Mills et al., 2008). Even if there is dispute about legal responsibilities for human rights fulfilment in foreign countries, a more modest responsibility for rich states not to *actively* contribute to and benefit from the violation of the right to health in poor countries has been suggested in the context of harmful migration.

The UK was the first country to try to ameliorate its actively harmful role by restricting active recruitment of health workers from poor countries. In the past the UK recruited large proportions of its health workforce from poor countries, but in recognising the incongruence of this behaviour with its stated international development goals it introduced an ethical code for the recruitment of international health workers (Department of Health, 2004). The code restricts active recruitment from a list of poor countries, although passive recruitment and active recruitment from countries which have specific agreements with the UK are permitted.

The idea of an ethical code is that the number of health workers immigrating from poor countries can be reduced without directly restricting immigration from poor countries with health workforce crises. Although there is no human right to immigrate and it is commonly accepted that states are at liberty to choose their own grounds for restricting immigration, it would nevertheless be grossly discriminatory to deny some people access to the freedoms of movement, opportunity and employment available to others specifically on the grounds of the relative poverty and need of their countries of origin. This would be another example of placing a double burden on the already burdened and may itself serve to compound poverty.

Ethical codes may therefore aim at reducing immigration from these countries, but the idea is that they achieve it in a more morally benign fashion by removing the harmful intervention of rich states rather than by imposing another form of harmful intervention. It seems to me, however, that this acts-omissions distinction is largely irrelevant. The consequences of the apparently more benign ethical code are either effective in reducing health worker immigration, in which case it has the same effect as restricting entry to people from poor countries and so the outcomes, if not the means, are ethically questionable; or they are ineffective in reducing immigration, in which case migration continues under more passive or alternative routes and the code has little practical impact at all.

The jury is out as to the effectiveness of the UK's ethical code. There is some evidence to suggest that the ethical code simply makes migration more difficult and expensive for migrants from poor countries without reducing migration (e.g. Mensah et al., 2005), which may heighten migrants' dependence on private recruitment agencies and make them more vulnerable to exploitation and abusive conditions such as debt bondage (e.g. Anderson and Rogaly, 2005; Skrivánková, 2006). The years since the inception of the UK ethical code have been associated with some decline in the number of health workers entering the UK to work from listed poor countries (Buchan et al., 2009). It is not possible, however, to distinguish the causal impact of the ethical code from that of other policies specifically designed to restrict skilled immigration, such as the new immigration system (e.g. Buchan et al., 2009; Cangiano et al., 2009). The impact of the code is therefore both practically and ethically ambiguous and reflects the complexity of taking measures to address harmful migration that do not themselves prove harmful in some other respect.

Whether particular ethical codes are effective in reducing harmful migration or not, desisting from the negative role of active recruitment seems an insufficient and morally ambivalent response to harmful migration. As it stands, the ethical code is a fine gesture, but may achieve little more than to salve consciences. It does nothing to address the harmful consequences of the continued passive harmful migration on health systems and the right to health in poor countries. It does not compensate for the harms caused by past active recruitment of health workers, and neither does it do anything to address the causal factors that prompt health workers to continue migrating even as it becomes more arduous to do so. Human rights instruments indicate that when a rights violation is proved the duty-bearer has an obligation not only to stop violating the right but also to provide 'effective remedy' (e.g. UNGA, 1948). The following section therefore explores the responsibilities of receiving states to provide remedy for their harmful roles in the international migration of health workers.

Responsibility to remedy

Responsibilities to provide remedy for rights violations are part of due process in the responsibilities of states for their citizens but are far beyond what are usually considered to be the responsibilities of foreign states. I think that due recognition of past wrongs is an essential part of retributive justice and is crucial for determining the sort of future we will have both in terms of preventing the continuation or repetition of harms and

also in terms of the value of honest dialogue. I am concerned though that remedy is an inappropriate focus for human rights responsibilities for harmful migration because it is difficult to accurately administer and because it spills over into far wider reaching and equally powerful historical claims. Nevertheless I think consideration of responsibilities to remedy leads us towards what are more important responsibilities, those of distributive rather than retributive justice, as I aim to demonstrate in the remainder of this chapter.

Even in the absence of significant human rights precedents, states are usually highly reluctant to admit responsibility for actions that violate or impede human rights in other states. One reason is because it presupposes that they have done something legally or morally wrong in employing health workers from overseas, an idea that many countries will reject, even if they accept that the associated deficits in the right to health for poor populations are regrettable. Another reason is because they will not be able to control the extent of the claims made against them as a result.

A more impartial concern with remedy is that working out exactly what remedy requires and of whom will be extremely, perhaps even prohibitively, complex even in the fairly discrete case of health worker migration. There is a considerable risk that establishing the exact forms, content, extent of reparation, compensation or even retribution may prove a considerable drain on resources.

What concerns me more than these issues, however, is that if states should accept responsibilities for remedying their harmful acts in this instance then we should also consider claims for remedy for other acts which have had negative human rights impacts in other countries. Receiving country governments, and rich countries in general, have had starring roles in the creation of failing health services in poor countries and the wider conditions of global inequality that perpetuate the directional movement of skilled labour from poor to rich countries even if they are not implicated in the active international recruitment of health workers. These roles ripple outwards in proximity to the current crisis. They include the championing of trade liberalisation in health services under GATS which facilitates harmful migration and poses serious threats to health in poor populations (Woodward, 2005). They include the imposition of structural adjustment policies which had catastrophic effects on salaries, working conditions, staffing levels, infrastructural investment in the health sector and ultimately rolled back progress in health and other social and economic human rights (e.g. Logie and Woodroffe, 1993; Ambrose, 2006; Daniels, 2006). They include the creation

of poor countries' crippling levels of debt and inability to refuse aid or loans with rights-harming conditions attached (Guissé, 2004). They extend back to colonialism itself which deprived great proportions of the world of rights to self-determination and allowed the colonisers to reap massive benefits at the expense of the lands and lives of the colonised, and further still to the slave trade which catapulted slave-holding nations into the positions of global affluence they inhabit today for the price of the lives, liberty and dignity of millions of people from what are now the world's poorest regions.

These may be matters of history but their impacts on health systems in poor countries and their legacies of inequality are still keenly felt. They have played a role in keeping certain populations poor and disenchanted and other populations rich and powerful and capable of determining the nature of global relationships. For the most part the current global patterns of affluence and deprivation within and between countries correspond to the roles played by historical nations and their racially differentiated sub-populations (such as indigenous people). These gross inequalities now both drive and are reinforced by harmful migration.

These roles, much like the active recruitment of health workers from poor countries, did not contravene any legal norms existing at the time but we nonetheless have reason to retrospectively find them morally unpalatable. If we are concerned with receiving countries' atonement for past wrongs, consistency would seem to require that we do not limit our concern to only the most obviously proximal actions when a great many others have also had a monumental impact on the situation. Harmful migration itself is not the only or even principal cause of the human resources crisis and the wider failure to fulfil the right to health in poor countries, even if it exacerbates these problems (Dumont, 2007). The real causal factors radiate outwards into history beyond the identifiable actions of specific contemporary agents.[3] Should all these harmful acts be entered into calculations for remedy in the context of harmful migration?

I think it would be unhelpful to prioritise the remedy of these harmful historical acts as responsibilities to remedy in the case of harmful migration. For a start, they exponentially magnify the difficulties of identifying and administrating just remedy to what I think would be a prohibitively complex task. Additionally, even if responsibilities to remedy can be cashed out there is the danger that addressing past injustice will not match contemporary need and may even create new inequalities and inequities, for example, if there are populations suffering today that are not identifiably the victims of past incidents of injustice or who

were also perpetrators. Human rights violations will be no less morally pressing in countries that were not victims of internationally harmful acts or that also perpetrated internationally harmful acts. These historic harms are of too great a magnitude to simply be ignored, but how they can be properly dealt with is a complex matter. The arguments for specific responsibilities of rich receiving states to provide remedy for active recruitment presented by Mensah et al. (2005) provide an avenue into reconciling these apparent conflicts.

Mensah et al. (2005) argue for restitution for the perverse subsidy that poor countries make to rich countries in harmful migration not only in financial terms but also in terms of international solidarity between health systems. The one obstacle to restitution that they see as credible is that it may be a disadvantage to migrant workers from poor countries by creating an incentive for health systems in rich countries to exclude them. They therefore suggest that 'restitution … should be detached from links to individual migrant staff. Instead, the extent of reliance … on staff from a particular low income country should inform and motivate government decisions to increase transfers of funds to rebuild those low income health systems in a manner that can tackle the causes of outmigration in the longer term' (ibid: 39). In other words, the harmful role of rich countries should not give rise to specific acts of direct remedy but should motivate the rich countries to make distributions that address, more generally, the human resources for health crisis in poor countries of origin. Indeed, Mensah et al. (2005: 38) claim that '[t]he proper approach to restitution therefore is one which involves *redistribution*'.

The UK may provide an example of the sort of measure Mensah et al. (2005) would endorse. The UK has complemented its ethical code with specific funding for human resources for health in a number of African and South Asian countries with critical shortages of health workers (Tyson, 2007). This funding even includes providing support for health worker salaries, which, as outlined in criticisms of international assistance above, is often avoided by donors who are reluctant to assume arduous long-term commitments and who also worry that such funding could be misappropriated (GHWA, 2008). This move to more sustainable funding which allows for long-term investments in human resources for health is to be commended. Without being a direct expression of a responsibility to remedy it nevertheless goes some way to compensate for the harms to health services which may have occurred as a result of the UK's role in actively recruiting health professionals from these countries.

I think that Mensah et al. (2005) make an even more profound point, however, when they claim that 'the ethical argument for compensation rests on the damage to health service users *of the inequalities that drive migration*' (Mensah et al., 2005: 39, emphasis added). In other words, they claim that the responsibility to remedy is predicated not on the wrongness of specific acts of rich countries (such as active recruitment) but on the underlying inequalities (whatever their cause) that drive the current patterns of harmful migration. This seems to be a considerable change in direction. Mensah et al. (2005) still use this argument to justify restitution between specific sending and receiving countries but if the real concern here, and basis for responsibility, is inequality rather than specific acts then there seems little reason to limit obligations of distribution in such a manner.

It seems that these concerns are drawing us away from practical human rights responsibilities towards concerns for global inequalities, which as indicated above are poorly accommodated by a human rights regime primarily concerned with inequality at an intra-state level. It is at this point that theories of global justice may begin to do some work in enriching our understanding of human rights responsibilities. Thomas Pogge presents a conception of global justice that accommodates these concerns of global inequality and feeds them back into human rights obligations. He has particularly applied his work to problems of global health and poverty, which makes it interesting to explore briefly here.

Responsibilities to remedy or of justice?

Like Mensah et al. (2005), Pogge also sees the historical connections between rich and poor countries as morally relevant in determining the responsibilities of the rich for the human right to health for people in poor countries, but he generalises these responsibilities even further than Mensah et al. do. Pogge (2001) catalogues the colossal history of internationally harmful acts and practices such as slavery and colonialism as instances of historical injustice. The effects of historical injustices are still evident today and alongside other causal connections (the monopolisation of natural resources by the rich to the exclusion of the poor and our shared global economic order which perpetuates inequality in favour of the rich) they give rise to responsibilities on the part of those that systematically benefit from them to those that are harmed by them (ibid.). Pogge's model assumes that the obligations arising from historical injustices give rise to general obligations of all the 'more advantaged citizens of the affluent countries' to all the disadvantaged, rather than particular obligations only from oppressors to victims (Pogge, 2005: 30). These are

obligations to promote a just world order in which all people can enjoy their human rights and are obligations of distributional justice.

I think that Mensah et al. and Pogge are right to draw our attention away from the particular metrics of remedy and the particular symptom of harmful migration to the broader problem of the inequality that allows harmful migration to prosper. To a certain extent the focus on harmful migration is a red herring. There is nothing inherently wrong with the movement of people including, or even especially, the movement of people from impoverished areas seeking better opportunities elsewhere. Indeed, health workers continue in the morally praiseworthy task of saving lives whether they do so in London or Lusaka. The real nub of the problem is that this current wave of migration takes place within a context of inequality that means it is largely directional and that benefits accrue to the richer nations at the expense of the poorer. The complexity of historical and global relationships has created an international system in which feedback loops, which perpetuate the distribution of benefits to the rich and the distribution of harms to the poor, now operate independently of specific and identifiable harmful acts. I think it is a mistake, however, to think that specific instances of historical harm can give rise to more general obligations of distribution to address inequity as Pogge claims.

Claims made by appeals to historical injustice cannot give rise to these obligations for distributive justice; this conflates two different types of justice that are ill suited to the match. Retroactive justice is concerned with the apportioning of blame and concomitant punishment, reparation or compensation for transgressions. Distributive justice, on the other hand, is concerned with the forward-looking just distribution of burdens and benefits in situations of relative scarcity. The two types of justice are widely held to be formulated differently with regard to moral desert.[4] Retributive justice punishes past offences but distributive justice does not similarly reward good moral actions; it is forward looking and is usually thought to apply irrespective of historical conduct (Rawls, 1971). As such, redress for historical wrongs should be the subject of retroactive justice whereas the fairness of contemporary distributions should be thought of in terms of distributive justice. Making claims under the former to give rise to obligations under the latter is problematic, especially in the way that Pogge claims.

On the one hand, distributional obligations fail to adequately take desert into account. For example, if a thief steals a very expensive car, the crime is not remedied by investing the value of the car in providing better public transport for all people who do not have a car, even if that

is a desirable public policy. Historical injustices such as slavery were grievous wrongs that cannot be remedied by general distribution to all those in need. Remedy gives rise to particular rather than general obligations; general obligations are inadequate compensation for injustices. On the other hand, retroactive obligations fail to adequately take the bases for distributional justice into account. Pogge, for example, is a self-confessed cosmopolitan, which means that he sees individuals as the units of moral concern and that this concern relates to all individuals globally and equally. His cosmopolitanism is formulated in terms of human rights (Pogge, 1992). His concern, then, is the universal realisation of human rights, not merely the realisation of rights for those who have been victims of specific historical injustice. Prioritising the latter would fail to satisfy Pogge's aim of equality in distributive justice.

The harmful historical acts discussed here do deserve retroactive attention, even if I do not think they can give rise to obligations of distributive justice. Addressing the past is essential for determining the sort of future we will have. It is unacceptable to continue with the misapprehension that deprivation and rights violations in poor countries today are the responsibilities of poor countries alone and for the transgressions of what are many of the world's richest countries to go unrecognised. There is still significant power in more conciliatory approaches including honesty, apology and symbolic reparation. These figurative rather than actual forms of remedy, however, can only be acceptable atonements for past wrongs if they are accompanied by genuine responsibilities of justice to challenge the institutions which perpetuate the gross global inequality that drives the harmful migration of health workers.

Theories of global justice can still be applied to enrich our understanding of human rights and real world responsibilities. Pogge's model is not dependent on historical harms to make sense and can help progress our understanding of the scope of responsibility for harmful migration. His model is based on human rights. It shares the same cosmopolitan foundations and it accepts the role of institutional mediation in the creation of those rights. Apart from highlighting the moral relevance of historical relationships it also highlights the other contemporary connections between people that strengthen their responsibilities of justice. According to his account the measurement of a just system is the extent to which it yields optimal human rights outcomes; institutional orders are unjust insofar as they violate human rights (Pogge, 1992). As such this presents a way to move forward somewhat from the state-based limitations of human rights realisation as responsibility is diffused among all parties who share the system, and especially among those who benefit.

By highlighting the importance of global interconnections for generating responsibilities this model reflects the real world experience that the extent to which the right to health is realised is dependent on global and relational (rather than just local and state-based) factors, which include harmful migration. The model stipulates responsibilities to distribute because we are connected and according to need. These responsibilities are not limited to states but they are incumbent upon states, especially rich states, given their prominence and bargaining power in international affairs. Solutions to harmful migration must include specific and directed measures to support health systems in poor countries and also measures to address the global systems – those rules of ownership, production and exchange – that perpetuate it. This may include, for example, altering the rules of migration not merely by restricting skilled immigration but by exploring moves towards more open borders (see Sager, chapter six in this book) or addressing the imbalance between immigration and emigration policy (see Cole, chapter seven in this book).

Pogge's model can also be applied to lend a fresh perspective to the other two responsibilities of receiving states discussed earlier – responsibilities to assist and to desist from causing harm. First, the responsibilities Pogge argues for are not obligations of beneficence but of justice based on these global connections. As such they cannot be discharged by the distribution of well-intentioned international aid which nevertheless thwarts the realisation of human rights in poor countries as discussed earlier. Obligations of beneficence may still exist, but any assistance must be implemented with a deeper awareness of potential negative externalities that might inhibit human rights fulfilment, such as undermining stability in the health systems they aim to benefit.

Second, the responsibilities Pogge argues for are to stop *actively* imposing a global order which is unjust because it foreseeably and avoidably violates human rights. Pogge does not see this active role only in terms of specific and identifiable acts such as the active recruitment of health workers from poor countries. Pogge sees gross global poverty and its associated under-fulfilment of human rights as being caused by global connections including contemporary shared economic institutions. Pogge (2001: 12) conceives of the global economic architecture as 'an extremely complex network of agreements and treaties about trade, investments, loans, patents, copyrights, trademarks, taxation, labor standards, environmental protection, use of seabed resources, and much else'. It is his claim that the natures of these institutions were determined by the affluent nations which represent that tiny minority of the world's population that control the vast majority of its money, power and information. As a result these

institutions are dramatically skewed towards promoting the interests of the affluent to the catastrophic detriment of the poor. As the consequences, whether deliberate, foreseen or not, enable the gross violation of human rights associated with poverty, they are unjust. Those individuals, corporations, states and intergovernmental institutions that participate in and benefit from these institutions are playing an active role in harming the global poor. On this view then, responsibilities to stop actively causing harm to the human right to health abroad through harmful migration cannot be discharged by simply stopping the active recruitment of health workers. This responsibility is more arduous and more audacious. It requires commitment and action to change the rules of the game that perpetuate the inequality that drives harmful health worker migration.

There is much that remains uncertain in augmenting understandings of human rights with theories of global justice, even those such as Pogge's which marries the current concerns of rights, global relationships and health. Most notably there is always the concern that fine words butter no parsnips and that accounts of justice seldom give rise to explicit and readily achievable policy solutions. To a certain extent this is true. What I hope this chapter has done, however, through an exploration of rights, responsibility and justice is to perform a prior and equally important role, which is to contribute to a better moral diagnosis of the problem. Appropriately understanding what is morally wrong can allow policymakers to more accurately and fruitfully concentrate their efforts. The contribution of a theory of global justice here should be to enliven the human rights discourse to move beyond the state relativity which currently limits the universal realisation of the right to health and to embrace concerns for global inequality. Such an understanding may help policymakers see how they can effectively harness the human rights discourse in measures to address harmful migration rather than allowing ostensibly ethical policies to make human rights appear divisive.

Conclusion

A central concern in the international migration of health workers is its harmful impact on the human right to health in poor countries. States have clear and direct responsibilities to respect, protect and fulfil the right to health of their populations but these are often matched with imperfect capabilities to do so. This problem is compounded by the fact that the inequalities between states implicitly drive harmful migration and the limitations of the human rights regime to accommodate concerns for global inequality.

Other states, however, including rich receiving states, have limited obligations for the human rights of populations in foreign countries. They have obligations to assist, but current experience suggests that the enormous influx of spending for health may make it harder for poor states to implement sustainable long-term objectives on the right to health, rather than easier. They may have obligations to desist from activities which actively violate the right to health in other countries, but even measures to avoid this active role (such as ethical recruitment policies) can render ethically ambiguous results. They are not usually held to have obligations to remedy under human rights law, but even if they should be, I have argued that it may not be appropriate, helpful or even fair to focus on responsibility to remedy. Nevertheless the myriad harms which the global rich have and continue to exact on the global poor demand attention. Given the limitations of the human rights regime to adequately address concerns for global inequality and past harm, I have suggested that conceptions of global justice may go some way to enrich our understanding of what real world responsibilities for human rights might look like.

Thomas Pogge's perspective suggests that human rights responsibilities should not be limited to states but diffused among all those that benefit from our unjust global system. In countering harmful migration specific responsibilities of the rich states to assist the poorer may exist but they must be enacted in a manner that does not further compromise the pursuit of the right to health. Examples of programmes which support long-term stable funding for human resources for health are to be commended. Specific measures, however, must also be accompanied by more general commitment to changing the global rules of the game that maintain the inequality that fuels harmful migration.

Notes

1. See Pogge (1992) for identifying these features of cosmopolitanism.
2. See, for example, Jeremy Snyder (Chapter 4), Phillip Cole (Chapter 7), Anthony H. Lesser (Chapter 8), Nir Eyal and Samia A. Hurst (Chapter 9) and Staffan Bergström (Chapter 10) in this book.
3. These causal factors of course also include actions of the leaders and the people in some poor countries themselves ranging from benign mismanagement of services to corruption, conflict and tyrannical dictatorships that have committed gross human rights violations and contributed to the long-term impoverishment of their countries. The human rights responsibilities of states for their own populations are not in doubt, even if they are not always observed.
4. Although this claim has been challenged by some, see for example, Mills, 2004; Smilansky, 2006.

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6
Brain Drain, Health and Global Justice

Alex Sager

Politicians, pundits and policy papers often suggest restrictive immigration policies as a remedy to brain drain. Among the most serious concerns is that developed states recruit badly needed health-care workers from developing states. Though I share this concern, I want to defend a paradoxical claim: the emigration of skilled workers from the developing to the developed world (brain drain) should lead us to support a more open immigration policy. The focus on brain drain in isolation obscures how migration takes place in the context of international and state-level institutions, institutions which are in some respects fundamentally unjust.

This requires a shift in perspective: instead of engaging in policies that penalise migrants to keep them in their place of birth, we should instead focus on the structural and institutional factors that lead to their emigration. Brain drain is not primarily about the movement of people. Rather, vast inequalities and human misery are the root causes. Insofar as the current regime of border controls unjustly serves as a partial cause of these inequalities, people who uphold them violate a negative duty not to harm.

This chapter proceeds as follows: first, I argue against policies that restrict emigration or immigration. Second, I address the moral wrongness of recruitment. Actions that deliberately attract skilled health-care workers away from regions in which they are desperately needed often violate a *negative* duty not to undermine institutions that provide the human right to basic health care. Third, I suggest that any realistic long-term solution to brain drain requires that attention to negative duties be extended to international institutions.

Brain drain and the restriction of emigration and immigration

The world's most vulnerable countries lose many of their most talented and qualified people to rich economies. The loss of skilled workers is particularly devastating for health care, since the migration of health-care workers triggers a depressing cycle: the lack of basic health care devastates the society and leads to fewer people being able to acquire the necessary skills to meet society's health needs. This weakens already fragile institutions and contributes to more flight of trained professionals.

In 2004, the US, the UK, Canada and Australia had between 220 (Canada) and 293 (the US) physicians per 100,000 people (Mullan, 2005). According to a recent report by Physicians for Human Rights, 38 out of the 47 sub-Saharan African (SSA) countries did not meet the World Health Organization's (WHO) recommendation of a minimum of 20 doctors per 100,000 people (Physicians for Human Rights, 2004). Ghana had only 6 doctors per 100,000, losing 70 per cent of its doctors to the developed world.

If brain drain prevents people from receiving basic health care, how should governments act? Before restricting freedom of movement and occupation, we should first examine attempts to tackle the problem that do not resort to unjustified coercion and morally repugnant restrictions of freedom. Many people leave because of low income, limited career opportunities, under-funded, under-equipped medical facilities, incompetent and corrupt administrations, woeful social security and the lack of personal safety (Alkire and Chen, 2006; Dovlo, 2006).[1] Governments need to ameliorate these circumstances if they want to retain skilled workers. Similarly, we should encourage attempts to facilitate voluntary circular migration, deploy remittances towards development and partner with destination countries to invest in source countries' health-care institutions.[2] Perhaps we can justify making education subsidies contingent on a period of service after graduation. There is also the possibility of changes to the training of health professionals to better suit their environment and discourage migration. For instance, Nir Eyal and Samia Hurst put forward a proposal for developing countries to change their curriculum to teach local rather than international medical techniques, particularly those suited to rural areas with limited access to state of the art instruments (Eyal and Hurst, 2008).

What if these measures turn out to be insufficient to stem the flow of educated migrants? States with health-care shortages might carry

out a ready but problematic solution: they could close their borders so that skilled workers cannot leave. In other words, they could restrict emigration.

This strategy has limited appeal. Many jurists and bioethicists hold that there is an asymmetry between restrictions on immigration and emigration. For example, Sabine Alkire and Lincoln Chen write, 'We reject [...] coercive means of medical professional retention' (Alkire and Chen, 2006: 166). At the same time, they recommend imposing quotas on the number of health-care workers admitted to developed states and employing temporary work visas to bring about circular migration. This exemplifies the view that states are largely free to set their immigration policy in terms of perceived national interests, but human rights law does not permit them to prevent people from leaving. Article 13 (2) of *The Universal Declaration of Human Rights* reads, 'Everyone has the right to leave any country, including his own, and to return to his country.'[3] There is no corresponding right to immigrate.

Human rights treaties are in part the outcome of bargaining and compromise, so we should be careful about uncritically treating them as moral standards. Is this asymmetry justified? A common justification for the asymmetry between immigration and emigration involves freedom of association. People do not generally have a right to join an association without the consent of its members. But, under normal circumstances, associations cannot legitimately compel members to remain. Similarly, to immigrate is to join a political association and enjoy its benefits, as well as potentially impose burdens on current members. To emigrate is to exit an association.

Emigration provides a powerful tool for withdrawing consent from a regime one has come to accept as illegitimate.[4] It is a key means of realising rights basic to well-being such as freedom of movement and freedom of opportunity, as well as escaping persecution and oppression.[5] Articles 13, 14 (the right to asylum) and 15 (the right to nationality) of the Universal Declaration of Human Rights respond to the Nazi persecution of Jews and other minorities (Morsink, 1999). We should keep in mind that most people are reluctant to leave their state under normal circumstances. Emigration is a traumatic experience for many people. When people choose to emigrate, it is usually because they are not well off (in the worst cases, they are fleeing persecution or civil war) or the prospects abroad are far better. Even when they do leave, they often intend to return.

Though restricting immigration may have the same effects as limiting emigration, international law is frequently understood to hold that

the right of sovereign states to control their borders outweighs any corresponding right of people who are not refugees to gain entry.[6] For our purposes, let us assume that states have a right to determine, within limits, who gets in. Even so, a state's right to control its borders does not entail that they can exclude immigrants for *any* reason. For example, most people have come to regard immigration policies based on racism as morally objectionable. Is the existence of harmful brain drain a legitimate reason for limiting immigration?

Imagine that a government concerned about international development and global welfare decides to structure the immigration system so that it is more difficult for skilled health-care workers to immigrate. In contrast to most current migration regimes that favour skilled workers, immigrants from states in which brain drain causes significant harm would have to prove that they *do not* have advanced degrees.

In developing this immigration policy the government would face questions about the range of just migration policies. We would expect that a just immigration policy should respect moral equality, basic rights and procedural norms of fairness. The government would need to justify differences in treatment. Liberal societies ought not to discriminate between members and non-members arbitrarily. What counts as 'arbitrary' is open to debate, but few today would accept policies that exclude people because, for example, of their race, ethnicity or gender.

Is the fact that somebody is a skilled professional from a state in which emigration would cause significant harm a morally valid reason for coercive exclusion? This policy is quite different from an immigration system that gives priority to those most in need. Skilled workers might very well be excluded by such a system as well, but the reason would be quite different. In the case of a need-based system, the justification would be that there are people who have a stronger claim to immigrate because their situation is more burdensome. If any restriction on immigration is justified, surely a system structured around need would be permissible. But if brain drain is the reason for exclusion, the claim is quite different: skilled workers are excluded because their services are more valuable in their country of origin.

Consider the parallel case in which a Toronto hospital refuses to hire a doctor on the grounds that she would accomplish more good if she worked in the sparsely populated Canadian territory of Nunavut. Would the doctor have cause to complain? The hospital justifies its actions by noting that any harm caused to the doctor (who may be well compensated if she relocates up North) pales in comparison to the misery caused by inadequate medical care. Is this an acceptable trade-off?

We should be wary of this policy. First, it ignores what Rawls calls the separateness of persons: it conflates individuals and dismisses their individual life plans or values. The policy ignores the fact that the doctor has her own legitimate plans for her life and is not to be treated as a tool for maximising the general good. In short, it runs roughshod over individual autonomy. Within developing states, migration from rural to urban areas is, if anything, more serious than migration across borders. But few people seem willing to suggest forcing doctors to remain in the countryside. If it is wrong to constrict a Torontonian doctor's opportunities so she can only work in Nunavut, it follows that a doctor from Botswana should not be excluded from working in Melbourne *because she's a doctor*.

Second, this sort of employment policy would violate the right to freedom of occupation. Employers have a responsibility to evaluate potential employees based on merit with regard to what the job requires. There may also be reason to give some weight to need or historical injustice (for example, by favouring employees who suffer or have suffered from systematic discrimination). However, the possibility that someone might do more good in another occupation is in most cases a poor reason for denying people jobs. It denies the right to freely pursue one's economic, social and personal development.

Usually, states have no right to obligate skilled workers to dedicate themselves to the common national good that *all* citizens do not share. It is unclear what special duties skilled workers have vis-à-vis their communities. It is surely a good thing if they dedicate themselves to public service, but it seems wrong to hold that we can compel them to do so. This does not rule out the possibility of special cases under which specific people have duties to their communities that others do not share. Generally, this would only occur under exceptional circumstances that are of limited duration. For instance, it might be justifiable to draft doctors into public service during an epidemic, if they proved unwilling to help out. But if these duties become more widespread, we risk a tyranny in which the skilled are coerced into serving the rest.

Beyond their noxious effects on human freedom, policies that try to force workers to remain in a limited territory are usually inefficient. Employers cannot guarantee that employees will be awarded the position in which they would do the most good. The economy is too complex to permit this ham-fisted attempt at planning. Shortages would occur in other regions as well-meaning bureaucrats' decisions lag behind human need. In the Canadian example, some doctors would elect not to work in medicine at all rather than endure Nunavut's winters, leading to

'brain waste'. Bright students would reconsider a career in medicine, electing for less arduous degrees with more options. Indeed, concerns of rights violations do not exhaust the issue: the consequence of singling out skilled workers for potentially onerous special duties could lead to an overall reduction of human capital.

There is a parallel with the case of health-care workers in the developing world. The interaction between migration and skill acquisition is complex. The possibility of migration to the developed world may create incentives for more people to seek higher education. If some of those people decide not to migrate or return after working abroad, it might turn out that there are actually more health-care workers than there would otherwise be. Furthermore, it is not clear that there is always the infrastructure that would allow workers to perform their jobs. Doctors may not have access to antibiotics, or even sterile water. Or the government may not pay their salaries, forcing them to turn to other ways of making a living. To focus on restricting immigration in isolation from larger national and international institutions is a mistake.

Brain drain and recruitment

So far I have addressed the policies that restrict movement. In source states, this would involve emigration restrictions which I have argued are morally problematic. Destination countries could restrict immigration. I have suggested that to target people because they are health-care workers unjustifiably infringes on their autonomy and freedom of occupation. It may also have the unforeseen result of reducing the opportunities of skilled workers and failing to improve the circumstances of any one else.

It is naïve, though, to think that international migration is merely a matter of workers freely choosing to seek work abroad within the context of immigration law. Rather, there are powerful agents that encourage migration. Activists and policy experts rail against the active recruitment of health-care workers from vulnerable regions. Consider the UK's *Code of Practice for the International Recruitment of Healthcare Professionals* (Department of Health, 2004). According to the code's third guiding principle:

> Developing countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the UK to support recruitment activities.

- Skilled and experienced healthcare professionals are a valuable resource to any country. Active international recruitment must be undertaken in a way that seeks to prevent a drain on valuable human resources from developing countries.
- The Department of Health and the Department for International Development have identified developing countries that should not be targeted for international recruitment under any circumstances.
- Individual healthcare professionals from developing countries, who volunteer themselves by individual, personal application, may be considered for employment.

The code intimates that international recruitment is morally wrong unless there is an agreement with the country's government. Furthermore, active recruitment from a list of vulnerable developing communities is forbidden. Though recruitment is problematic, the code allows for hiring individual health-care professionals who seek employment in the UK on their own initiative. Relatively little, however, is said about what grounds these judgements. The effect of hiring someone who comes on her own accord is likely to be the same as hiring a recruited worker.

Though the wrongness of recruitment may seem obvious to some, it is surprisingly difficult to pinpoint why this is so. In less dire circumstances, recruitment is normally a mutually beneficial practice. Active recruiting provides information to the potential employee, such as the job description, working conditions, salary and benefits. It also presents employees with the opportunity to accept the position if they so choose. Assuming that the information recruiters present is true and accurate and their audience freely chooses to act on this information, it is difficult to identify what is morally problematic.

To take a potentially perturbing example related to the public good, a powerful legal firm might 'poach' talented young lawyers from the public sector after the latter has invested resources in hiring and training them. Some people may find this example morally dubious, but most would balk at laws that prevent private firms from seeking out and enticing talented public employees. Also, many sources divulge information about opportunities, including personal contacts in companies and organisations. For example, many jobs are filled with the help of friends and acquaintances, who connect companies and qualified people. If we accept this as morally innocuous, why should we worry about the actions of a recruiter, who provides the same information? Granted, recruiters may be more aggressive and in a better position to negotiate with potential employees but it is unclear why this is morally wrong.

Under normal circumstances recruitment is morally innocuous, but when access to primary health care is endangered the situation is different. Active recruitment policies sometimes interfere with states' ability to guarantee basic positive rights owed to their constituents.[7] States have an obligation to guarantee that the rights of people within their territory are protected. Agents who intentionally act to prevent people from living in an environment where their human rights are honoured thus violate a *negative duty* not to cause harm. This is quite different from failing to prevent someone from entering your country to seek work. If there were a duty to do so, it would be a positive duty to take action to prevent harm. Instead, people die *because* states draw away physicians and nurses who could have saved their lives. It is analogous to a crapulous tycoon who buys up all the food in a region threatened by starvation. Normally, the tycoon is free to indulge her/his gluttony, but under these circumstances her/his actions cause people to starve.

Any rights-based account of morality must show how rights can account for differing circumstances. An example is illustrative. Canada had a net annual loss of over 500 Canadian trained doctors to the US. The moral wrongness of the American recruiters' action, however, is slight.[8] After all, the Canadian government has the resources to adopt policies to retain more doctors if it wished. For example, it could raise doctors' wages so that they are commensurable with American salaries or it could address many of the concerns of doctors working in the public system, creating better working conditions. The precise measures necessary to make Canadian doctors stay is an empirical issue but there is no reason to think they could not be determined and addressed. Most importantly, Canada remains capable of providing a basic level of health care to its citizens.

The case of government policies actively encouraging doctors from SSA to migrate is much more problematic. Developed states that recruit have far more resources at their disposal, so the power asymmetry is great. It is doubtful if the Ghanaian government could do much to compete with the US, for example. As well, despite health-care shortages in the US, Canada, Australia, New Zealand or the European Union (EU), they cannot be compared to the devastation caused by the lack of doctors in SSA or the Caribbean. Thus, recruitment, in some contexts, involves powerful agents intentionally preventing people from accessing their right to health care.

Brain drain in context

So far I have argued that states of immigration should not use brain drain as a reason to restrict immigration. When states allow skilled workers to

immigrate they do not violate any rights. States normally do not have a claim over where workers choose to deploy their talents due to freedom of opportunity and the importance of individual autonomy. However, under some circumstances, recruitment is wrong because people have a right to institutions that guarantee basic health care: actions that knowingly undermine these institutions *harm* people and thus violate a negative duty to not unjustly prevent people from exercising their rights.

The attention to negative duties draws inspiration from Thomas Pogge's work on global justice. Pogge is well known for his claim that we have a negative duty not to uphold unjust institutional structures, particularly at the international level, which systematically violate negative rights (Pogge, 2002; cf. Risse, 2005). For example, the institution of state sovereignty as it is presently understood allows abusive governments to borrow money internationally and sell natural resources in the global market. This provides an incentive for dictators to seize control of oil-rich territories (the resource curse), benefiting tyrants and foreign consumers at the expense of the domestic population (Pogge, 2005; cf. Wenar, 2008). Brain drain is a symptom as well as a cause of misery in a world in which hundreds of millions of people lack access to the minimal level of care necessary for a decent life (World Bank/The International Bank for Reconstruction and Development, 2008).[9] Furthermore, this squalor is not solely due to bad luck, barren geography or corrupt governments but, in part, exists because many of the major institutions benefit the developed world *at the expense of the global poor*.

A global focus helps put matters in perspective. States should refrain from actively recruiting health-care workers when it contributes to the inability of states to provide basic care. However, the attention to recruitment is often misplaced and sometimes misguided. Though the short-term effects of brain drain are tragic, countries need to build sustainable institutions that will lead to long-term improvements. In some cases, recruitment may create conditions for generating remittances, return migration, medical tourism and inter-country cooperation (Macaranas and Stewart, 2007).[10] Push-pull factors that drive migration play a more important role than recruitment in migration flows – if people did not stand to benefit, they would not migrate.

The limitations of approaches that try to curb migration should lead us to locate brain drain in the broader context of global justice. Governments spend billions of dollars on border controls that restrict immigration. But as long as there are vast disparities in wealth and opportunity between regions, people will continue to move. As mentioned above, root causes of brain drain include the lack of health-care institutions,

corruption and insecurity in developing states as well as poverty. Insofar as these do not develop in isolation but in the context of global markets structured by economic institutions such as the World Bank and International Monetary Fund (IMF), and major political actors such as the Group of 8 (G8), there is a moral obligation to reform these institutions so that they do not prevent states from meeting their citizens' human rights.

It is too easy to treat these institutions as part of a natural order. In many cases, they are created to favour the interests of the powerful over the basic needs of the world's poor. This is not inevitable but a product of apathy and wilful ignorance on the part of many residents in the developed world. Their indifference ignores the fact that people lucky enough to live in democracies that protect their rights have a *causal* role in upholding the international order. Just as governments are accountable to their citizens, citizens are responsible when they fail to prevent their governments from causing harm.

Admittedly, the average citizen has only a minor role, but in aggregate people have the power to change policy. Unfortunately, most people rarely vote with an eye to global justice, instead focusing solely on domestic well-being. We see this time and again in elections that speak entirely to local concerns and interest groups. This indifference is perhaps the largest obstacle to global justice. When people have a causal role in supporting an institutional structure that leaves hundreds of millions of people destitute, they are shirking their moral obligations.

Brain drain is not primarily about the movement of people but rather concerns distributive justice. Prosperity, equitable distribution of wealth and democracy are among the best indicators of whether a population receives adequate health care. The nature and requirements of global distributive justice take us beyond the goals of this chapter. Instead, let us focus on a major element of state sovereignty: the right to control borders unilaterally and admit or reject immigration applicants more or less at will. Border controls are an obstacle to more widespread equality. The rich and poor are not only separated by borders – sometimes they are rich or poor *in virtue* of the current regime of borders. Many economists have argued that increased liberalisation of movement would lead to economic gain by increasing efficiency: the movement of workers from lower to higher wage countries allocates labour resources to where they produce the most value (Hamilton and Whalley, 1984).

Estimates vary, but Jonathon W. Moses and Bjorn Letnes develop a model which suggests that free mobility could lead to an efficiency gain

of US$3.4 trillion, whereas Ana Maria Iregui places the efficiency gains at more than 50 per cent of the world Gross Domestic Product (GDP) (Moses and Letnes, 2005; Iregui, 2005). Of course, methodological questions need to be addressed and we should be cautious about accepting their figures, but the conclusion that increased migration would create a significant gain in efficiency is widely accepted (Martin, 2005). Efficiency tells us little about the distribution, but if wealth is increased through South-to-North migration, it will benefit at least some of the world's poorer people, especially those who currently lack the skills to migrate legally.

At present, most countries use class-based discrimination to determine immigration admissions (class here is understood in terms of income, education and/or profession). Migration is split between those who travel on the intercontinental airstreams with visas and checked luggage and those who set out on wobbly boats or on foot with a few belongings stuffed into a bag. The people who pass through customs flashing a passport and those who slip across borders at night are divided not by merit or by the needs of the host society but by the fact that privileged members of the world's population have structured the rules in their favour. If a politician tries to mobilise her/his constituents by railing against business and technological migrants, companies dispatch their lobbyists and file lawsuits. Senior colleagues will take her/him aside for admonishment and an economics primer. But the asylum seekers or undocumented workers who clean the offices and babysit the children of the country's managers and engineers are fair game. The world is like a country club: members, privileged by birthright, hand their car keys to the valet and stroll past the maître d', while the staff sneaks around security through the back door.

If people who do not possess advanced degrees and specialised skills could escape from desperate conditions in search of work, pressure on rickety health-care systems might be eased. Admittedly, the poorest people in developing states may still not have the means to leave. But we should not overestimate these obstacles or underestimate the resourcefulness of the world's poor. Already there is a great deal of migration between countries in SSA concentrated in South Africa. Despite the violent means used to guard 'Fortress Europe' and the US-Mexico border, people do leave. They risk their lives in the desert in Arizona or on the Mediterranean, often hiring smugglers. Furthermore, the immigration of a few people leads to chain migration. Once a few people from a town or family have set up home, they can send back remittances that enable others to come.

A more liberal migration regime could lead not only to greater efficiency but also greater equality. In theory, wages would rise under open borders in the country of emigration and fall in the country of immigration, eventually reaching an equilibrium at which immigration would halt. Timothy J. Hatton and Jeffrey G. Williamson in their economic history of the mass migrations from Europe to the New World between 1850 and 1914, conclude:

> European emigration had a significant impact on labour markets at home: the departure of the movers improved economic conditions of the stayers faster than would have been true without emigration – raising real wages, lowering unemployment and eroding poverty. By glutting labour markets abroad, the mass migrations must also have reduced the pace of real wage growth in immigrating countries. Thus, mass migration must have tended to create economic convergence among the participating countries.
>
> (Hatton and Williamson, 1998: 206; cf. Hatton and Williamson, 2005)

The theoretical and empirical issues surrounding the costs and benefits of migration are fiendishly complex. Models make unrealistic or simplistic assumptions, sometimes positing rational agents who act in perfectly efficient markets without externalities. Of course, in the real world, migrants have non-economic motivations and they are frequently irrational or misled by mistaken information. This simply draws attention to the fact that the moral and empirical issues surrounding migration are complicated and that the impacts on each region and group may differ. Similarly, more needs to be said to determine whether the economics of more open borders today would necessarily resemble the past. Still, while the role of border controls varies from region to region, considerable evidence suggests that border controls often partially cause or amplify inequality.

The shift from examining the brain drain in isolation to considering it part of a global migration system bound to international economic institutions provides a surprising possibility: a significant opening of borders in a just international economic regime would very well do more to alleviate the negative effects of brain drain than measures that aim to prevent emigration. Beyond the effects on inequality, opening borders would lead to investment opportunity from abroad, and the convergence of wages in economic regions, which would lower emigration levels over the long run. The ability to immigrate legally could also encourage circular migration and its potential benefits.

It is well and good to focus on broader issues of distributive justice and work towards global institutions that allow people across the globe to flourish. Nobody seriously believes that restricting immigration will solve chronic health-care shortages around the globe. Without structural and economic development, absolute poverty will continue to ravage much of the world. Still, will focusing on brain drain not do some good in some cases, especially in the short term?

In some situations it may, particularly if states focus on improving working conditions and salaries as well as negotiate mutually beneficial compensation schemes that are filtered back into educational programmes in developing countries. Still, this resembles trying to mend cracks in a levee as water pours over the top. Developing states will continue to lose their best and brightest until the world becomes a more equitable place. It is an error to focus on brain drain with little consideration of its underlying causes. Brain drain – and migration in general – is one aspect of the globalisation which takes place in a world in which nation states are separated by massive inequalities and human rights violations. The problem is not that people seek work abroad when they are needed more at home. Rather, it is the severe problems in many states that make it entirely reasonable to seek opportunity abroad. In a global legal and economic institutional structure that systematically favours developed states, the problem of brain drain may very well lead us to advocate more open borders and an agenda of international institutional change.

Notes

1. Dovlo quotes many nurses and physicians' concerns and frustrations.
2. The Physicians for Human Rights report cited above reviews many strategies for addressing brain drain.
3. For a sample of similar statements, see Article 12 of the International Covenant on Civil and Political Rights; Article 22 of the American Convention on Human Rights; Article 12 of the African Charter on Human and Peoples' Rights; Article 20, Arab Charter of Human Rights; Article 26, the Convention relating to the Status of Refugees; Articles 2 and 3, Fourth Protocol to the European Convention for the Protection of Human Rights and Fundamental Freedoms.
4. For example, among the 400,000 or so Americans who emigrated to Canada between 1968 and 1978, many were skilled workers politically opposed to the Vietnam war.
5. Not surprisingly, countries that currently restrict emigration include North Korea, China, Burma and Cuba.
6. I leave aside the debate on open borders.
7. The following argument only applies when recruitment actually causes harm. This is more difficult to establish than one might think. For example,

Michael A. Clemens (Clemens, 2007) presents evidence that chronic health shortages in Africa are largely unaffected by the migration of doctors.

8. This assumes that the doctors were recruited. Many of them probably applied for positions they knew were available.
9. For example, according to the World Bank, around 1 billion people live in extreme poverty, over 10 million children under the age of five die from disease each year and 1 million people die from malaria.
10. For example, Federico Macaranas in his 11 July 2007 Carnegie Council lecture discusses the health-care shortages in the Philippines but acknowledges that migration is a global issue and global health a responsibility that must be addressed internationally.

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7

The Right to Leave versus a Duty to Remain: Health-Care Workers and the 'Brain Drain'

Phillip Cole

Global migration is a recent topic for political philosophy but one that is receiving increasing attention. Traditionally, philosophy has conceived of political communities as hermetically sealed spaces, with no outside, such that all questions of ethics and justice are, in effect, negotiated between fellow citizens. My book, *Philosophies of Exclusion: Liberal Political Theory and Immigration*, was the first monograph devoted to the ethics of immigration controls, but growing political controversies have led to increased theoretical attention to this aspect of migration. However, the focus of this attention has been upon the problems caused by those who wish to enter the political community from the outside and the limits upon the state's ethical obligation to admit them, in other words, to questions of immigration policy and practice. The question of *emigration* has been largely missing from these debates, and I argue that political theory has to embrace the right to leave. At the practical level, while immigration may be the key political question for developed states, emigration poses far more serious, and perhaps far more real, challenges for nations in the developing world. If political philosophy is going to reflect and inform the experiences of the wider world, it needs to address the movement of people leaving their home country.

At the level of theory, too, we cannot adequately debate the ethics of immigration without, at the same time, discussing the ethics of emigration. After all, the immigrant is at the same time an emigrant, immigration and emigration are different end points of a single process, and the right to leave and the right to enter must have some kind of relationship with each other. In my previous work I have pointed out the theoretical and ethical asymmetries that are assumed to exist between immigration and emigration in mainstream liberal political philosophy, such that the state's moral right to exercise immigration

control is taken for granted, within some limits, but emigration controls are assumed to be completely unacceptable (see Cole 2000). I argued that liberal theory faces three choices: to identify a morally significant difference between immigration and emigration which can justify their different treatment; to be consistent between them; or, finally, to lapse into incoherence on the question of membership.

However, while I identified one possible symmetry as illiberal, one which recognises no right of entry *or* exit, I assumed that, from a liberal point of view, restrictions on the right to leave were simply unacceptable and that the second option, of liberal consistency, required a commitment to complete freedom of international movement; open borders. I therefore failed to recognise that while a 'hard' illiberalism towards entry and exit is unacceptable from a liberal point of view, there may be a 'softer' position that concedes many of my arguments against immigration controls, but, because it recognises 'soft' limits to the right of emigration, can maintain a coherent symmetry of limited immigration.

But is there a coherently liberal position that would embrace 'soft' limits to the right of emigration? There are two reasons to think that there might be. Firstly, although the right to leave is embodied in international law, it remains derogable, that is, unlike core human rights, it can be overridden by individual states under extreme circumstances. As the right to leave *is* limited in international law, we can speculate where those limits might lie. Secondly, a challenge that has been consistently put to me when I argue for open borders is the impact freedom of international movement would have, not on the developed world in terms of the mass influx of immigrants but on the developing world in terms of the mass departure of emigrants. This departure – the 'brain drain' of trained professionals in various fields as they emigrate to find better prospects elsewhere – is already a problematic reality for many such nations. This challenge shifts our attention away from immigration to emigration. When placed in the context of concerns for global inequality, poverty, and justice, the prominence of the right to leave begins to soften. And so the right to emigrate faces a set of challenges from the more radical, progressive field of political concern.

The issue of emigration raises the question of the moral relationship between the member who has left or who wants to leave and those who remain. Is there an ethical relationship here and, if so, is it strong enough to impose duties upon the would-be emigrant? And is it, under some circumstances, so strong that it obliges the would-be emigrant to stay, at least for a specific time period? I want to pose that question in relation to the 'brain drain', and specifically that of health workers

leaving the developing world for the developed world. The case of health workers is especially challenging for those who defend the freedom to migrate, because the argument that the effect of remittances and other benefits often outweighs the cost to the sending country has little weight here. Even the most enthusiastic defender of freedom of movement has to accept that this is not the case with health-care professionals (see LeGrand, 2007). The resulting degradation of health systems in the developing world is, according to the British Medical Association, a 'medical emergency' and, according to the World Medical Association, 'one of the most serious global problems today'.[1]

In an interesting and important paper, Judith Bueno de Mesquita and Matt Gordon (2005) point out that what we have here is a clash of fundamental human rights. The right to leave one's own country is an internationally accepted human right, embodied in Article 13 of the Universal Declaration on Human Rights: 'Everyone has the right to leave any country including his own.' But the right to health is also inscribed in international law. According to Article 25 (1) of the UDHR: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care.'[2] Article 12 of the International Covenant on Economic, Social and Cultural Rights states that 'The States Parties to the Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' Signatories commit to the 'creation of conditions which would assure to all medical service and medical attention in the event of sickness'.[3]

The general understanding of the right to health embodied in these international instruments is that it is the right to the highest available standard of health. This was expanded upon and interpreted by the Committee on Economic, Social and Cultural Rights when it adopted General Comment 14 in 2000. General Comment 14 in itself is not binding and remains an interpretation of the right to health embodied in international law. However, it has shaped the work of the United Nations (UN) and the UN's special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. According to General Comment 14, health is a fundamental human right and includes certain components which are legally enforceable (paragraph 1). It is not to be understood as a right to be healthy but as a right to health *care*: 'a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health' (paragraph 9). According to General Comment 14, certain aspects of the right to health impose legal obligations upon states. Three types of

general legal obligation fall upon states: to respect, protect, and fulfil the right to health (paragraph 33). The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health, the obligation to protect requires states to prevent third parties from interfering with the right, and the obligation to fulfil requires states to take appropriate measures towards the full realisation of the right. The duty to not discriminate, outlined in paragraph 18, is itself a legal obligation which should be nationally enforceable. There is, therefore, a human right to health embodied in international law and that right must be respected, protected, and fulfilled without discrimination by the states that have signed and ratified the treaties that embody the right. Despite this, Bueno de Mesquita and Gordon observe that 'although the language of human rights is often invoked when considering the right of health workers to freedom of movement, it is less commonly invoked to explore the situation of communities losing access to healthcare services as a consequence of migration' (2005: 7). The fact is that because of the level of emigration of health professionals, 'the right to health of health system users in the health workers' country of origin may be threatened' (2005: 10).

And so if we are looking for the basis for a moral duty to remain, it might lie here with the human rights approach. Does the right to health of local health systems users override the health worker's right to leave? Bueno de Mesquita and Gordon say there is no simple solution here because human rights 'must be considered of equal value – in other words, no right is intrinsically superior to any other right, and no one right necessarily trumps another; the freedom of movement of health workers does not ordinarily trump the right to health of individuals, or *vice versa*' (Bueno de Mesquita and Gordon, 2005: 35). And so the fact that the right to emigrate and the right to health clash with each other does not mean that either can be given priority over the other. As far as Bueno de Mesquita and Gordon are concerned we have to find a strategy which respects both rights.

They consider two general types of measures: mitigating strategies, 'which do not aim to prevent or interfere with the flow of health workers, but which encompass proposed mechanisms to mitigate the negative impact on source countries' and preventative measures, 'which seek, through coercive action or incentives, to prevent the flow of health workers from South to North' (Bueno de Mesquita and Gordon, 2005: 42). The preventative measures are of interest to us here, which, for Bueno de Mesquita and Gordon, consist of ethical recruitment by destination countries, managed migration, and the bonding of health

workers by source countries. They conclude that these strategies are acceptable from a human rights point of view as long as there is no coercive element, although the question of their effectiveness remains. On managed migration they say: 'Efforts of a coercive nature to stimulate return by workers overseas must be avoided to preserve *the right to migrate*' (Bueno de Mesquita and Gordon, 2005: 53). And on bonding they conclude: 'Methods of limiting mobility that are non-voluntary and non-contractual, i.e. coercive, are very unlikely to be acceptable under human rights law' (Bueno de Mesquita and Gordon, 2005: 58).

The most interesting kind of measure for this discussion is that of bonding, which can take two forms: monetary, which requires the payment of a fee by the emigrant worker to compensate for the costs of training and in-kind bonding, which ties the worker to the state health system for a fixed period of time. Ghana, for example, implements both kinds of bonding: South Africa uses in-kind bonding for doctors and the UK military services use both kinds of bonding for university graduates they have financed through their studies (Bueno de Mesquita and Gordon, 2005: 57). While monetary bonding is by no means unproblematic, I will focus here on in-kind bonding and ask two questions concerning its ethical status. First, is in-kind bonding the kind of measure that Bueno de Mesquita and Gordon identify as respecting both the right to health and the right to leave? Second, even if in-kind bonding does not respect the right to leave, might it still not be the practical expression of a moral duty to remain, and so a morally defensible limitation on the right to leave of health workers? On the first question, I have argued elsewhere that it is extremely difficult to see in-kind bonding as non-coercive (Cole, 2008). First, there is debate within liberal theory about the correct definition of coercion. Some would argue that coercion only takes place when the person subject to it has all choice removed, for example they are forbidden from emigrating as such. However, others would argue that coercion takes place when a range of choices, but not all, are removed. In other words, the choice to emigrate remains and the choice of becoming a health worker remains, but the choice of becoming a health worker and emigrating is removed. The individual is free to enter into a contract which allows them to become a health worker as long as they work within their country of origin for a fixed period, but they are not free to enter into a contract which does not have this condition attached to it. And so a freedom has been removed, and this could be seen as coercive (e.g. if it was removed without consent). Of course, it might be replied that all choices have conditions attached and therefore everybody is being coerced much of

the time. I would offer two replies to this criticism: first, it actually may be true that we are being coerced much of the time – the supposition that we are free may be a liberal illusion; second, and more relevant here, it depends which freedom is being removed – if it is a particularly important freedom, then we might want to describe its removal as coercive. In this particular case the freedom being removed is a fundamental human right and therefore it is not at all obvious to me that contracts which remove this right are not coercive.[4]

Another reply may be that the freedom to emigrate is only being removed for a limited period. But still, coercion does not have to last a lifetime to be coercive, and this point brings us to the second problem with contractual bonding. If we are looking for a strategy which respects both the right to health and the right to emigrate, in-kind bonding is highly questionable. Article 13 states that everyone has the right to leave any country including their own, and while it does not specify a timescale, we have to assume that it means they should be free to leave when they want, not at the convenience of the state. Of course, Article 13 is derogable under extreme emergency, including threats to public health, but it is questionable whether the emigration of health workers meets the test for derogability, or that preventing them from leaving meets the threshold limits for reasonable state response to such emergencies (see Bueno de Mesquita and Gordon, 2005: 15; Cole, 2006). To the reply that these contracts are freely entered into and therefore the people subjected to them are freely choosing to give up their fundamental right to leave, we can ask whether we can seriously contemplate a situation where a state can place certain of its citizens in a situation where they are encouraged to negotiate away some of their fundamental human rights. It seems a primary concern from a human rights point of view that we guard against any such situation, and while Article 13 and other rights are derogable, they are not negotiable. A final problem with the bonding argument is that it is not obvious that it would work. Rather than enter into this kind of contract, people may choose other professions which are equally rewarding but not subject to bonding. Bueno de Mesquita and Gordon comment that there is 'no consistent evidence that bonding schemes that have been applied in health systems in low-income countries have been successful' (2005: 57).

However, the second question I raised was, even if in-kind bonding stands as a coercive restriction of the right to leave, whether it was the practical expression of a moral duty to remain. Does the would-be emigrant health worker have a moral duty to remain which outweighs the right to leave? We can only make sense of such a moral duty within the

context of a comprehensive moral theory, and we have already seen that the human rights approach by itself does not tell us whether there is such a moral duty: all it presents us with is a clash of rights, without telling us how that clash should be resolved. Not all moral theories would recognise an obligation to remain. For example, a theory of libertarian individualism would have difficulty in accepting that there was any such thing as a right to health, and the individual right to leave would be paramount. Libertarian individualism, however, offers no coherent response to the problem of health worker migration, and what we are looking for is a moral theory that offers a solution. One moral theory which could act as the basis of a duty to remain is communitarianism as it morally ties the individual to a specific community simply by virtue of that community's existence and their membership of it. The duty of providing health care is owed to these particular people over and above any other people however extreme their needs, and despite the fact all have an equal right to health care, simply because they and we belong to the same moral community. The nation as a moral community plays a central role in embedding this moral obligation as owed to fellow citizens rather than to immediate family members or more local communities.

However, despite the fact that communitarianism gives us the answer that health workers have a moral duty towards their own community over and above the needs of others, we do not yet know that this is the right answer, and we certainly do not know that this is the right theory. We may find communitarianism unacceptable as a comprehensive theory. Indeed, I outline a number of problems with it elsewhere (Cole, 2000) and I will develop the most relevant of them here. These problems concern the focus on the nation as the relevant moral community, such that the health worker has a special obligation to the health-care needs of their fellow citizens over and above the needs of others. The first problem is that theorists fix on the nation as holding special moral value for the individual at the very moment when processes of regionalisation and globalisation question that value. It is becoming harder to equate the 'nation' with a specific nation state, as regions increasingly identify themselves as historical nations; and the nation state itself is not necessarily the prime actor in international relations as global structures of decision making become more clearly defined (see Brown, 2001). The second criticism is that the communitarian is inconsistent. If we ought to focus on the community which holds the strongest moral value for the individual, why suppose this to be the nation state or even the nation? If the communitarian is claiming that people, as a matter of fact, do value their nation state above all other forms of community,

they face the simple rebuttal that many people, as a matter of fact, do not do this. If they are claiming that people *ought* to value their nation state above all else, they are in danger of lapsing into the kind of reactionary nationalism they would condemn. Following from this, the third criticism is that these theorists are taking an under-theorised and over-romanticised notion of the nation and are simply passing over the vast body of thought that shows how problematic it is. To suppose that an idea as complex, ambiguous, and shadowy as the nation can help us solve any moral problems concerning membership is highly questionable.

Another approach which may provide a context for a moral duty to remain is contractualism. Here, we might argue that the state invests heavily in the education and training of health-care professionals and is therefore entitled to a return on its investment, and fellow citizens have indeed contributed to this in terms of taxation. In-kind bonding is a way of ensuring that return, or at least monetary bonding would be some kind of compensation. However, there is a problem of fairness here. The state invests heavily (one hopes) in the education of all its citizens, and so why are all the citizens not obliged to remain for a certain period? I received a state grant to study philosophy at undergraduate and postgraduate level, why should I not be bonded to work in the UK as a philosopher for a specific time period? That it costs more to train a health worker than a philosopher is no answer to the puzzle. Fairness requires that all citizens be bonded for a period of time, that period being determined by the cost of their education and training. It is morally inconsistent to pick out health workers for this kind of constraint. The answer to all this is, of course, that the state needs health professionals while it does not need philosophers, but this response does not begin to address the question of fairness. Besides, the duty to meet this need falls upon the state, which is obliged to train sufficient numbers of health workers to meet the needs of the community, taking into account the numbers likely to migrate. If a particular state is unable to do that, the obligation to meet the needs of the community should not shift onto the shoulders of particular individuals, whose human rights can then be suspended in order to meet it. Bueno de Mesquita and Gordon observe that although health workers are agents of the state and so partly responsible for meeting its obligations to respect the right to health, 'this does not place a personal responsibility on individual doctors, nurses, technical assistants or other workers to *fulfil* human rights such as the right to health' (2005: 20). The obligations of the health worker last as long as their contract of employment lasts. They

have no special moral obligation underlying that contract which stipulates that it must be for a specific period. And so 'if the health worker chooses to terminate that contract then their State has an obligation to ensure that an appropriate replacement is found, if necessary' (Bueno de Mesquita and Gordon, 2005: 21). Far from helping, contractualism seems to beg the moral question.

Another moral theory that may offer a coherent solution to the problem of health worker migration is utilitarianism. Does utilitarianism provide the theoretical basis for a moral duty to remain? On the face of it this looks to be an encouraging approach. If our goal is to maximise welfare, then it seems obvious that, if restricting health workers' rights to leave would as a consequence mean they worked in the local health system, and that system would be in crisis if they departed, then welfare is maximised. Of course we are assuming that the welfare cost to health workers who have their right to leave restricted for a period is outweighed by the benefits to the health system users who receive their services, but this assumption seems reasonable. However, notice that this argument only works if the particular political community, the nation state, is the focus of our moral theory, a kind of 'national' utilitarianism which sets aside welfare considerations in the wider world. But if we are concerned with the moral status of the nation in communitarianism, there seems no reason to accept it here.

However, a global utilitarianism might still give the same answer, in that, even on a global stage, the welfare cost to health workers who have their right to leave restricted is still plausibly outweighed by the benefits to the users of health systems which are suffering from the effects of the 'brain drain'. But this would be to move too quickly to the conclusion we want: a global utilitarianism has access to a wide range of strategies aimed at tackling global health inequalities other than health worker migration. Bueno de Mesquita and Gordon warn against mis-specifying the problem as 'being international health worker migration, rather than the real problem of inequality between source and destination countries (of which international health worker migration is merely a symptom)' (Bueno de Mesquita and Gordon, 2005: 55). It may well be that those alternative strategies score far better in tackling the problem of inequality than limiting the right to leave, which may give rise to other negative consequences such as people choosing alternative careers which have no such restriction.

However, I want to offer another theoretical perspective that I think contributes substantially to a global solution to the problems raised by health worker migration without imposing a duty to remain upon health

workers. The theoretical framework I would want to develop here is what some might describe as radical cosmopolitanism. This form of cosmopolitanism recognises the moral equality of all persons regardless of their membership of particular associations, but the moral equality it recognises is 'thick' rather than 'thin' – that is, it embodies a view of human well-being which cannot be respected through a negative strategy of non-interference, as suggested by libertarian individualism; instead, respect for human well-being may well require positive and collective strategies. In terms of health this moral equality would be embedded in what J. P. Ruger refers to as a 'robust concept of human flourishing', something she derives from Aristotelianism, which she combines with 'the desire to live in a world where all people have the capacities to be healthy' (Ruger, 2008: 999–1000).

The application of radical cosmopolitanism here points towards the recognition of the universality of the human right to health and the importance of meeting it globally. Other moral theories, such as the human rights approach, point in the same direction. However what radical cosmopolitanism adds, which is missing from Bueno de Mesquita and Gordon's human rights approach, is the possibility of a system of global governance relating to health provision. Ruger refers to 'shared health governance', where global, state, and local agencies work together to tackle global health injustice (Ruger, 2008: 1001). Global health institutions have centrally important roles here, such as 'to rectify global market failures, create public goods and address concerns of fairness and equity on a global scale' (Ruger, 2008: 1001). This picture of a global but shared health governance answers, at least in part, the objection that global health agencies and institutions would be too remote from local needs to plan effective health-care delivery. Just as the nation state delivers health care through local agencies, a system of global governance would do the same, only now the distribution of health-care resources would take into account global questions of distributive justice, not just national ones.

How would this system of global health governance affect the right of health workers to emigrate freely from their home countries? One thing to keep in mind here is that the right to emigrate is not the right to work where one wishes. The right to work where we want is an opportunity right, where no one is obliged to provide us with a specific opportunity; however, opportunities to work in particular places must be open and fairly distributed. The fact is, though, that the distribution of opportunities for health workers to work in particular places is subsumed under the distribution of need for their skills. However, under

the principles of radical cosmopolitanism, there is no special moral obligation for a health worker to work in their 'home' health system, even for a limited period of time, and so there is no moral justification for legal or contractual limits on their right to leave. And at the same time, under a system of global health governance the powerful developed nations would be prevented from subsidising their own costs by recruiting relatively cheap labour at a cost to the developing world.

A system of global governance shifts our perspective back to the mitigating strategies that Bueno de Mesquita and Gordon identify in their paper. These include health systems strengthening in countries of origin, restitution or compensation for the costs of health worker migration and better human resource planning in destination countries (Bueno de Mesquita and Gordon, 2005: 44–51). However, it is difficult to see how these strategies could be successful without a robust system of global health governance. Bueno de Mesquita and Gordon suggest a move towards such a system when they recommend that the World Health Organization (WHO)/World Health Assembly 'should provide a forum to develop a multilateral, and multi-stakeholder, legal or policy response that sets out a framework for action for a range of actors. This legal or policy response should be explicitly grounded in international human rights law' (2005: 63). However, their detailed recommendations identify the duties of states, both countries of origin and of destination, as well as private sector recruitment agencies and employers and international financial institutions. If the majority of such duties fall upon states and their agencies, we need to ensure that those duties are being met, and when particular states are unable to meet them they are supported until they are in a position to do so. If, according to liberal theory, certain welfare needs are so central to human well-being that they should not be determined by morally arbitrary factors like market forces, this is an argument for welfare systems that meet those needs not only at the national level but also at the global level. If those welfare needs should not be determined by market forces at the national level, then surely they should not be determined by market forces or by competition between states at the global level. The moral responsibility here does not fall upon the shoulders of individual health workers, nor can it fall upon the shoulders of individual states whose capacity to meet it is being undermined and overwhelmed by the competitive global order. The moral duty here is a collective one, that is, to work towards the establishment of a fair and equitable system of global health governance which respects and protects the human right to health for all.

Notes

This chapter builds upon a previous publication on the same topic (Cole, 2008). However, while that paper used the migration of health workers as a case study for thinking about theoretical issues around global migration, this chapter recognises the importance of the 'brain drain' as an urgent issue in its own right, and so takes my arguments forward in new and more applied directions. This chapter was presented at the 'Global Health, Justice and the "Brain Drain"' conference at the University of Keele in September 2007, at a workshop on political theory and public health at Manchester Workshops in Political Theory, September 2008, and at research seminars at Middlesex University. I received much helpful criticism and feedback which I hope have helped strengthen the arguments. I would like to thank Rebecca Shah, Jurgen De Wispelaere, Angus Dawson, and Souzy Dracopoulou in particular.

1. *The Independent*, 27 May 2005. For the statistical evidence behind the problem, see de Mesquita and Gordon, 2005.
2. United Nations, *Universal Declaration of Human Rights*, www.un.org/Overview/rights.html, accessed 10 July 2008.
3. For the full version of the International Covenant on Economic, Social and Cultural Rights, see www.unhchr.ch/html/menu3/b/a_cescr.htm, accessed 10 July 2008. For other international codes in this area see International Organization for Migration, *World Migration 2005: Costs and Benefits of International Migration*, Volume 3 – IOM Migration Report Series, 2005: 330.
4. For discussion on the concept of coercion see Nozick, 1969 and Frankfurt, 1973.

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8

The Right to the Free Movement of Labour

Anthony H. Lesser

In considering what ought to be done about the 'brain drain' of skilled medical workers, of many kinds, from the poorer to the richer countries, one key issue is the question of whether there is a right to the free movement of labour, a right to sell one's labour wherever one chooses and wherever there is someone willing to buy it. This question can be framed in two ways. If one believes in moral rights, one may ask whether there is a right to the free movement of labour. If one believes that the concept of a right is a legal and political one, and that one cannot talk properly about rights unless they are legally supported, one will ask whether there ought to be a right to the free movement of labour. But nothing, I think, hangs on the way the question is framed, provided that one does not mix the two ways of talking. This chapter will be considering a slightly narrower question: is it ever justified to interfere with the free movement of labour, and on what grounds?

To tackle this question, one first needs to ask what the reason might be for maintaining that interference is never justified. One could argue this for one of two reasons. The first would be utilitarian – that free movement of labour enables work to be provided where it is most needed and workers to sell their labour for the best price they can get, so that both the incoming workers and the host country benefit. To this it may be objected that this is often true but not always. There are two possible harms that the movement of labour may bring. The first is the possible harm to the workers in the host country who may find that they cannot find work because of the increased competition, or that their wages are static or even falling because the incomers are prepared to work for less money than the workers of the host country. There is admittedly a problem with raising this issue. Whenever there is immigration in appreciable numbers such fears arise, but very often

they are in fact groundless and there is enough reasonably paid work for everyone. Moreover, these claims, that immigrants are taking jobs or causing the lowering of wages, have often been made for political purposes by people who know they are false, and whose political programme is disreputable, whether because it is racist, anti-democratic, or both. Nevertheless although the claim is very often false, and either a mistake or a lie, it is still, if and when it is true, a valid point. The people seeking work would of course be in no way to blame, but leaving them free to do so might do more harm than good.

Secondly, there is the problem with which this book is particularly concerned – the effect on the countries that people are leaving, particularly if what is happening is that those countries, which already have a serious shortage of skilled people, have the situation made worse by the fact that many of these people, having been trained at considerable expense, promptly leave in order to earn more money in the wealthy half of the world, which actually needs their skills much less. So if the argument for non-interference with the movement of labour is utilitarian, it seems to fail as an overall argument. The appropriate conclusion would be that there should be a presumption that it is beneficial, but when movement of labour appreciably harms either the countries to which people are moving or the countries which they are leaving, interference on utilitarian grounds is legitimate, and perhaps even required. To repeat, this holds good only when harm is really being done or is really a serious threat, and one must keep in mind that people tend to see a danger here when in fact there is none and that other people are very ready to exploit these fears for their own ends. Nevertheless harm can be done; and if the argument is utilitarian, it follows that the movement of labour should be allowed when, based on the evidence, it is overall beneficial but not when, based on the evidence, it is doing more harm than good.

But this is not the end of the argument. One can argue for non-interference on another and rather different ground, namely that one's skills and labour are one's own property so that one ought to be allowed to sell them to anyone willing to buy them at an acceptable price, and especially one ought to be allowed to use all honest and non-coercive means to try to get the best price available. One should not be allowed to lie about one's skills or qualifications or to force anyone to give one employment, but one should be allowed to compete anywhere for a job, to be appointed if one is in fact the best person, and to accept any offer of employment that is freely made and that one finds satisfactory. This, it may be argued, is simply a matter of respect for individual people,

which must include respect for their property. Respect for property must include allowing people to sell or hire it out as they think best, and in this respect skills are like actual property. No one is obliged to employ any particular person any more than they are obliged to buy their house or go to their shop, but they are obliged, on this view, to allow them to compete on equal terms wherever and whenever they choose.

The first question here is whether it is right to treat skills and capacity for work as property, or as analogous to property. I suggest that it is at any rate reasonable, and not likely to be misleading, when considering questions regarding the freedom to use those skills and the freedom to decide at whose disposal one will put them; but this works only in one direction. For it would seem that one's skills 'belong' to one in a stronger sense than one's possessions, and therefore it is reasonable to argue that any freedom with regard to one's possessions should also be granted with regard to one's labour, but not necessarily reasonable to argue that a restriction, which can legitimately be applied to how one may deal with one's possessions, can also be legitimately applied to how one may sell one's labour. Let us see how this works out.

One must immediately observe that there is no theoretical or practical reason for saying that property rights are absolute and that if one owns a thing one may do as one pleases with it. Legally, and similarly morally, there may be conditions attached to ownership. So, the question is: what sorts of conditions can it be legitimate to impose? The first move might be to say that one should not be allowed to use one's property to do harm to others, or risk doing harm; one is no more entitled to point one's own gun at someone else than to point anyone else's. But then one has to define harm. It cannot be simply putting someone at a disadvantage or depriving them of a benefit: in that sense, to work for A would inevitably be to do harm to employers B, C, D, and so on (assuming one's work is worth having!), and similarly to sell an item to A or buy an item from A. It must involve some kind of violation of rights or duties or, a milder case, doing something to a person which they have a right to prevent.

Can this be applied to the movement of labour? We may first consider it from the point of view of the country to which people wish to immigrate in order to work. There are two grounds on which such people might be excluded, or their numbers limited. The first would be that there was a serious risk that if admitted in any numbers they would proceed to violate the rights of the existing inhabitants. This is not an issue now in most parts of the world but has been in the past, with Europeans being probably the worst offenders. Thus Kant in 'Perpetual Peace', while arguing for a universal right to hospitality, that is, a right not

to be treated with hostility so long as one's own behaviour is peaceful, also argues that this does not extend to the right of a guest, and goes on, after listing the crimes committed against the natives in America, Africa, and India, to say that 'China and Japan (Nippon), having had experience of such guests, have wisely placed restrictions on them' (Kant, 1991, second section, third article: 106–7). This seems, indeed, to be a justifiable ground for exclusion – provided there really is such a danger and it is not a case of the elephant fearing the mouse. But mercifully it will, nowadays, have few if any applications.

The second consideration is more complex. Suppose that it is true that the jobs and/or the wages of some workers in the host country really are threatened by the immigrants – to reiterate, these claims are often false, but may not always be false. Is this a reason for preventing people from seeking work in that country? By entering into competition for jobs there, they are neither violating anyone's rights nor breaking any duty. The argument here must be a rather different one. It would have to be that the host country workers, by virtue of being citizens, are entitled to certain kinds of protection, not only of their lives and property but also of their jobs – not total protection but protection from some types of competition, even if this limits the right of others to compete at all. There is obviously more to be said about this argument: for the moment it will just be noted as, at any rate, not altogether implausible.

Our real concern is with the effect of the movement of labour on the countries that are losing people, in this case skilled medical people. The question is whether the country of which they are citizens and where they did their training could be justified in restricting their right to emigrate, either permanently or for a certain number of years, so that its citizens may have the benefit of their skills. Once again, there are two arguments. The first is analogous in some ways to the argument made earlier. It is that the citizens of this country, having contributed through their taxes to the training of these people, are entitled to benefit from that training: it might indeed be said that although they were not in fact consulted about how much tax they should pay and how much should go to the training of doctors and nurses, had they been consulted they would have agreed very happily, but only on the condition that they or their fellow citizens would have the opportunity to benefit. If they had known that a particular person would emigrate, they would not have been prepared to finance his or her training. And it could further be argued that even a person who has paid all of their own fees has still benefited from things done at least partly at public expense – the setting up, for example, of a part or even all of the college

or hospital where they studied. It should also be noted that even people who do not pay taxes (if there are any) are still in effect contributing, in that they are affected by the fact that public money is used in this way and not some other way, conceivably more advantageous to them. There is a real and strong sense in which one can say that their whole society has contributed to their training.

Secondly, it may be said that the doctors and nurses themselves have an obligation to the society which trained them and gave them the skills they now possess: it may not be an obligation to work there for all their lives but it is an obligation to spend some years there. So, it might be said that the citizens have an implicit claim against the people who have been trained in their country that they should repay the benefit they have received of becoming more skilled and able to earn more money by using those skills, at least for a time, in that country. They also have an implicit claim against their government that in return for providing for the training they should be given the opportunity to benefit from it. Hence, for justice to be done, the government should honour this claim, and if necessary force people to do their duty, by requiring them to remain and work in the country for a specified number of years after their training has been completed. There are those, moreover, who would make the stronger assertion that the citizens, having provided the money and resources for the training, have not merely a claim but an actual right that the resultant skills be put to use in their country, and to emigrate after qualifying violates this right.

To this two replies may be made. They do not conclusively disprove these claims, even the stronger one, but they show that they are problematic. The first reply is that skills, once acquired, are the property of the person who has acquired them, and may be used as they think best. To train a person, it might be said, is analogous to making a gift. Having made a gift, with no explicit conditions, one has no further control over that piece of property; having trained a person, with no explicit conditions, one has similarly no authority over how they then use what they have learnt. One might make the gift, or carry out the training with certain expectations, but this does not put the person who has received the training or the gift under any obligation to fulfil those expectations. For that to be the case, there must be an explicit contract between giver and receiver that the gift, or the training, will be used in certain ways. In itself, making a gift creates no rights.

Secondly – and the two points are connected – one might deny that there are any such things as implicit claims or contracts. If they are not explicit, how can one know what they are, and what one's obligations are?

Moreover, in this case, it might be said, one is not even dealing with obligations to any particular individual. If one could identify exactly which group of people had made a person's training possible, then it might be argued that there were some obligations to them that were obvious even if not made explicit, that is, even if they did not explicitly say that they expected the person being trained to stay in the country for a time, had he/she or 'an officious bystander' asked them if that was what they expected, it was clear that they would reply with a 'testy "of course"'. But can this be applied to the citizen body as a whole?

If one puts all these arguments together, the following is suggested. The last two arguments show that there is some problem with supposing that by accepting the opportunity to be trained one thereby enters into any implicit obligation, or implicit requirement, to meet a claim held by one's fellow citizens; similarly, there is a problem with supposing that by providing the opportunity for training, the fellow citizens acquire the right to benefit from it. But these arguments do not affect another possible inference from the earlier arguments, namely that there would be nothing unjust, and much that is positively just, if such a contract were explicitly made, and it were an explicit condition of being trained that one worked in the country for a certain number of years – as indeed is the case in some countries. It may or may not be true that a person is in some way bound by the unexpressed hopes of the people paying for their training, but one would certainly be bound by an explicit contract. There is no ground for thinking that such a contract is in any way unjust: the only possible argument would be that property rights must always be absolute, and we have seen that there is no reason, theoretical or practical, to accept this.

I would therefore tentatively conclude as follows. There should be a right to offer one's skills and labour for sale or hire wherever one thinks best, unless this violates an existing duty or violates or threatens the rights of others. It is possible, but not certain, that by accepting training in a relatively poor country one acquires an obligation to use one's skills in that country at least for a few years, and that the country might legitimately require this. But since this is uncertain, a much better option is for the obligation to be made explicit and for people to have to sign a contract at the time of their training, agreeing to remain in the country and the profession for a determined number of years. This would produce a clear duty, moral and legal, to stay in the country. Such a condition would in no way be unjust, since there is no reason to think that people have any right to better themselves without incurring any obligations. They may be lucky enough to do so, but they have no reason

to expect it, nor is there any reason to say that property rights, even the rights over one's skills and their exercise, must be absolute. Skills are the property of the individual in a certain sense, but the people who made it possible for them to be acquired surely have a right to make some conditions on how they are used. They do not have the right to make any sort of condition; it would be entirely wrong to train a doctor on condition that he/she never treated members of a particular racial group, for example. But the condition that some part of the doctor's or nurse's professional life be given to the society that enabled them to be doctors or nurses is surely just – if not paradigmatically just!

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9

Coercion in the Fight Against Medical Brain Drain

Nir Eyal and Samia A. Hurst

Medical brain drain

Several contributions in this book tell of doctors' increasing emigration from developing countries where they are in critical shortage, especially from the underserved rural and public sectors of countries in sub-Saharan Africa (SSA) and South Asia. They point out the severe harm from that migration to some of the world's poorest and sickest populations who have no other doctors to turn to, and gain little from their emigration. Since significant harm to the badly off is bad, decline in that migration is usually a good development. But how to strive to achieve it?

Most policy proposals to address medical brain drain are emphatically non-coercive, proposing, for example, incentives for doctors who stay and training paraprofessionals to replace them. Coercive policies and policies often perceived as coercive, such as formal limits on doctors' immigration and emigration, are usually rejected outright on grounds of doctors' basic freedoms of movement, occupation, and education (Physicians for Human Rights, 2004; Hunt, 2005: paragraphs 46–9, 60ff.; WHO Secretariat, 2009). In this spirit, while international institutions currently consider a draft global code of practice on health worker recruitment, the latest draft emphasises that 'nothing in this code should be interpreted as limiting the freedom of health personnel, in accordance with international law, to migrate to countries that wish to admit and employ them' (WHO Secretariat, 2009, section 3.4).[1]

However, could some seemingly coercive measures to diminish the brain drain be morally justified? This chapter gives a strong affirmative answer to this question – setting aside the question whether they are legally justified (WHO Realizing Rights Initiative, 2009). By 'seemingly coercive' we

mean to cover both coercive policies and policies merely perceived as coercive. The second section notes several seemingly coercive policies. The third section elaborates on one, which we call 'locally specialised medical training'. The fourth section mentions ways in which actions and policies that initially seem too coercive can be (a) non-coercive, (b) coercive non-problematically, or (c) justified on balance. The fifth section uses this insight to defend locally specialised medical training from the charge of excessive coerciveness. The sixth section further defends locally specialised training from that charge by comparing it to two policies in other areas, which are more coercive, less urgent, and yet, clearly legitimate: conditioning doctors' board certification on working as residents; and redistributive taxation.

Seemingly coercive responses to the brain drain

Some policies that seek to diminish medical brain drain may seem to involve a problematic degree of coercion. Consider the following examples.

Since 2008, the UK has stopped issuing work visas to doctors and other health workers from countries outside the European Union (EU), including ones with critical shortages (Travis, 2008). If many more Western countries adopt similar policies, perhaps following global legislation on health worker migration, then international employment options for doctors from countries with critical shortages would be severely curtailed.

In 2007, the Indian health ministry proposed to apply a policy already in use in many countries: to make a compulsory year of rural service a precondition for basic medical degrees. This set off student demonstrations, strikes, and 'Gandhigiri' protest including fasting to death (Kalantri, 2007; Shivakumar, 2007). In Ghana, MD degrees are given only a year past graduation (Dovlo and Nyonator, 2003), presumably in order to force graduates not to rush to emigrate but to stay, reconsider, and develop local ties that may discourage emigration.

More than 20,000 Cuban doctors staff many of Africa's, Haiti's, and especially Venezuela's underserved rural clinics (De Vos and Van der Stuyft, 2006; Mullan, 2008). According to some reports, circumstances in Cuba place considerable pressure on these doctors to provide this help (de Albornoz, 2006). For example, for many, serving abroad is currently the only legal way to live outside Cuba.

Are these policy responses to the brain drain legitimate, despite their seeming coerciveness? Presumably, responses to the brain drain can be wrong for being too coercive. Imagine a 'super coercive policy' in which

posts in rural clinics are filled by forcibly allocating doctors to specific understaffed clinics for good. Such a policy would constitute a form of enslavement. It would clearly violate the freedoms of movement and occupation of these doctors. It would expose them to exploitation and arbitrary power in their new 'workplaces'. It would defeat virtually any personal project that these doctors will have formed earlier in life.

This may still appear justified to some, since the stakes for these doctors' patients are often even higher – life itself can hang in the balance. However, higher stakes for others do not always legitimise extreme coercion. First, one lesson from Judith Thomson's violinist example (Thomson, 1971) is that highly onerous coercion against one person is not always amply excused by the greater stakes for others from coercing him/her. In Thomson's example, the protagonist wakes up to discover that someone connected a violinist to her body: if the protagonist ever leaves her bed, the violinist will die. As Thomson points out, intuitively, the protagonist is allowed to leave her bed, and should be allowed to do so. The fact that life itself is at stake for the violinist does not legitimise coercing another person to stay in bed for good. Is it then legitimate to coerce doctors to spend their professional lives in a certain rural clinic, just to save other people's lives?

Additionally, being turned into slaves would surely alienate doctors. Workforce morale, already low enough to thwart effective medical delivery in many instances (Dovlo, 2005), would take a further plunge – a highly counterproductive development.

And yet, in other areas, some policies that at least initially seem coercive are legitimate: forcing doctors who harbour stigmas against Human Immunodeficiency Virus (HIV) patients to treat them, mounting pressure on families to take their children to undergo Measles-Mumps-Rubella vaccination, locking up a convicted criminal after due process, and redistributive taxation. The fact that a policy seems coercive is far from being a conclusive reason against it. Some such policies are legitimate, either because they are not really coercive, or because the coercion they involve is not problematic, or because overriding factors make these policies legitimate on balance.

Locally specialised medical training

Consider one policy response, locally specialised medical training, which we proposed elsewhere for resource-poor countries in which medical emigration exacerbates critical or severe doctor shortages (Eyal and Hurst, 2008).

Locally specialised medical training in these countries would openly prepare graduates primarily for work in the local rural and public sectors. Training would focus on the realities of work there: locally endemic diseases, strategies applicable in conditions of scarcity, and the extensive use of low-tech primary care, epidemiology, decision analysis, and teaching and management skills. Much less attention would be given to highly technological diagnostic and treatment tools, specifically Western standards of care, and the 'diseases of the rich'. Students from underserved rural areas and ones expressing desire to work there would receive preferential admittance. The training template would be based on underserved communities and the bulk of practical training would take place in rural areas.

To illustrate, a typical locally specialised medical school in SSA would teach knowledge necessary in circumstances like erratic drug supplies or having patients share beds. It would hone skills that Western doctors rarely require, ranging from truly advanced stethoscope diagnosis to the coordination of hospitals staffed with nurses or paraprofessionals. Programmes in Cuba, The Gambia, and Venezuela, as well as in several African medical schools, already train doctors with a community-based, preventive, low-tech emphasis and other components of what we call local specialisation.

Elsewhere we defend local specialisation and encourage governments to condition the bulk of school subsidies on such orientation. We argue that, coupled with improvements in doctors' work conditions, local specialisation is likely not only to improve the quality of care in the rural and public service but also to increase hiring and retention there, in multiple ways (Eyal and Hurst, 2008).

However, colleagues worry that local specialisation would do so through excessively coercive means. In particular, our paper expressed hope that local specialisation would make graduates' skills more relevant for work in under-resourced areas, but less relevant for work in the private sector and in the West; and that less exportable skills would close many graduates' options to work in resource-rich contexts and to obtain Western licensure – 'pushing' them to work in under-resourced areas.[2] This raised concerns about possible coercion and compromise of the freedoms of education, occupation, and movement (as well as about poor quality care, unfairness to students, and other concerns addressed in our original piece). For in the proposed system, medical graduates choose rural practice partly because, in virtue of the educational reform, they are unqualified for most high-paying jobs in cities or abroad, and they receive fewer job offers there. Their options are curtailed.

Additionally, prospective medical school applicants receive the following conditional offer: either (a) study in a subsidised medical school and specialise locally, with low earning prospects, or (b) study or practise something other than medicine, or (c) study medicine under financial hardships in an unsubsidised, 'westernised' school. Many, it might be thought, will have no real choice except locally specialised medical training, the only affordable medical education (option (a)). Someone who chooses between a bad option and even worse options may be said in ordinary English to be forced or compelled to choose the merely bad option (Cohen, 1979). Moreover, insofar as the shift to local specialisation aims to diminish the brain drain, these constraints on applicants' and graduates' options are specifically intended, not flukes of nature.

In short, this mechanism to diminish brain drain seems to intentionally curtail prospective applicants' future options with the express aim of manipulating their later choices of where and how to spend their adult lives, forcing a choice of low earning prospects. All that may seem highly coercive and hence illegitimate. But is it?

Coercion and legitimising factors

According to Frederic Von Hayek, 'By "coercion" we mean such control of the environment or circumstances of a person by an other that, in order to avoid greater evil, he is forced to act not according to a coherent plan of his own but to serve the ends of an other' (Hayek, 1982: 20ff.). For Hayek, interventions are coercive only when they are *intended* thereby to delimit someone else's options.[3] Robert Nozick's definition of coercion requires, specifically, a threat (Nozick, 1969). Alan Wertheimer's also requires a threat, but it explicitly incorporates a moralised baseline: the coercer must threaten to make his/her victim worse off than that victim *ought* to be (Wertheimer, 1987).

Coercion is usually considered ethically problematic. In political philosophy, most forms of the contract theory rest on a presumption against coercion. In bioethics, informed consent is valued as a bulwark against coercion. Lockeans, Kantians, and Millians agree that coercion tends to be problematic and wrong.

We do not contest these anti-coercion positions here.[4] However, when an action (or a policy) seems to involve impermissible coercion, some factors may still make that action justified all things considered – as policies like seat belt laws and just punishment demonstrate. The action may remain (a) non-coercive, (b) non-problematically coercive, or (c) justified only on balance. Call factors that tend significantly to make actions

(a), (b), and/or (c) *potentially legitimising factors*. Philosophers disagree about the legitimising power of particular factors, but there is some agreement and overlap. We believe that there is enough agreement to make the combination of many potentially legitimising factors, even in a seemingly coercive action, strong evidence that the action is legitimate.

The following potentially legitimising factors are not mutually exclusive. Neither is their listing exhaustive.

Factors that may make actions non-coercive

Pre-approved 'coercion'

To enforce compliance with an explicitly binding contract that a person had entered freely, rationally, and without compulsion is only rarely problematic. It may even not constitute coercion. Suppose that, unforced, I sign a contract to hand you my car and that I do so in sound mind and for good reasons: you pay me handsomely. 'Coercively' holding me to that agreement seems perfectly reasonable, and some would deem it non-coercive. Not all such agreements are legitimately enforceable, but most are.

In the future, if India's undergraduate medical degrees involve rural service, students will choose medical school knowing this. On some conceptions, these students could not be said to be (problematically) coerced to perform rural service. One year of rural service followed by a medical career is arguably not a deal so bad or undignifying that students' own pre-approval could not justify it.[5]

'Coercion' without a violation of prior claims

According to Wertheimer, coercion requires a threat to make the victim worse off than she *ought* to be. Therefore, on his view, some of the policies we outlined as seemingly coercive are not coercive. If we do not all have claims to work in the UK, then the British decision to ban hiring non-EU doctors cannot be coercive. Likewise, studying towards a medical degree for years does not create moral entitlement to a medical degree; so conditioning that degree on passing final exams or on prior rural service does not obviously constitute coercion.

Even if we reject Wertheimer's assumption that coercion requires the violation of an independent claim, we can agree that the absence of prior claims makes (seeming) coercion less problematic.

'Coercion' with acceptable alternatives

For Wertheimer and for others, if someone has acceptable alternatives other than to succumb to a threat, then the threat does not coerce him/her to succumb.

Many Indian undergraduate medical students have acceptable alternatives to studying medicine, for example, they can study biology or engineering, which can also lead to comfortable lives. Thus, so long as mandatory rural medical service is announced before prospective students are invested in studying medicine, they initially have objectively acceptable alternatives. Subjectively, such alternative studies may satisfy most medical students who resist rural service: students for whom medical careers are often more about comfort and intellectual challenge than about helping the neediest patients. On some accounts, the existence of these alternatives therefore prevents the enforcement of rural service from constituting (problematic) coercion.

'Coercion' without intention to manipulate choice

According to Hayek, Nozick, and Wertheimer, there is no coercion when a person must decide in a certain way, but without anyone having intentionally manipulated that person's decision. Other philosophers point out that when we can decide only between the bad and the worse, there is a sense in which we are 'compelled' to pick the merely bad, even when no agent intentionally manipulates our options (Williams, 1973; Cohen, 1979). However, outright coercion is for most philosophers far worse than such 'compulsion' (Fried, 1983).

As an illustration, Cuban doctors work in short-staffed clinics in the remote corners of the developing world, sometimes because this is their only way to live outside Cuba. Since pressures on all Cuban citizens to stay in Cuba are clearly *not* intended to manipulate Cuban doctors to staff those clinics, then arguably, like other Cuban citizens, Cuban doctors are not coerced to serve in those clinics (although some compulsion may be involved, and although all Cuban citizens are coerced *to stay in Cuba unless they are doctors who move to those clinics*).

Factors that may make actions non-problematically coercive

Coercion without humiliation

One problematic aspect of coercion is that it is often humiliating. For example, consensual sex is seldom humiliating, but coercive 'sex' typically is, and that is part of what makes it wrong. Avishai Margalit says that when a landslide forces a Palestinian passenger to take a detour, this is not humiliating, but that when an Israeli soldier does so, that is humiliating.

Nevertheless not every instance of coercion is humiliating, and non-humiliating coercion is probably less problematic. For example, being

coerced by a regular traffic officer to take a detour is not humiliating, and it does not wrong drivers; while libertarians sometimes claim that income tax is humiliating in treating us as mere means and by recalling enslavement, the rest of us do not feel that way about taxes, which is part of why taxation is legitimate. Similarly, mandatory placement for some young doctors, a proposal that seems to have sparked a sense of humiliation among students in one Indian state in 2007, exists without giving rise to protest in Malaysia, Singapore, Norway, Spain, and other countries (Norwegian Medical Association, 2005; Kalantri, 2007; González López-Valcárcel and Barber Pérez, 2008).[6]

Coercion without domination or exploitation

Part of what makes coercion problematic is its tendency to translate into domination (arbitrary power to coerce as one pleases) and exploitation (taking advantage of someone's unfairly disadvantaged position). For example, when someone is forced to work at a certain rural clinic to obtain his/her degree, his/her boss may have arbitrary power over her and take unfair advantage of that position.

However, these prospects can be averted. When, for example, trainee doctors on rural service can complain against bosses and move between different understaffed clinics, mandatory rural service hardly exposes them to domination or exploitation (Eyal and Bärnighausen, draft).

Coercion without inefficiency

The heavy hand of coercive government is often less informed and less mindful of specific needs than freewheeling agents would be. The threat of coercion can antagonise agents and damage performance. Adherence to coercive dictates can be impossible to monitor. Such dictates can drive individuals to take expensive routes just to avoid coercion.

Coercively banning non-European doctors from practising in the UK may seem to lead to extreme inefficiency. The British system offers less cost-effective care; currently, exhausted Polish doctors *commute* to the UK to fill in posts (Cappuccio and Lockley, 2008); and Indian doctors go back to serve exclusively the elites and medical tourists (Nelson and Taher, 2007).

However, coercion is sometimes efficient. When the truth is obvious and individualised choice cannot generate further information, coercion does not hinder information gain. When coercion can remain covert, its antagonising impact is nil. When enforcement is possible, and clearly there are no expensive ways to evade it, dictates can work. In the case of a ban on hiring non-European trained doctors to practise

in the UK, several factors make for likely overall efficiency. The adverse impact on the British system remains less momentous than the potential benefits for many impoverished non-European patients. The ban is enforced along with measures designed to increase the future number of British doctors. Certain legitimate arrangements could potentially channel return migrants to assist impoverished populations, not just elites and tourists (Eyal, draft).

Coercion to enforce duty

Intervention to prevent someone from assaulting or pilfering from another seems fully legitimate. Part of what makes such intervention legitimate is probably that it is our duty not to assault or pilfer.

Some debates on India's mandatory service plan and other seemingly coercive policies are based on whether doctors are independently under a positive duty to help impoverished local populations. Some hold that we should all assist the global poor, that Indian doctors have special professional obligations and special relational obligations to underserved compatriots, and that they should give back to a community that subsidised their medical training (Benatar, 2007; Dwyer, 2007; Kalantri, 2007). If it is doctors' moral obligation to help local underserved populations anyhow, then for some, mandatory rural service is typically legitimate.

Coercion against the willing

Whether or not I wish to do something, it is possible to coerce me to do it. But coercion tends to be far worse when I am actually loath to do it. If I am known to aspire to do something anyhow, coercing me to do it tends to wrong me significantly less.

According to some reports, the best Cuban medical school graduates who stay in the country are allocated to work in Cuba's poorest region, and are generally happy about caring for patients there (Field and Reed, 2006). If most Cuban medical graduates indeed entertain this sense of social commitment, coercive allocation to poor regions is morally far less problematic than it would have been if working there was seen as a calamity, or contravened personal integrity.

Coercion against the elites

Coercion specifically against social pariah is virtually never right. But when coercion is fairly minor, directing it only at people who enjoy robust social standing helps to legitimise it further. Thus, although coercively barring gay people from entering a straight club is generally wrong, coercively barring straights from entering a gay club is often legitimate. This ethical

difference stems partly from the typically worse impact of acts that appear humiliating on populations with volatile social standing (Eyal, 2003).

Since doctors usually enjoy robust social standing, this consideration may help legitimise some coercive measures to counter the brain drain. For example, Cuba treats its *doctors* somewhat coercively, not its low status health workers. This makes Cuba's somewhat coercive policies more justified.

Factors that may make actions justified on balance

Relatively minor coercion

Sometimes, coercion is not harmful, and it constrains choices only on matters that are insignificant, both objectively and from the coercee's viewpoint. Furthermore, it constrains those choices without impingement or impact on very personal spheres. *Minor coercion*, to give a name to this pervasive and under-explored category of conduct, is relatively easy to justify. Even extreme left libertarians, who claim that coercive violations of bodily integrity are never permissible, admit that minor violations, like pushing aside someone, seem perfectly permissible when they serve to prevent calamity (Vallentyne et al., 2005: 208).

Thus, the level of coercion that a policy to reduce the brain drain involves affects its justification. Coercing doctors to work in rural areas for one or two years post graduation may be legitimate even if coercing them to work there for 15 years is not. Issuing migrant doctors only temporary work visas (Kupfer et al., 2004) may be legitimate even if denying them entry visas is not.

Whether an instance of coercion is sufficiently minor depends among other things on what it allows us to accomplish. Pushing someone aside to help another avoid calamity seems permissible; doing so to bring dessert to the table seems impermissible. Even the staunchest opponents of coercion recognise that in certain conditions, the stakes are high enough to justify even extreme coercion, all things considered. A famous footnote by right-libertarian Robert Nozick says that the prevention of 'catastrophe' does justify extreme coercion (Nozick, 1986: n.30, 180–1).

Consequently, if the plight of medically underserved rural communities counts as an evil of the relevant scale, even highly coercive policies to reduce brain drain could be justified. These instances of coercion would count as sufficiently minor.

Suitably compensated coercion

Suppose that the only way for me to open wonderful option A to you is to close off option B, which you correctly consider far inferior to A.

Presumably, the net gain typically legitimises my closing off B. Surely, then, opening wonderful option A as *compensation* for coercively closing off far inferior B is also typically legitimate. It involves opening, and closing, the very same options. Admittedly, my aims in the two examples are different, but philosophers increasingly deny the relevance of intentions to the evaluation of action (Kamm, 2007: Chapter 4). This consideration suggests that suitable compensation (say, opening wonderful A) typically legitimates coercion (say, closing off B), at least on balance.

Consider therefore whether it is legitimate to condition doctors' employment in the private sector on their part-time service in understaffed public clinics (Eyal, draft). If doctors remain on private sector salary throughout, this coercive policy could be thoroughly legitimate. Guaranteed high private sector salaries combined with part-time meaningful work in public clinics would benefit most doctors more than the alternative – to help only rich patients for the same pay. This policy enables doctors to stay in their home countries and dedicate themselves part-time to the sort of patients that many became doctors hoping to help. For among citizens who choose to study medicine not other lucrative professions, personal aspirations usually extend beyond earning high salaries. While currently, fulfilling these aspirations involves a big salary cut that many doctors are loathe to take, this arrangement would pre-empt the salary cut. A small minority of doctors may not feel so, but we have already said that coercing only a few members of a social elite is often legitimate.

Is locally specialised training illegitimately coercive?

Interestingly, many of these legitimising factors apply to our own proposal to use locally specialised medical training against the brain drain. Consider:

Factors that may make actions non-coercive

Pre-approved 'coercion'

Applicants to a locally specialised school could be fully informed about their constrained career prospects prior to enrolment.

Coercion without violation of prior claims

Locally specialised medical training may seem in breach of independent claims to freedom of movement, occupational choice, and freedom of education, but it is not.

Violations of the human right to free movement include, for example, arbitrary imprisonment, and the super coercive policy. Locally relevant education is quite different. It neither holds a threat against doctors who wish to emigrate nor causally leads to blocking the option of migrating. Instead, it blocks an option closed to most other citizens: that of both migrating and earning salaries that others can only envy.

While the super coercive policy definitely violates a prior claim to freedom of occupation, local specialisation does not. It is clearly Westernised hospitals' right not to issue work offers to locally specialised doctors. Such doctors are unable to find jobs in those hospitals, but so are graduates of poetry schools, and *that* does not violate the freedom of occupation. There are no threats against hiring those doctors, employment quotas, or other transgressions of the freedom of occupation.

Neither does locally specialised training violate the freedom of education, at least as long as it remains legal to open a private school with a different orientation. Violation of that freedom would presuppose absurdly that African governments are under independent duty to subsidise just any particular course of study, including courses that do not promote development (like astronomy and Icelandic history) and ones (like westernised medicine) that actually set it back. As we elaborated elsewhere, plausible human rights cannot include such duties (Eyal and Hurst, 2008).

'Coercion' with acceptable alternatives

Most prospective applicants would have acceptable alternatives to applying to a locally focused school. In the future, many could probably take a private loan to train at a private school, against future Western or private sector doctors' salaries; the bulk of qualified medical school applicants would qualify to study other professions, including other 'exportable' professions.[7]

Factors that may make actions non-problematically coercive

Coercion without humiliation

In Margalit's example of the road blocked by a landslide not Israeli soldiers, the absence of threats largely rules out humiliation. Locally specialised medical training involves no threat either. It makes doctors' skills non-exportable and thus pre-empts work offers abroad; it does not threaten doctors against accepting work offers.

Now it may seem as though local specialisation blocks migration options in ways that remain humiliating even without involving threats. Imagine a sadistic Israeli soldier who detonates a device to trigger a

landslide that physically blocks the road, all in order for Palestinians to have to take a detour. Surely this is humiliating. One may insist that the pre-emption of work offers abroad is similarly humiliating.

This is unlikely. Farmers' skills are not marketable in the cities, and the skills of journalists writing in local languages, not marketable abroad. And yet it is not humiliating to be a farmer or a journalist. It is true that when local specialisation is adopted specifically in order to diminish the brain drain, then somewhere in the causal chain there is intention to make doctors' options limited and non-marketable. That intention is not present in the examples of farmers and journalists.

However, is this intention humiliating? The claim that it is can be either normative or psychological. It can mean that doctors are treated wrongly, and thus disrespectfully, or that many are likely to feel humiliated. But the normative claim is irrelevant: if we are right about the failure of other arguments against intentionally limiting doctors' marketability, then to intentionally do so is *not* wrong and disrespectful. The psychological claim is clearly false: the relevant intentional action could potentially lie so remotely in the causal chain as to rule out widespread sense of utter humiliation. It could for example be the intention on which one government official introduced school reform many years earlier: an odd and unusual ground for a destructive sense of humiliation and for injury to self-respect. Indeed, by giving graduates a goal of excellence achievable in the areas where they are most likely to work, and by contributing to the prestige of that area, locally specialised training may support their self-esteem (Eyal and Hurst, 2008).

Coercion without domination or exploitation

The super coercive policy disallows doctors to leave specific clinics, thereby potentially handing local superiors dominion over them, and inviting exploitation. Locally specialised education admittedly also limits doctors' options. They can find work mainly in underserved sectors; but that leaves ample freedom to escape bad situations and domineering local superiors.

'Coercion' to enforce duty

On many ethical theories, practitioners do have a moral duty to practise locally, and medical students, a moral duty to train in locally oriented medicine rather than in 'export medicine'. On utilitarianism, this duty is based on the life and death stakes for many potential patients; on prioritarianism and egalitarianism, also on the fact that these patients are

typically worse-off than doctors; theories of nationalism and reciprocity would emphasise that these patients are compatriots, and that students enjoyed direct and indirect subsidies. Admittedly, some theories ascribe us a moral prerogative not to sacrifice our utmost commitments on the altar of social goals. But very few commitments are strictly incompatible with several years of communal work (Fabre, 2006: Chapter 3) and it should take only several years to get alternative training, if one's utmost commitments slip away. The lives of sub-Saharan doctors in rural areas and public service jobs are usually good, objectively speaking (Makasa, 2005) not utter personal sacrifice.

Coercion against the willing

To be made to practise a form of medicine *un*willingly, a prospective student of a locally specialised school would have to combine (a) aversion to help the neediest patients, (b) insistence on practising medicine, not other comfortable, intellectually challenging professions, and (c) inability to procure a loan to study westernised medicine in a private school despite the high earning prospects in westernised medicine. Very few students would fulfil (a)–(c).[8] In addition, in selecting for initially interested students and then exposing them to the plight of rural patients *and* enhancing the professional prestige of rural practice, locally specialised training may tend to increase graduates' *willingness* to work in underserved areas (Eyal and Hurst, 2008). That makes any coercion that local specialisation may involve somewhat less problematic.[9]

Coercion against the elites

Doctors usually enjoy robust financial and social standing. Local specialisation constrains only doctors' options. That counts towards its legitimacy.

Factors that may make actions justified on balance

Relatively minor coercion

Medical brain drain dramatically affects many people with the same rights to basic health care that you and I possess. These people lack effective voice, but critical doctor shortages do prevent the delivery of antiretrovirals to them and translate into substantial maternal, child, and infant mortality; 'in some countries the skills drain is helping to turn a health crisis into a health catastrophe' (Hunt, 2005: paragraph 55).

Local specialisation involves no threats, humiliation, or exploitation, it leaves acceptable alternatives open to candidates and it affects the options of only a small number of rather well off citizens.

Unfolding catastrophes justify many otherwise illegitimate measures, including the use of relatively high levels of coercion. If local specialisation dramatically improves the ratios of doctors per population, then the (at most) relatively minor coercion that it involves seems fully justified on balance.[10]

Suitably compensated coercion

We already mentioned that only few students who study medicine, not other lucrative professions, are likely to feel truly oppressed by having a career trajectory that focuses on the neediest patients. For the majority, we now wish to add, local specialisation *enables* that important career trajectory. Nowadays, the option to stay in one's home region and dedicate oneself to rural or public sector patients is often foreclosed by unsuitable training that increases the likelihood of later frustration and severe 'burnout' (Eyal and Hurst, 2008). Locally specialised training could help to open up this option. For the majority of applicants who choose medicine over other comfortable professions, this option constitutes a significant compensation for the foreclosure of others.[11]

In sum, many potentially legitimising factors apply to locally specialised training. This probably fully protects locally specialised training from the charge of excessive coercion. For even if some potentially legitimising factors are not truly legitimising, or if we are in some cases wrong in thinking that these factors are present in local specialisation, enough other factors are probably both legitimising and present. While the presence of a single legitimising factor generally does not suffice for legitimacy on balance, the presence of many usually does: by tending significantly to make actions non-coercive, non-problematically coercive, or justified only on balance, each legitimising factor significantly increases the likelihood of legitimacy on balance. The accumulation of many potentially legitimising factors therefore usually suffices for legitimacy on balance. Importantly, this result is robust across reasonable ethical theories that disagree on the legitimising nature or the presence of some or all of these factors. So long as on each such reasonable theory, enough of these numerous factors are considered both legitimate and present in locally specialised medical training, all these theories can agree that such training is legitimate.

Two instructive comparisons

Finally, compare the seemingly coercive aspects of locally specialised medical education to the seemingly coercive aspects of two other policies,

which most of us consider fully legitimate: conditioning certification to practise medicine on medical residency and redistributive taxation.

Medical residency

Around the world, graduates of medical schools are required to work for several years as medical residents and offer relatively cheap care to the community as a precondition for certification. Residents are overworked, and attend not only to cases that boost their knowledge and skills. A major independent determinant of residents' schedules is social need for the labour they provide. Nevertheless despite some compromise of residents' freedom, this basic arrangement for residency programmes is widely accepted: even critics of the excessive and medically risky overworking of residents stop far short of suggesting that residents should work only to the degree that optimises their skills. Even they accept the all-things-considered legitimacy of using residents, to some degree, to fill socially needed posts (IOM, 2008).

Compare that basic arrangement as a way to fill medical posts around the world to locally specialised medical training as a way to fill medical posts in countries with critical doctor shortages. Local specialisation assists some of the world's least served communities, where needs are far greater than in many parts of the world where medical residency is accepted.

Where residency requirements apply, they are imposed through formal threat to deny certification; hardly a field or a sector of medicine is then left where doctors can practise without doing residency. Doctors cannot instead learn more medicine on their own or enrol in a private medical school. Residents are allocated to specific hospitals and relocation is complicated, increasing the potential for domination and exploitation. None of this applies to local specialisation.

The basic arrangement of medical residency may be justified on the ground that graduates of medical schools lack any special claim to practise medicine without having done residency; but graduates similarly lack any special claim to practise medicine in specifically resource-rich contexts. Medical residents do know about residency prior to their studies; but so would enrolees to medically specialised schools.

It may seem as though residency programmes are less coercive than local specialisation because they affect doctors only temporarily. By contrast, the non-exportable skills of locally specialised practitioners limit them for life. However, locally specialised doctors can, admittedly with difficulty, procure continuing education over several years to become proficient for work in resource-rich contexts.

The existing arrangements surrounding residency appear fully legitimate. Local specialisation serves even more urgent causes and is no more coercive. *A fortiori*, local specialisation is fully legitimate.

Redistributive taxation

Supporters of generous welfare policy ascribe the state a duty to tax the middle classes and the rich at high rates so that the poor can have a better life. They support not only some redistributive taxation to protect bare necessities but also generous redistribution protecting much more. This policy is quite plainly coercive. Citizens must pay taxes, on formal threat of fines and jail terms. Many are compelled to put in extra work if they wish to fund expensive personal projects (Nozick, 1986: 169ff.). It is true that taxpayers usually keep a living salary. But tax could still compel many to forego some cherished commitments. Whether or not this could happen in an ideal egalitarian society (Otsuka, 2005: introduction and Chapter 1), generous redistributive taxation is arguably legitimate in the actual world.

Now compare locally specialised medical training to welfare state-level taxation. Unlike prospective students in locally specialised medical schools, taxpayers face a formal threat of punishment. They lack acceptable alternatives (there is no 'To avoid tax, just study engineering' option). Locally specialised training serves even more urgent purposes than generous welfare state-level taxation does – often survival needs. On the plausible assumption that generous welfare state-level redistributive taxation is fully legitimate despite involving coercion or other compromises of freedom, locally specialised medical training is also legitimate. Such training involves lesser compulsion and it fulfils a more basic need.

It is true that local specialisation closes off many options to students; but taxation closes off many options to taxpayers. It is also true that, unlike local specialisation, taxation directly confiscates only a social good: income. But the bulk of valuable options that locally specialised education blocks are also options to social goods: to forms of higher education, work, and income. Finally, taxation is the work of the state or public agencies, but so is public education. Thus whatever makes taxation legitimate – negative duties to address past wrongs against the poor, positive egalitarian or prioritarian duties towards fellow citizens, or other coercion-justifying factors – would equally apply to (typically middle-class) doctors in the developing world whose fellow citizens require urgent assistance.[12]

Conclusion

The seemingly coercive aspect of locally specialised training does not rule it out. Local specialisation remains a legitimate policy response to the medical brain drain crisis.

The argument we presented is robust in *not* assuming any highly determinate theory on when seemingly coercive actions are justified. We merely presuppose that virtually any reasonable determinate theory would agree that many potentially legitimising factors, of which each individually nearly suffices to justify seemingly coercive actions, characterise local specialisation. This, we argued, most probably makes local specialisation highly justified on balance.

Personally, we endorse only some of the factors that we called potentially legitimising. However, the combination of so many of them clearly exonerates local specialisation from the charge of being too coercive, both on our determinate view and presumably on most of yours. Moral uncertainty regarding which determinate view is right hardly threatens this robust result.[13] We also offered an argument from the likeness of local specialisation to two policies that seem perfectly legitimate although they are more coercive, and serve less urgent needs.

Thus the ethically problematic nature of coercion does not rule out locally specialised training in response to medical brain drain. Since such training is otherwise legitimate (as we argued elsewhere), it is legitimate overall. More generally, leaders and policy designers should not rule out seemingly coercive responses to medical brain drain. While the super coercive policy is unjustified, other seemingly coercive policies are fully justified. They could complement existing policies in the fight to provide access to basic care for all persons.

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Notes

1. As this book was being written the WHO process to approve the draft ethical code for the international recruitment of health personnel was still underway. At the time of publication the code had just been adopted by the 63rd World Health Assembly in May 2010.
2. We added that local specialisation would increase rural retention in other ways. It would align rural and public sector practice with graduates' expectations, diminishing the frustration that is reported to drive emigration. It would somewhat increase the prestige of rural practice. Locally focused schools would generate career development options in underserved sectors. Finally, student recruitment and training primarily in rural areas, and recruitment of students who wish to work there, are known to increase graduates' rural retention.
3. Cf. 'while we can legitimately say that we have been compelled by circumstances to do this or that, we presuppose a human agent if we say that we have been coerced. … Coercion implies both the threat of inflicting harm and the intention thereby to bring about certain conduct' (Hayek, 1960: 133).
4. But see Eyal, 2008.
5. See also Nir Eyal and Till Bärnighausen (draft), 'Conditioning Medical Scholarships on Long, Future Service: A Defense'.
6. We thank Miquel Angel Capo Navarro, Kjell Arne Johansson, Francisco Leon, Antonia Martín-Perdiz, and Ingrid Miljeteig for helpful conversations and correspondence on this.
7. Additionally, it will take a while before the proposed reform towards local specialisation overtakes entire regions of the developing world. Before that time, the result of a school's moving to locally specialised training would only be greater diversity and *added* alternatives for all prospective applicants.
8. That choosing another comfortable profession over medicine would be unacceptable to a prospective applicant only on subjective grounds – because he/she is subjectively wed to the idea of being a doctor (for the rich), not because non-medical careers are objectively worse – may also be thought to legitimise exclusive subsidies to local specialisation. Such exclusive subsidies would force him/her to internalise the cost of his/her own preferences (Dworkin, 2000: Chapters 2, 7).
9. Admittedly, some graduates would still wish not to work in underserved areas. However, since coercion against such students would be relatively minor (as we argue later), their small number may legitimise locally specialised medical education. Minor coercion affecting only a few people is

less grave than similar coercion affecting many. While some philosophers would argue that extreme coercion remains unacceptable even against a few, numbers clearly do make a large difference when relatively minor coercion is involved.

10. An opponent may respond that an individual doctor has little impact, and thus coercion against an individual doctor does not really prevent catastrophe. However, compare this case to the following one. It seems acceptable to mandate the Measles-Mumps-Rubella vaccine, as several US states do. But there is no specific individual on whom forcing vaccination is necessary in order to prevent a catastrophic future epidemic. The legitimacy of this coercive policy in each individual case stems from the necessity of the general policy. Local specialisation, which involves no violation of bodily integrity, and aims to stop an unfolding catastrophe, not a future one, is likewise justified in individual cases because of its general necessity.
11. Locally specialised education opens the option of serving poor local patients in an additional way. It may potentially free students from existing family pressures to migrate. One reported driver of medical migration is 'pressure from the family requiring the graduate to take care of him or herself' (Masembe, 2008). Aware that students trained largely in rural areas, families may realise that their children are underqualified to work elsewhere, and decrease their pressures on them to migrate.
12. Cf. Fabre, 2006.
13. One of us currently (Nir Eyal) develops this approach to moral uncertainty more formally, in collaboration with Gustaf Arrhenius.

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10

Maternal Survival and the Crisis in Human Resources for Health in Africa: Impact of the Brain Drain

Staffan Bergström

> *Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.*
>
> (Prof. Mahmoud Fathalla, 1997)

Introduction

This chapter focuses on what might be the ultimate challenge in human resources for health: currently there are more pregnancy-associated deaths than all deaths from AIDS, malaria and tuberculosis combined. Every year more than half a million women and girls die during pregnancy or childbirth (WHO, 2007). Of all health indicators, maternal mortality shows the starkest disparity between rich and poor countries; 99 per cent of maternal mortality occurs in low- and middle-income countries (WHO, 2007). The staggering number of maternal deaths still represents a small minority of deaths due to pregnancy complications; approximately seven per cent. We tend to forget the 'passenger deaths' of babies when we focus on the 'carrier deaths' of mothers. There are, annually, around four million stillborn babies in the world and three million early neonatal deaths (deaths very soon after birth), amounting to seven million deaths (Stanton et al., 2006; Lawn et al., 2006). In comparison, AIDS causes around 2.1 million deaths, tuberculosis around 1.6 million and malaria around 1.3 million, or, combined, around five million deaths per year.

Many, if not most, of these maternal and neonatal deaths could be avoided with improved access to ante- and post-natal health care for the global poor. To cater to these potentially avoidable deaths there is

shrinking workforce. Globally, there is a deficit of approximately four million health workers to achieve the Millennium Development Goals (MDGs). Among them the deficit of midwives amounts to 300,000–400,000. This deficit is the consequence of ongoing extensive brain drain and insufficient training capacity of all low-income countries to substitute the loss. The better-off world is the winner in this game and the most deprived category in the poor countries is the loser; the women, or, 'the underclass of the poor'. An OAU statement (Connel, 2007: 19), concluded in 2003 that

> [l]ow-income countries now sponsor high-income countries by approx. US$ 500 million/year in the exodus of trained health workers.

This chapter reviews the history of ambitious global targets for the reduction of maternal mortality and analyses the reasons why they remain unmet. In particular it highlights the moral, financial and organisational 'price tags' which inhibit progress on maternal mortality. This chapter proposes a solution applicable from within my own, frontline, profession of obstetrics and gynaecology which may help to overcome these price tags; namely embracing an 'ectoscopic' (outward-looking, community-based, low-tech) approach rather than an 'endoscopic' (inward-looking, high-tech, elitist) approach. The limited examples of success stories in the field of maternal mortality support obstetric ectoscopy as a promising solution.

Failures of global commitments on maternal mortality

Of the 20 countries in the world with the highest maternal mortality, 19 were found to be situated in Africa (WHO, 2005: 11). All over the continent there have been frustrated policies to achieve tangible reductions of these levels. There is of course nothing wrong in expressing even far-reaching intentions and commitments and short or medium term goals to be achieved over a defined period of time. There is, however, in retrospect a clear historical trend over the last 40 years for big international conferences to have formulated such far-reaching goals that obviously have no credibility bases. Expressions of wishful thinking could be considered fairly innocent, had they not expressed utter ignorance of the harsh reality and the magnitude of the problem that constitute the real background for the commitment in question. This ignorance is widespread and extends well beyond maternal health goals, also encompassing children. In Rome in 1975,

one of the statements at the Food and Agricultural Organization's conference was:

> No child will go to bed hungry by the year 2000.

In the laudable primary health-care initiative the well-known slogan from Alma Ata in 1978 was:

> Health for all by the year 2000.

The Safe Motherhood Initiative in 1987 in Nairobi for the first time launched another mantra, which was echoed at a much higher level three years later with more than 120 heads of state, presidents and prime ministers present at the World Summit for Children in New York in 1990, reiterating the commitment that

> [m]aternal mortality will be reduced by 50% by the year 2000.

The following year, in 1991, the World Bank president, Lewis Preston, publicly declared that

> [t]ogether, we can halve maternal mortality by the end of the decade. We can help women have more voice and choice in their lives.

At the time (1991) the World Bank had not yet decided to start lending to health care. The change came with the important annual report *Investing in Health* (World Bank, 1993). Preston's statement came to represent yet another rhetorical example of wishful thinking on maternal survival.

In Africa itself, the same mantra was again expressed four years later at the famous International Conference on Population and Development in Cairo in 1994:

> Maternal mortality will be reduced by 50% by the year 2000.

Next, at the Fourth World Conference on Women in Beijing in 1995, the commitment was echoed:

> Maternal mortality will be reduced by 50% by the year 2000.

And again at the World Summit for Social Development in Copenhagen in 1995 the commitment was that

> [m]aternal mortality will be reduced by 50% by the year 2000.

Even before we reached the magic year of 2000 several of the above-mentioned conferences had actually expanded the goal to include the reduction of maternal mortality ratios by three fourths of the 1990 levels by the year 2015. The turn of the century has passed and we can now see what has happened to these proud commitments: there have been no signs of any measurable reduction in maternal mortality. And yet we now have the well-known fifth MDG, which stipulates a reduction in maternal mortality, by the year 2015, to 25 per cent of the level of 1990.

Even before Cairo 1994 it was quite obvious that all commitments so far had been wishful thinking. There are a number of underlying environmental factors, which have hindered the achievement of these targets. First, there is formidable under-registration of maternal deaths. National statistical figures, most often of poor quality, have consistently been corrected upwards several times by maternal mortality research. The most blatant example is maybe the study in the Sofala province of Mozambique by Songane and Bergström (2002), where careful field research demonstrated that official maternal mortality figures should be multiplied up to *nine times* to come to the figure demonstrated on the ground. It should also be indicated that the baseline year from which progress on MDG 5 was to be measured (1990) had fairly questionable estimates of maternal mortality, by which it will be very difficult to assess whether or not the MDG 5 has actually been attained in 2015.

Second, in the poorest nations demographic momentum suggests that for many years to come the number of pregnant women will increase due to the influx of young girls into reproductive age. This will be associated with significantly more pregnancies and more maternal deaths, even if total fertility rates are diminishing and strategies are successful in making pregnancy safer. It is noteworthy that the World Health Report 2005 has estimated that 'Worldwide, the number of live births will peak at 137 million per year towards 2015: 3.5 million more than at present. Most of the increase will be in sub-Saharan Africa and in parts of Asia, where the number of births will continue to grow well into the 2020s even if fertility continues to drop' (WHO, 2005: 7).

Third, AIDS has, since the 1980s, entered the field of maternal mortality through a number of maternal morbidities such as cerebral malaria, severe tuberculosis, postpartum and post-caesarean septicaemia and

will, by all probability, be most important in the additional maternal deaths to be seen in the near future.

On top of these three factors it is important to note that a cause of maternal death is routinely reported for only 100 countries in the world, *which corresponds to about one third of the world's population*. In as many as 62 low-income countries, most of those with the highest assumed levels of maternal mortality, the only existing estimates of the causes of maternal mortality are based on statistical modelling with very large uncertainty ranges (WHO, 2005: 62).

While these background factors have undoubtedly contributed major challenges, they only tell part of the story for the failure to significantly reduce maternal mortality. The following section considers a set of 'price tags' or unaddressed barriers to reducing maternal mortality.

The price tags of maternal survival in Africa

The reasons for the conspicuous failures in achieving enhanced maternal survival in Africa would seem to be related to the neglected 'price tags' associated with achieving the laudable goals. Overcoming obstacles implies a cost and all these obstacle-related costs (the 'price tags') represent African challenges, hitherto most often neglected, non-observed or not acted upon. At least three such different price tags can be identified here; the moral or legal, the financial and the organisational price tags. Each present challenges that we must confront in order to enhance maternal survival.

The moral/legal price tag

The moral and legal issues surrounding sex, reproduction, control of women's bodies and control of populations have served to stymie progress in the field of maternal mortality. In most African settings unmarried adolescents are not expected to have sex but we know that a majority of adolescent women in many African countries have been or are pregnant by the age of 19. The moral 'blinding' to this fact has retarded a humane and appropriate approach to the problem of adolescent pregnancies, which are presumably unwanted in many if not most cases. In addition, the sensitive issue of abortion-related maternal mortality is not addressed or not taken seriously due to the criminal character of such maternal deaths in many countries. The concept of 'safe legal abortion' is increasingly an important, potential but partial solution to this problem.

The delay in recognition of maternal survival as a most important priority for obstetricians/gynaecologists can be partly explained by the focus among very influential donors on 'population control' instead of on 'maternal survival' during the period from 1970 to 1990. Gynaecologists from high-income countries were recruited to serve as forerunners in campaigns to achieve population control in the 1970s and early 1980s. Maternal health was not considered a priority and, in retrospect, we can only deplore the fact that interest in maternal survival has come so late. Interest in child survival historically preceded and took precedence over interest in maternal survival. Women were considered to be problematic, pregnancies were to be 'averted' and attempts to reduce maternal mortality were almost considered suspect in some circles. An interesting expression of this attitude among obstetricians arose in a meeting with all Scandinavian professors in obstetrics and gynaecology in the late 1980s. One of the most prominent representatives of this group of specialists, a Swedish professor of obstetrics and gynaecology, questioned at this meeting whether it was reasonable and prudent to combat maternal mortality given that more surviving women of reproductive age would, automatically, worsen the population problem in the world(!). Perhaps just as shockingly, there was no protest expressed against this outrageous and ethically unacceptable statement. Still, these kinds of attitudes and arguments are important to remember when we look at the roots of the resistance to considering maternal mortality a priority: blaming the mothers for the 'population problem'.

The financial price tag

The overriding financial problem of achieving maternal survival has not been taken seriously. Of the three price tags identified here the financial tag appears to be the most challenging but it is also the one which can be alleviated with assistance from donors. Except for the direct cost for material and human resources (see later on in the chapter) there are other dramatic costs involved. The clearest example is the AIDS-related, indirect maternal deaths, which are on the increase in many countries in Southern Africa.

For an individual poor family paying out of their own pocket to get basic maternal care, such care may be impossible to access. Maternal and newborn care is an area where commercialisation of health care delivery – overt or covert – finds a readily exploitable public. Payments for a spontaneous vaginal delivery may amount to at least two per cent of annual household cash expenditure in countries like Benin and Ghana (WHO, 2005: 93). In case of complications, costs may reach

more than 30 per cent of annual household cash expenditure (Borghi et al., 2003). But direct payments are only one aspect of the whole problem. When the commercialisation of maternal health care becomes widespread, the availability of life-saving skills for the poorest families deteriorates.

In many African countries mothers are excluded from access to health care as no form of financial protection is available. Current estimates show that out-of-pocket household expenditure in these poorest countries is between two and three times the total expenditure by governments and donors, and a substantial proportion of these out-of-pocket expenses are being captured by commercial providers or through the payment of informal fees (WHO, 2005: 138). In some cases the introduction of user fees has been accompanied by an improvement in the quality of services, the elimination of informal fees and a transparent fee structure; the revenue has permitted the revitalisation of moribund services. Even in these cases, however, the drawbacks overshadow the benefits and in most countries, for example Kenya and Tanzania, the introduction of user fees has resulted in increased exclusion, including a diminished uptake of maternal, newborn and child health services by the poorest population groups. In many African countries efforts to mitigate the exclusion that goes with the introduction of user fees have been disappointing. The main beneficiaries of exemption schemes are frequently capable of paying – including staff of health facilities and their relatives (Briasco et al., 2004). Loan schemes to assist with a cost associated with childbirth have been piloted in some countries (Fofana et al., 1997).

There is evidence that the introduction of user fees in African countries institutionalises the exclusion of the poor and does not accelerate progress towards universal access and financial coverage. Nevertheless abolishing user fees, where they already exist, is no solution. It needs to be accompanied, from the very day they are brought to an end, by structural changes and a refinancing of health services. The South African government, for example, has eliminated user fees for maternal and child health care in a targeted approach to reduce health inequalities (WHO, 2005: 139).

It is an important criterion for setting priorities by public funding that cost-effective intervention packages exist (Jowett, 2000; WHO, 2002: 178). Still, there is little doubt that cost-effectiveness is just one of the criteria for public funding. Other such criteria include the generation of positive externalities among which an important one is to avoid catastrophic expenditures (Musgrove, 1999). Catastrophic payments for health care,

which may push an estimated 100 million people into poverty every year, occur wherever health services require out-of-pocket payments, where there are no mechanisms for financial risk-pooling and where households have a limited capacity to pay (Xu et al., 2005). There is little documentation on such catastrophic payment from African countries but the situation is certainly worse than in Brazil and Colombia, where as many as ten and six per cent of households, respectively, face catastrophic payments (Xu et al., 2003). Catastrophic expenditures are particularly relevant when we talk about reproductive ill health and unsafe motherhood in the poorest countries of Africa. Major obstetric problems are largely unpredictable and can lead to disastrous expenditures that may push households into poverty (Borghi et al., 2003).

The organisational price tag

This is a health system's 'price tag', which is particularly apparent when it comes to human resources for enhanced maternal survival. But other aspects of the health system are also relevant here: for instance how antenatal care is organised, how much is controlled, how much is missed or never asked for and how often visits are recommended.

In Africa, Egypt is probably the only country that has documented a fall in maternal mortality (Thonneau, 2001). At a sub-national level the Kigoma experience (Tanzania) is now well known; Dr Godfrey Mbaruku embarked in 1987 on an analysis to follow and to audit maternal deaths in Kigoma, western Tanzania. By focusing on avoidable contributing factors and acting to minimise them, he demonstrated an 80 per cent reduction of maternal mortality over seven years (Mbaruku and Bergström, 1995). Apart from these examples evidence regarding success stories in Africa is scarce. Outside Africa, Sri Lanka and Malaysia are outstanding examples of very significant maternal mortality reduction (Padmanathan et al., 2001). It is remarkable that there is one common denominator if we consider these 'success stories': human resources. It is increasingly recognised that the issue of human resources was insufficiently contemplated when the MDGs were formulated. In an overview article in the *Lancet* focused on human resources for health, it was noted that current spending patterns on such resources are inefficient and fragmented. The authors emphasise the legacy of chronic underinvestment in human resources and state that

> two decades of economic and sectoral reform capped expenditures, froze recruitment and salaries and restricted public budgets, depleting working environments of basic supplies, drugs and facilities.

> These forces have hit economically struggling and politically fragile countries the hardest.
>
> (Chen et al., 2004: 1984)

In the same article the authors also, with special reference to Africa, suggest the monitoring of 'health worker density' and use it to demonstrate the correlation between this indicator and survival rates. They calculate that 'Sub-Saharan Africa has a tenth of the nurses and doctors for its population that Europe has and Ethiopia has a fiftieth of the professionals for its population that Italy does' (Chen et al., 2004: 1985). Furthermore, low-density areas have a much higher burden of disease than high-density areas. This has particularly negative repercussions for maternal survival in Africa. WHO has calculated that Africa has approximately 25 per cent of the burden of the world's diseases but only 1.3 per cent of the world's health workforce (Chen et al., 2004: 1985). On a global scale it has been estimated that the global shortage of health workers is more than four million and that 'sub-Saharan countries must nearly triple their current number of workers by adding the equivalent of one million workers through retention, recruitment and training if they are to come close to approaching the Millennium Development Goals for health' (Chen et al., 2004: 1985). This applies particularly to MDG 5 and the target of a drastic reduction in maternal mortality by 2015.

Clearly the organisational and financial price tags interact considerably. The same structural adjustment policies that led to the introduction of user fees also forced governments to freeze salaries for public health-care staff and there has been a virtual exodus of such staff from the public sector to the private sector. This has led to staggering shortages and imbalances in the distribution of health workers. With insufficient production, downsizing of recruitment under structural adjustment and fiscal stabilisation policies, and with frozen salaries and losses to the private sector, migration and HIV/AIDS, filling the supply gap will remain a major challenge for many years to come (Lowell and Findlay, 2001; USAID, 2003; Zurn et al., 2004; Tawfik and Kinotti, 2001; JLI, 2004).

An associated problem is that of absenteeism. It has been calculated that absenteeism of health district doctors in Burkina Faso amounts to between 30 and 80 per cent (Bodart et al., 2001). Vacancy rates for doctors in Ghana in 1998–2002 approached 50 per cent with a similar percentage registered for nurses (Dovlo, 2003). It is obvious that much of absenteeism is related to insufficient salaries and adverse working conditions with declining staff morale. In many developing countries

the real wages for much of the health workforce declined in the 1990s. Estimates indicate that they have dropped more than 20 per cent in Togo and 30–40 per cent in Burkina Faso, Guinea Bissau and Niger. In addition, however, absenteeism is often motivated by the cultural duty to be present at funerals, many of which are due to AIDS-related deaths. HIV/AIDS may cost Africa's health systems 20–25 per cent of their employees over the next few years (Tawfik and Kinotti, 2001).

In Africa, one of the most dramatic examples of the depletion of human resources for health, however, is the emigration of nurses and midwives from the continent. WHO has calculated that there will continue to be a deficit of physicians, nurses and midwives between 2000 and 2015 (Chen et al., 2004: 1986). Furthermore, the simultaneous increase in population means that *the number of health workers per capita is decreasing* even more markedly.

Malawi is one of the countries most severely affected by 'brain drain'. Broadhead and Muula (2002) claim that there are more Malawian doctors in Manchester (UK) than in the whole of Malawi. Even if this statement is not based on formal statistical assessments, it is evocative of the extent of the human resource crisis in poverty-stricken countries in Africa.

As was the case in the era of maternal health 'mantras' there have been many big conferences and meetings in which initiatives have been unveiled for how to overcome the crisis in human resources for health in Africa. All these commitments, suggestions and proposals are much needed but have not proven capable of remedying the acute shortages of doctors, nurses and midwives in the least privileged countries, especially in rural areas. This situation has led some governments to think radically about how they might provide short-term solutions.

Depletion of human resources and maternal survival: The bias against community obstetrics

This section now proposes a conceptual lens for providing some redress to the extensive price tags associated with reducing maternal mortality. It focuses on a human resources issue from within the frontline profession of obstetrics and gynaecology.

The hospital orientation of the vast majority of obstetricians in high-income countries has certainly contributed to the low status of community-oriented obstetrics and public health aspects of maternal survival in low-income countries. I have tried to address this problem by shaping a new concept – *obstetric ectoscopy* (Bergström, 2005b). We

can define 'endoscopy' as the act of 'looking into' (inside hospital gates) and we may therefore, consequently, define 'ectoscopy' as the act of 'looking out of' (outside hospital gates). Table 10.1 tentatively compares the two entities in the following way.

Even if both endoscopy and 'high-tech' are good and needed, there is in undergraduate training as well as in postgraduate training to become specialists in obstetrics and gynaecology a disproportionate interest in the clinical discipline and a disproportionate lack of interest in community obstetrics. All of us obstetric specialists will easily access catalogues with the most sophisticated endoscopes for sale but I cannot buy my 'obstetric ectoscope' on the market. The sad thing is that an 'ectoscope' does not exist even if there are 'obstetric ectoscopists'. We can say that ectoscopy stands for an attitude, a priority wanting to address unmet obstetric needs in a world rhetorically devoted to 'Safe Motherhood', 'Reproductive Health for All' and so on, even though these slogans have long since lost their substantive meaning.

The current generation of obstetricians in most countries of the world certainly has much more experience of endoscopy than of ectoscopy. The market for endoscopists is obvious while that for ectoscopists is meagre or even non-existent. Only a very small proportion of the world's obstetricians bother about reduction in maternal mortality ratios in the world, because maternal death is next to forgotten in high-income countries even though it is a daily threat in the remaining part of the world, particularly in rural areas. Many specialists in high-income countries have not seen even one mother die during their career.

Obstetric ectoscopy implies a plea to the profession to look outside the hospital gates and discover all the unmet needs in the less fortunate strata of the world, particularly for pregnant women in Africa. That is where a pair of gloves is a luxurious commodity and mothers may be

Table 10.1 Comparison of obstetric endoscopy and ectoscopy

Endoscopy	**Ectoscopy**
Artificial light	Daylight
High-tech	Low-tech
Inside hospitals	Outside hospitals
Often commercialised	Non-commercialised
High cost	Low cost
Available to few	Available to many
Negligible impact on maternal mortality	High impact on maternal mortality
Highly 'prestigious'	Little 'prestige'
Attractive to many doctors	Attractive to few doctors

denied delivery in health units because they cannot afford to buy a pair, which may be the entrance ticket to the labour ward, where the shelves are empty. That is also where syringes, needles, sutures and infusion sets must be purchased by poor relatives in a nearby pharmacy to enable the doctor to perform a life-saving caesarean section. In that same world, severely anaemic women may die from circulatory failure after a blood loss of less than 500 ml after delivery, and cerebral malaria continues to be one of the major killers of mothers during pregnancy, childbirth and puerperium.

The obstetric profession worldwide, but particularly in Africa, has a special responsibility: as long as we remain silent, hospital-oriented and inward-looking and do not provide alarming facts to politicians and decision makers, the slogans of halving of maternal mortality (or more) will have no or little impact.

A tangible example of an 'ectoscopic' solution to the problem of human resource scarcity: Task-shifting of life-saving skills

Looking outside the hospital gates to confront the devastating problem of maternal mortality requires facing the most serious problem of human resource scarcity alongside the other price tags. Some countries offer thought-provoking experiences of policy responses which have been successful, at least temporarily, at addressing these problems.

Mozambique is one such country, in which a long-standing war after independence in 1975 led to a crisis in the provision of human resources for health outside urban areas. As a result the ministry of health was forced to take the initiative of creating a new cadre of surgically trained medium-level providers of care. These so-called técnicos de cirurgia are non-physicians, most often experienced nurses, who have received three years' training in surgery (see Vaz and Bergström, 1992; Vaz et al., 1999 for details). They correspond to surgically trained assistant medical officers and clinical officers in other southern and eastern African countries. There is little doubt that Mozambique's experience has been successful in terms of reducing maternal mortality and provides a model for other low-resource settings that have insufficient numbers of physicians serving in underprivileged areas. Studies that have addressed the quality of obstetric care carried out by this category of non-doctors have demonstrated remarkably good post-operative outcomes even in advanced major surgery like obstetric hysterectomies, bowel repairs and emergency caesarean sections (Pereira et al., 1996; Chilopora et al., 2007).

Particularly noteworthy was the finding that the post-operative outcome of almost 2000 caesarean deliveries was almost identical for obstetric specialists and técnicos de cirurgia (Pereira et al., 1996).

Karolinska Institutet, in collaboration with the AMDD programme (Averting Maternal Death and Disability) of Columbia University, is currently assessing the benefits of delegation of surgical emergency obstetric care in several sub-Saharan African countries. Preliminary studies indicate that in Mozambique, Malawi and Tanzania the vast majority of caesarean sections at district hospital level are carried out by non-doctors (Bergström, 2005a). Our research indicates that, at district hospital level, around 90 per cent of caesarean sections in Mozambique (Pereira et al., 2007) and in Malawi (Chilopora et al., 2007) are carried out by técnicos de cirurgia and clinical officers, respectively. In Mozambique, it has been estimated that it will take about 50 years to produce the number of doctors needed to fill the gap of current deficit. The next question, still more crucial, is whether or not the doctors to be produced will settle in rural, remote areas, where técnicos de cirurgia now reside. We have studied three batches of medical graduates and graduated técnicos de cirurgia in Mozambique and it is remarkable that not a single medical doctor remains at district level seven years after graduation, while around 90 per cent of técnicos de cirurgia remain at district level seven years after their graduation (Pereira et al., 2007).

There remains much resistance to the concept of delegation of surgery to non-doctors (Rao et al., 2002: 32–3). Among the medical profession in many African countries, particularly among older and influential obstetricians, the reluctance to accept delegation of major surgery to non-doctors is strong (Cumbi et al., 2007). The alarming depletion of human resources in the most deprived countries has, however, forced most of us to question the traditional roles and responsibilities within the health care system.

The scaling up of projected requirements for maternal, newborn and child health assumes the global production in the next ten years of at least 334,000 additional midwives (or professionals with midwifery skills) and the upgrading of 140,000 others. Some 27,000 doctors and technicians have to learn the skills to provide the back-up maternal and newborn care, and 100,000 full-time equivalent multipurpose professionals have to learn to follow up maternal newborn care with integrated child care.

Conclusion

Reducing maternal mortality remains a global challenge of enormous magnitude. While the international community has long proclaimed

laudable targets on maternal mortality, progress has been insignificant. The costs or price tags of this progress – moral, financial and organisational – are often neglected, especially the depletion of human resources for health. I have proposed that, within in the field of obstetrics and gynaecology at least we need to look at the problem through an ectoscopic lens to find practical and possible solutions.

One of the most prominent African obstetric ectoscopists, Professor Mahmoud Fathalla, made an important contribution at the 13th World Congress of Gynaecology and Obstetrics in Singapore, in September 1991 (Fathalla, 1991: 203). He gave a presentation titled 'How much are mothers worth?' His point of departure is a good example of obstetric ectoscopy, challenging not only politicians but also obstetricians. Obstetric ectoscopy should provide a perspective that the obstetrician has to convey to politicians. Instead of always blaming the politicians, we should provide them with the increasingly unpleasant knowledge that we harbour. We should also make ourselves more literate in obstetric economics: there is a financial price tag, as we have seen, for maternal survival. Already at the International Conference on Population and Development in Cairo in 1994 the stipulated cost for 'Reproductive Health Care for All' per year was estimated at a minimum of 17 billion $US, of which only half is being paid at present. This sum of US$17 billion, seemingly huge, corresponds in fact to only one week of global military expenditure.

While wealthier countries that have poached professionals from Africa must bear some financial responsibility, most African governments do not invest sufficiently in strategies for serious and significant maternal survival. They still have to decide – with professor Fathalla's words – whether mothers' lives are worth saving. We can therefore say, with confidence, that

> [a]ny country has the maternal mortality its government deserves.

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11
Should I Stay or Should I Go? Brain Drain and Moral Duties

Anne Raustøl

Introduction

There is a critical shortage of qualified health-care workers in many poor developing countries. One reason for this shortage is that many of the trained health-care workers from poor developing countries move to wealthier countries to take up health-care work there. This leaves the poor developing country with a shortage of health-care personnel. In this chapter, I will discuss the moral duties of the individual health-care worker and give an overview of some of the justifications for these duties. Does the health-care worker have a moral duty to stay and work in her home country, or is she morally permitted to leave?

By moral duty I simply mean what the agent ought to do, morally. If the agent fails to do her duty, she is morally to blame. This kind of duty is not necessarily correlated with someone else having a claim on the agent to fulfil this duty, as is often the case in discussions of rights-based accounts.

I will lay out an account of two alternatives that the health-care worker in a poor developing country with a possibility to leave for work in a wealthier country faces. I will then discuss whether she ought, morally, to choose one of them over the other. Considerations such as aggregated utility and priority of the worst off suggest that the health-care worker ought to stay in her country, but they may also suggest that for instance European health-care workers ought to go and work there. Intuitively we seem to believe that a European health-care worker does not have a duty to do so. I will proceed by discussing some factors that might distinguish the health-care worker from a poor developing country from their counterpart in Europe. The factors I discuss are some different ways in which the health-care worker from a poor country

stands in relation to the people who benefit if she stays: as compatriots, through contractual obligations and because of the physical proximity of the health-care worker to the beneficiaries. It is worth mentioning that these are all complex and rich issues that deserve thorough attention, and that this chapter merely discusses them briefly, relating them to the specific case of migration of health-care workers.

The two alternatives

The alternatives that the health-care worker faces are:

(i) Leaving her home country for work in a wealthier one, and
(ii) Staying and working in the health-care services of her own country.

There are several factors we have to consider when we assess these alternatives: the size of the sacrifice for the agent, the degree of need of the beneficiaries and the ties between the agent and the beneficiaries. All these factors can influence our moral duties.

I will focus on two groups of people or beneficiaries:

(a) The health-care worker and her family and loved ones,[1] and
(b) The population of the health-care worker's home country, including patients (actual and potential) and possibly their families and loved ones.[2]

In alternative (i), where the health-care worker leaves her country, she will benefit enormously. The salaries, working conditions, housing and general living standard are often much better in the new country than in the home country.[3] If the health-care worker has a family, the benefit for them is also huge, whether family members accompany the professional to the new country or stay in their home country. The large increase in the professional's income can provide an increase in the general living standard for a substantial number of family members. Record and Mohiddin (2006) suggest that the economic benefit of remittance from emigrated health-care workers in a poor country is significant enough to boost the economy of the country, and that the allocation of these resources often goes straight to the people who need it most. Remittance of money from emigrated health-care workers abroad may be a better way of aiding poor people in poor countries than through traditional organised aid. So, the benefit to the relatives of an emigrated health-care worker, and their local community, is significant.

On the other hand, the potential patients in the health-care worker's home country will lose out on reliable health-care services. In many cases, health-care workers are so scarce that when one single professional leaves, a ward or health-care centre has to close down partially or fully, because no adequately trained replacements are available. As the number of health-care workers who leave increases, the less adequate the health-care services become. A lack of adequate health-care services is a threat to the health and life of the population of that area. It is highly likely that some patients will die because of lack of health-care staff. The consequences for the persons around the patients are also bad: if there is a lack of health-care services, others have to provide care for the sick. A society suffering from a serious lack of sufficient health-care services will lose out on labour resources as both the patients and those caring for them withdraw from the rest of the economy. So, the loss for the population and potential patients in the health-care worker's home country if she leaves is significant.

In alternative (ii), where the health-care worker stays, the population and its patients will benefit enormously as they are more likely to have access to reliable health-care services. Consequently, some people will survive who would have died in alternative (i). But the health-care worker loses out on the benefits described earlier.

Utility

Some might argue that staying in the country is a duty because of utilitarian factors. Act-utilitarianism requires one to perform the act that gives the highest sum of well-being. Now let us look at the implications of act-utilitarianism for the case at hand.

Although leaving the home country will hugely benefit the health-care worker, the benefit for the patients and general population if she stays is of a more essential character; the difference between being dead or alive is greater than the difference in the welfare of the health-care worker in the home country and in the foreign country. In addition, the number of people benefiting if the health-care worker stays is higher than the number of people benefiting if she leaves. For these reasons, the sum of well-being is likely to be much higher if the health-care worker stays. Hence, act-utilitarianism requires the health-care worker to stay.

Priority to the worst off

Now consider this case: We have a resource to distribute. It will benefit person A by four units of well-being, or person B by five units. The

Table 11.1 Priority

	Well-being (WB) at time (T) 0	Alternative 1: distributed units of WB	Alternative 1: sum of units of WB at T1	Alternative 2: distributed units of WB	Alternative 2: sum of units of WB at T1
Person A	3	0	**3**	4	**7**
Person B	8	5	**13**	0	**8**
Total WB	11	–	**16**	–	**15**

act-utilitarian agent will be required to give the resource to B. Now, suppose that A only has three units of well-being in the first place, while B has eight. Should we still give the benefit to B?

In Table 11.1, act-utilitarianism favours Alternative 1, since it results in greater total well-being (even if only by a small margin). However, a principle of giving (at least some) priority to the worse off would favour Alternative 2, since it results in a considerably better outcome for the worst off.

A principle of giving priority to the worst off can have several motivations. One is *equality*. Benefit to the worst off diminishes inequality, so that the parties are more equally well off. One criticism of pure egalitarianism is that it allows destruction of resources, or 'levelling down' (see for example Parfit, 1997; Hooker, 2008). If in this case we took five units from person B at T0 and destroyed them, we would achieve equality. But the total level of well-being would be lower than when we started. Brad Hooker (2000: 55–65, 2008) argues for a *weighted prioritarianism*, where the general norm is to give priority to the worst off, but not if the benefit is much larger to someone else.[4]

However, in our case, the worst off are also the ones who will benefit most if the health-care worker stays. It might be worth mentioning that the potential patients are not only worst off in this particular case but are also probably among the worst off altogether, from a global perspective. So, according to both the principle of maximising utility and the principle of giving the benefit to the worst off somewhat more weight than the benefit to someone else, the health-care worker ought to stay in the country.

Relation between the agent and the beneficiary

Now consider the following case: imagine a British qualified nurse. Few people seem to think that she does something wrong or morally

blameworthy by not moving to, for instance, Malawi to work as a nurse there. In contrast, some might argue that a Malawian nurse has a duty to work there. The sacrifice for the British nurse in going to Malawi to work is probably less than for the Malawian nurse not going to UK to work,[5] so it cannot be the size of the sacrifice that gives the Malawian nurse more demanding duties than the British nurse has. Likewise, obligations according to utility and priority would also appear equal for both the British and the Malawian nurse. On what grounds does the Malawian nurse have more demanding duties than the British nurse has?

It seems that the Malawian nurse relates to the actual and potential patients in Malawi in a way that the British nurse does not. We have some special duties towards people we have special relations with that we do not have towards others. What distinguishes the British nurse from the Malawian might be one or more of the following relations: her relationship with her compatriots, contractual relationships and her physical proximity to her country's patients.

Duties towards compatriots

Many people would argue that we have special duties towards our fellow citizens or compatriots. But what are such duties grounded in?

The nurse's compatriots may have contributed to her society, and may for instance have paid taxes to fund her education. Hence, she may have a duty to 'pay back' by working in the country. But Robert Goodin (1988) points out that there are some people who will not be able to contribute to society in this way, as they are too badly off. If nurses only had a duty towards those who contribute to society, then those who are so badly off that they cannot contribute to society would be without health-care services. This would leave the worst off even worse off, which is unfair. Goodin suggests instead that any special duty is a distribution of impartial duties, based on a principle of most efficiently distributing general good. In this way the worst off will also be included as beneficiaries, as doing so generates more impartial good than not doing so.

Some philosophers hold that special duties are not always derived from or justified by impartial duties. Samuel Scheffler (2001) argues that special duties arise from the intrinsic value of the relationship. Friendship is a typical example of such a relationship. Having a special duty towards the beneficiary is a part of what it means to be in relationships of intrinsic value. Andrew Mason (1997: 443) argues that being part of the collective that makes law and policy, and which exerts

control over the collective life in one's society, is what gives citizenship intrinsic value.

Even if Mason is right, there is still the question of what degree of value citizenship has. If the value of the relationship gives rise to special duties, then the more valuable the relationship, the stronger the duties attached to it must be. It is reasonable to attach more value to one's close personal relationships than to one's relationship with compatriots, who are mostly strangers. However, this does not mean that it is always right to do so. We do for instance believe that the duty towards compatriots, in way of respecting the law, most of the time rightly outweighs our duty towards our family and loved ones.[6] Also, soldiers are expected to give more weight to their duty towards fellow citizens than towards their own family, although no one expects them to value their fellow citizens more than their family. Whether the Malawian nurse's duty towards her compatriots ought to outweigh her duty towards her family and loved ones is too demanding a topic to solve in this chapter. Nevertheless it is plausible to believe that the Malawian nurse has some duties towards the Malawian population that the British nurse does not have, based on special duties towards compatriots.

Contractual duties

There is another factor that might distinguish the duties of the Malawian nurse from the duties of the British nurse. The Malawian nurse took up her education in Malawi: the British nurse did hers in the UK.[7] For both, the state provided for much of the education. I have already mentioned that Goodin questions whether the duty to stay in Malawi is rooted in a duty towards those who paid tax to fund the training. Even so, there might be a *contractual* understanding of a duty to stay and provide health-care services *for the state* no matter whom the patients are.

We can distinguish between two different kinds of contracts – explicit contracts and implicit ones. The explicit contracts are those that are somewhat defined, often written and even possibly signed. Their conditions are generally clear to all parties. Many health-care workers in developing countries have contracts like this that they are aware of when entering professional training, obliging them to work for the public health-care services in their country for at least some fixed period of time after their graduation.

An implicit contract is a contract without explicit declarations. The duties and benefits of the parties can be rather vague. Still, such a contractual duty can be the root of some moral pressure on the health-care

worker to stay in her country. The aim of providing health-care education in a country is to be able to provide health-care services to the country's population. The explicit contract between the health-care worker and the state has to balance duty and sacrifice; if this balance were unreasonable, no one would enter the training in the first place. Still, there might be an implicit contractual duty to continue working in the country even after the explicit contractual duties are discharged. This moral pressure arises from a mutual exchange of goods, which is typical of contracts: the state provides education and career, and in return the nurse provides health-care services. However, there is also a lack of nurses in the UK, and a British nurse is not blamed for not working in the UK as a nurse. Therefore, the duties of the Malawian nurse seem much more demanding than the duties of the British nurse. Do some implicit contractual duties apply to health-care workers in poor developing countries that do not apply to those in western countries?

Consider the following example:[8] A moderately wealthy African country has a moderately well-functioning health-care service with more or less satisfying access to qualified health-care personnel. The health-care workers in the country have the ability to work abroad in wealthier countries, and some do this. They are under no explicit contractual obligation to stay in the home country. Still, most do stay. Due to unforeseen circumstances, the country becomes poorer, its population's living conditions worsen and more health-care workers leave. Then a terrible disease hits the country, so devastating that it influences the country's economy and infrastructure. At the same time, the need for health-care workers naturally increases enormously. In addition, more health-care workers leave. Has the duty of the health-care worker changed? And if so, for what reason?

We now have a *state of emergency*, and special duties can increase when we face an emergency. They surely would in typical personal relationships, such as friendships and familial relationships: I ought to sacrifice more for my friend when he is in great need than when he is not. If we have special duties towards compatriots because of our special relationship with them, then it seems as if these duties would increase when the need of our compatriots increases.

Likewise, an implicit contractual duty might arise in the case of an emergency. If the emergency happened in the UK, it seems as if the British nurse would have a stronger moral duty to work there than if there were no emergency. It also seems plausible to say that she would have a stronger duty to do so than for instance a Malawian nurse would have. There is an implicit expectation that when the country

is in extreme need of health-care personnel, those health-care workers trained at the country's expense ought to help out.

However, our moral duties in emergencies can also be relaxed. Tom Sorell (2002) argues that we are more likely to excuse agents who break some moral constraint when faced with an emergency. For instance, stealing cars is not normally accepted, but we see it as excusable and often even admirable to steal a car in order to save someone's life. Sorell argues that agents are permitted to break some moral constraints in order to 'save oneself'.

Sorell also argues that public emergencies, as the one described above, permit increased powers for governments. Therefore, on the one hand the government in the plague-stricken country is morally permitted to exercise more power than normal over its citizens in order to protect them. This could for instance involve extending the period of commitment of qualified health-care personnel even if it happened in a somewhat unjust way, for instance after the individual entered the contract. On the other hand, the health-care worker is also one of the 'victims' of the emergency, her and her family's life is influenced by it in a very bad way, and she is morally permitted to break some moral constraints in order to 'save herself'. It seems as if the fact that there is a state of emergency does not bring us closer to an answer.

Emergencies can give rise to implicit contractual duties, and this can suggest that the Malawian nurse ought to stay and work in her home country. However, when the nurse is herself a victim of the emergency, she might be morally justified in leaving the emergency area, to save herself and her loved ones. This section shows another difference between the Malawian nurse and the British nurse, namely different implicit contractual duties or moral pressure. However, it does not give us a firm conclusion about how much weight the agent ought to give this implicit contractual duty.

Physical distance

One could also argue that what distinguishes the Malawian nurse from the British nurse is the difference in physical distance to the beneficiaries. The Malawian nurse is close to the Malawian population and patients while the British nurse is not. But is physical distance morally relevant?

Frances Kamm (2007) argues that it is. She bases her argument on our intuition that distance makes a difference to our moral duties, so that our duty to aid others is stronger when we are near than when we are far

away, other things being equal. Relevant 'other things' are things that we often associate with being physically near someone: our perception and understanding of the situation, our identification with the person in need, the salience of that person's plight and our ability to help. Kamm (2007: 345–91) considers all these issues. But she argues that the mere physical proximity, even if it would not bring about any of the features normally associated with being near someone, strengthens our moral duties. Her argument for this is as follows: we have a prerogative to give somewhat more weight to things that matter to us and are associated with us, such as ourselves and our 'efficacious means' (Kamm, 2007: 387). According to Kamm my immediate surroundings matter to me because I happen to be located in them. Kamm extends this prerogative not to merely give us some *permission* to care for what is near us but also to give rise to an *obligation* to do so (ibid.). So, I have a duty to care somewhat more for things that are near me and my efficacious means, than for things that are far away from me.

If Kamm is right, then the Malawian nurse has a stronger duty to work in Malawi than the British nurse has because she happens to be closer to the suffering people there than the British nurse is. However, there are at least two worries about this view.

Firstly, it is not clear what Kamm means by 'being near, absolutely' (Kamm, 2007: 350). She seems to argue for a position where she understands absolute nearness as that the agent is within reach of the victim without artificial means (Kamm, 2007: 354). However, if this is her position, then it seems as if what gives us the duty to help is being in a position to help, without undue cost to the agent, not physical nearness in itself.

Secondly, if Kamm's notion of 'absolute nearness' is not helpful, then maybe we should rather understand her to hold that the *degree* of distance is what matters. Hence, our duties are stronger the closer we are. But this would give our Malawian nurse an incentive to leave her own country and place herself further away from the suffering, so as to limit her obligations. Kamm argues that we are not permitted to remove ourselves from the vicinity of the suffering in order to avoid obligations, although she thinks we are permitted not to move ourselves closer to the suffering in order to increase our obligations (Kamm, 2007: 358). This argument is based on cases where I have one particular person in front of me, where it would be wrong to remove myself from him simply to avoid the duty to help. But what seems wrong in this case is not *that I remove myself*, but rather that by removing myself I do not help someone I ought to help. If I do

not have a weighty obligation to help this person, say I only had a slightly stronger reason (but not sufficient to require an action) than I would were I further away, I cannot see that the mere relocation is impermissible. If this is correct, then it is not the physical distance in itself that matters, but rather our ability to help.

The case of the Malawian nurse differs from the case that Kamm bases her argument on. The Malawian nurse's dilemma is not concerned with one particular person who needs help right here and now. Her concern is mainly on future, potentially suffering persons rather than particular actually suffering ones. If it is wrong to remove oneself from an area where there happens to be a lot of suffering, even if one is not at the moment of removal faced with one particular suffering person, foreign aid workers would not be permitted to go home before the suffering in their host country is completely alleviated, and we surely believe they are. Kamm could argue that there is a difference between the foreign aid worker and a local person if she allowed her 'location criteria' to be expanded to apply to 'where we belong/come from' rather than 'where we actually are'. But then her argument that mere physical proximity, and not simply features normally associated with proximity, can influence our moral duties, would fail.[9]

Therefore, what makes physical proximity morally relevant is not the proximity in itself, but features normally associated with it. Some of the typical features only apply in direct encounter with the suffering person, and the Malawian nurse may not directly encounter the suffering person (at least not at all times). However, one feature associated with being near that does apply to the Malawian nurse is this: there is great need, and health and life is at stake for many people. The Malawian nurse is right there, right now, with the ability to help. Even if the sacrifice is great, there is strong moral force in being there, able to help, when someone is in great need. A bystander who passes someone about to drown in a pond right next to him has a duty to help, even if significant risk or sacrifice is involved. However, he is not required to risk his own life. So, is there a relevant difference between the health-care worker and the bystander?

The nature of the sacrifice

There are reasons to answer 'yes'. The sacrifice of the health-care worker is of a different nature than that of the bystander. Whilst the bystander has a duty to sacrifice something (and sometimes a lot) in the moment of rescuing the victim, he does not continue sacrificing *over time* and

with great negative influence over his life. The health-care worker does; she would have to give up the life she would otherwise have chosen. Imagine that the bystander risked his own life in order to rescue the drowning person. We consider such risks supererogatory, or beyond what duty requires of us. By analogy, we could argue that the sacrifice of the health-care worker, by giving up the life she would otherwise have chosen, would be supererogatory.[10]

If the nurse stays, she loses out on some key human goods. For instance, it can be very difficult for her to make future plans and experience that she directs her own life. We are sometimes required to set aside our own projects and plans for the sake of others. However, if we do so over a significant time span, for instance over years, we will experience that we do not have control of our own life. This can be undesirable from a utilitarian perspective: a person who sacrifices too much might not provide as efficient help to others as those who sacrifice less. However, there are other reasons why not being able to make future plans and direct one's own life is problematic. An agent who is not able to pursue her own projects and life plan does not live a flourishing human life, as human beings essentially do direct their own lives.[11]

Although the nurse in our case does not necessarily risk dying if she stays, like the bystander who acts in a supererogatory way, she might sacrifice things that are essential to living a good life. To sacrifice essential goods over a significant time span, say over years, is of such a nature that we would consider it supererogatory. Therefore, a moral requirement to stay in a poor developing country when one has the opportunity to leave can in many cases be unreasonable.

So, although there is significant moral force in being right here and now when someone is in desperate need of help, the sacrifice for the Malawian nurse is of a more existential nature than the sacrifice for the bystander who is near someone about to drown. The sacrifice for the Malawian nurse if she stays is supererogatory, and therefore cannot be required.

Justice

There is also a prioritarian worry about requiring the health-care worker to stay in her home country. The health-care workers in poor developing countries are among the worst off health-care workers in the world. By requiring vastly more demanding sacrifices from the worst off than from the better off, the worst off becomes even worse off. This is unfair.

Although special relations and the ability to help can increase our duty, they do not necessarily trump other factors. Being in a position to help has moral force. Those who must sacrifice less are in a better position to help than are those who must sacrifice more. There are ways to solve the crisis of brain drain without laying too much strain on already badly off individuals, such as by distributing the responsibility more widely to the international community. The problem of brain drain in poor countries is a poverty related problem, and such problems require broad strategies. To suggest strategies for solving these issues is beyond the scope of this chapter.

Summary

I have argued that the health-care worker in a poor developing country does not have a duty to stay and work in the country. If the health-care worker stays in her country, this maximises impartial good and gives priority to the worst off. In addition, the health-care worker has some special ties with the population of her country, and this can give her a more demanding duty towards them than for instance health-care workers from other countries would have. On this basis the local health-care worker can be required to sacrifice more for the sake of the patients in her country than people from other countries would be required to sacrifice for them.

However, huge sacrifices can alter our duties. I have argued that the sacrifice a health-care worker from a poor developing country suffers, if she stays in her country instead of leaving for work in a wealthier country, can often be supererogatory. Therefore, staying in the country cannot be required.

On the other hand, there is a desperate need to address the problem of the brain drain of health-care personnel. And something ought to be done. However, it is unfair to assign vastly more demanding duties to a group of people who are already badly off than on others who are better off. Therefore, actions to help with the crisis of brain drain of health-care personnel in poor developing countries must be spread beyond local health-care workers of these countries to the international community.

Notes

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1. I will assume that the health-care worker has family or other people that she cares for in some way, and who will also benefit financially if she does. I do this because most health-care workers who migrate to wealthier countries for work have significant economic responsibilities. However, most of my conclusions will also apply to a health-care worker without such responsibilities.
2. This is a simplification. The health-care worker is of course part of the population of her home country, so she will benefit when group (b) benefits. But since she will be likely to benefit from better health-care services in the new country of residence, I do not consider this point in this chapter.
3. There are disadvantages and losses in well-being associated with leaving one's home country, such as leaving one's family and friends, feeling isolated from the new society and more. However, I will assume that the benefits that the agent achieves by leaving her country outweigh these losses in well-being.
4. In health care, we often face this problem: what gives the highest sum of well-being does not always benefit the worst off. Patients who are only slightly ill, say, suffering from a simple kind of malaria, will benefit hugely from a relatively small resource: the price of some pills. While for patients who are very ill, say, suffering from AIDS, enormous resources are required to benefit them only slightly, and they will never benefit as much as the patients with malaria. Hence, we are also able to help many more malaria patients than AIDS patients with the same amount of resources. It is not obvious that we should always give priority to the worst off in such cases.
5. I base this on the fact that European nurses are most likely to work for an international organisation if they take up work in developing countries and will hence have a better salary than most local nurses.
6. Brian Feltham suggested this point to me.
7. Here I assume that the nurses undergo their training in their home country. The fact that many health-care workers undergo their training in other countries than their own complicates the issue. However, the arguments in this section also apply to those who undertake their training abroad, but at the expense of their home country, local community or some organisation in their home country.
8. Thanks to Brad Hooker for this case. It is not fiction.
9. Michael Slote (2007: 21–32) criticises Kamm's account and argues that rather than mere physical distance, it is features associated with distance that trigger our duties. He argues that it is our ability to respond empathically to the plight of others that makes physical nearness, in form of direct encounter, morally relevant.
10. We are sometimes required to risk or give up our lives, such as in a state of total war. However, this is not a state of total war. Special thanks to Brian Feltham for helpful suggestions on this paragraph.
11. There is rich material on this matter. See for instance B. William's 'integrity objection' in Smart and Williams (1973), Scheffler (1982) and Cottingham (2010). Due to limited space in this chapter I cannot discuss these issues in detail here.

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12
Nurse Migration from South Africa and the Ethics Discourse

Colleen McNeil-Walsh

Introduction

The negative consequences of migration have led to an ethics discourse in which the central concern is the diminished ability of developing countries to provide adequate care at a time of extensive outmigration of health professionals (World Health Assembly, 2004). The purpose of this chapter is twofold; first to situate South Africa in this 'brain drain' discourse and second to consider the place of nurse migrants through a 'discourse from within'. The debate around the outmigration of health professionals from developing countries has paid little attention to the perspectives of health professionals themselves (Mensah et al., 2005). This chapter aims to show how the everyday experiences of nurses as professionals and migrants result firstly, in a particular set of interests and desired outcomes of migration, which to some extent conflict with other stakeholders in the migration debate (Xu and Zhang, 2005: 578), and secondly, in a different vantage point from which nurses engage with the ethical debate in the context of migration. By paying attention to the position of nurses within the broad ethics discourse, an alternative discourse is identified, in which nurses are located at the centre.

The first section of this chapter begins by outlining the brain drain discourse in the particular economic, political and historical context that is South Africa and the ethical complexities it gives rise to. It then sets out nurse-migration flows out of South Africa and provides brief discussion on policy responses to these flows. This sets the context for the discussion of the 'discourse from within' revealed by migrant nurses themselves in the second section.

In the second section the narratives of South African nurses in the UK[1] are used to expose two key insights into the position of nurses in

the ethics discourse. The first is that the global demand for nurses in the past decade has resulted in an increased acceptance by nurses that nursing is a 'portable skill' (Kingma, 2006) and that their profession is situated firmly in the global labour market. The extent to which a nurse's clinical skills are wholly transferable varies enormously, but the caring element of nursing – embodied in the concept of calling - serves to add to perceptions of nursing as a global profession transferable across national contexts and provides a deeply moral motivation to the practice of nursing.

The second, more practical insight, is that return migration is an important consideration for migrant nurses but the intention to return is viewed with uncertainty and ambivalence, and that a return to nursing (in particular to South Africa's overstretched public sector) is the intention of very few. This position differs significantly from that promoted by other stakeholders[2] and the view that return migration is a viable strategy by which the impact of nurse migration on sending countries can be addressed.

The chapter concludes that adequate consideration of this 'discourse from within' is crucial to understanding the outcomes of policy responses to health professional migration and that the ethics of care, which appears to be a strong moral motivation for many nurses, is an essential addition to the traditional dominant ethical discourse on health worker migration.

South Africa and the 'brain drain'

Context to health worker migration

While the 'brain drain' discourse has been used to explore the impact that skilled worker migration has on sending countries across professions, it is the migration of health professionals that has proved most politically controversial (Alkire and Chen, 2006). Medical professionals as a generic group have constituted one of the smallest proportions of skilled workers migrating out of South Africa (Bailey, 2003) and yet the migration of this group of workers has raised particular concern. In the case of nurses, concerns arising out of their migration are emotionally charged (Xu and Zhang, 2005) due in part to the view that nurses in Africa are the 'backbone' of health-care provision (Chikanda, 2005) and also due to the growing emphasis on primary care in South Africa, which puts nurses increasingly at the forefront of health-care provision (Kingma, 2006).

At the centre of the debate on the migration of health professionals is the tension inherent in the recognition of individual rights and the recognition of societal rights (Ogilvie et al., 2007). As for all potential migrants, a medical professional in the first instance is a 'locus of human rights' (Alkire and Chen, 2006: 116) in that nurses have the right to freedom of movement. However, the medical professional is also crucial to the delivery of the right to health held by all members of a population. The 'medical exceptionalism' argument presented by Alkire and Chen (2006) highlights this specificity of migration of medical professionals. Put simply, for developing countries, the consequences of health professional migration are different to those of the migration of other groups of workers because they provide a critical service.

In the case of South Africa, the migration of health professionals gives rise to an ethics discourse created out of its specific economic, political and historical conditions and which includes different, and at times conflicting, stakeholder interests. As such, the ethics discourse is influenced by several factors, four of which are singled out for discussion here.

The first is the cost of training health professionals that is carried by the state and its taxpayers. Highly qualified workers represent a loss of economic potential to developing countries (Dumont and Lemaitre, 2005) because their wages represent a loss of consumption and investment expenditure (Bhorat et al., 2002). In the case of health professionals, state-subsidised training helps to ensure a supply of these critical workers (Sevilla, 2006) and also compounds the economic cost of migration. The immediate benefit a destination country reaps from these skills (having made no financial investment in the development of those skills) fuels the ethical debate.

The second factor is increased demands made on South Africa's health-care system since the fall of apartheid in 1994. The transformation of the public health-care system from one of inequality and inaccessibility to one that aims to enable all population groups to access public health care in an equal manner has entailed a shift in focus from tertiary to primary care. With these changes, the demand for health professionals to deliver this care has increased considerably (Kingma, 2006) but, at the same time, has increased patient load and therefore the demands made of health professionals (Farham, 2005). These new workplace pressures contribute significantly to the migration decision-making process. Hence, migration cannot be seen as the sole cause of nursing shortages in South Africa and although

migration and nurse shortages are linked, they are not bound together (Aitken et al., 2004).

The third factor is that contemporary international migration in South Africa takes place in an historical context of internal migration. One such flow was the migration of African women from the 'independent homelands' set up under Apartheid (Davenport and Saunders, 2000) to work as domestic servants (Cock, 1984). As Ramphele (2005) points out, the social and human costs of the migrant labour system that operated under apartheid are 'still painfully apparent' (Ramphele, 2005: 12). The current prevalent outward migration of health professionals from South Africa, although different in form and taking place under different conditions from previous internal migration, nevertheless occurs within this historical context where migration has had deep-seated and largely negative consequences. As noted by Bhorat etal. (2002: 24), the dramatic political and social changes in South Africa since the early 1990s has generated 'collective expectations as well as anxieties', causing the loss of skills through outward migration to be considered by some stakeholders, in particular government and health-care users, to be a threat to economic security and to long-awaited political and social change.

The final factor is that South Africa's relative economic prosperity makes it an attractive destination for migrants from other countries, particularly those in sub-Saharan Africa (SSA) (Dumont and Meyer, 2004). In the health sector specifically, South Africa is not only a source of health-care migrants for countries in the developed world, but it also employs nurses from other countries, mostly from those in the Southern African Development Community (SADC). Numerically, inward migration does little to balance the drain caused by outward migration – in the years 2001/2002 over 2000 South African nurses registered in the UK alone (NMC, 2006). By comparison in 2001, there were only 439 nurses from SADC countries in South Africa's nursing workforce (Rogerson and Crush, 2008), this being in part due to recruitment guidelines set out by South Africa's department of health in 2003 which encourage employers not to recruit from developing countries (op. cit.).

These four factors (among many potential others) serve to indicate the complexity of health worker migration and its associated ethical discourse in the South African context. The easy distinctions of rich versus poor and give versus take, which underlie many moral objections to and concerns for mass health worker migration, are muddied by the particularities of South Africa's economic, social, political and historical status.

Nurse migration out of South Africa – policy responses

Professional nursing bodies in South Africa and the UK provide the main source of information on the migration of nurses through verification and registration figures. The South African Nursing Council (SANC) provides data on the number of nurses who have applied to the council for verification of their qualifications and practice history and the UK Nursing and Midwifery Council (NMC) provide information on the number of nurses who take the next step towards migration, that is to apply to the council for registration, a process required of all nurses intending to practise in the UK. Yet an accurate picture of the outmigration of nurses is difficult to arrive at partly because the verification and registration data used to measure migration flows indicates the intention to migrate, not the number of nurses who actually do so. Nevertheless the sources provide a general picture of the extent of outward migration and importantly, show patterns over time.

From the NMC and SANC information, two important conclusions can be reached. The first is that the UK has always been the most popular destination for migrant nurses from South Africa and at one point (2001/02) more South African nurses (2100 that year) were accepted on to the NMC register than any other group of internationally qualified nurses (NMC, 2008). Secondly, the migration of nurses from South Africa has declined significantly with only 32 applications for registration to the NMC in 2007/08 (NMC, 2008).

Attempts within South Africa to address the outmigration of skilled workers have largely been orientated around controlling immigration (in order to protect the South African workforce from competition from foreign nationals) rather than addressing emigration (Bhorat et al., 2002). In the case of health professionals however, the specific consequences of the migration of this occupational group and nurse migration in particular, have resulted in policy responses at national and international level.

At a national level, a compulsory community service scheme established by the department of health aims to address the geographical misdistribution of doctors and nurses. A two year period of compulsory service was introduced for doctors in 1999 and in 2007 the South African department of health adjusted the regulation set out in the Nursing Act of 2005 to include one year of compulsory service for nurses on completion of their minimum three year period of education and training. Although in the case of nurses, the new regulation does not serve the direct purpose of delaying immediate migration as one of the requirements of UK NMC registration is that nurses must have

practised as a registered nurse for at least 12 months after qualifying (NMC, 2009), the policy development does indirectly address the shortage of nurses caused in part by outward migration. At an international level, the Ethical Code of Recruitment set out by the UK Department of Health in 2001, and adjusted in 2004, was put in place to address criticism of the systematic recruiting of nurses from South Africa (and other developing countries) by UK agencies. The code states that nurses from South Africa can no longer be recruited through recruitment agencies to work in the National Health Service (NHS). However, the code is generally viewed as 'soft regulation' (Bach, 2007) as the independent sector is not part of the agreement, so it is possible for nurses to enter the UK through the independent sector and then later seek employment in the NHS or to access information on employment opportunities advertised by recruitment agencies online (Dumont and Meyer, 2004). Nevertheless the impact of the code cannot be ignored, and it might well be a contributory factor in the decline in applications by South African nurses for registration to the NMC. For those seeking employment in the NHS in the UK, the cost and time involved in registration, obtaining a work permit and finding employment in the UK without the services of a recruitment agency, has arguably made migration a less accessible process.

Nursing: Portable skill, global commitment

Having surveyed the broader socio-economic and normative context of and policy responses to health worker migration in South Africa, this section focuses more closely on the employment and migration experiences of migrant nurses and what this might contribute to both ethical and policy debates. While these individuals are at the very core of the issue, their perspectives are nevertheless often neglected amidst the policy debates and voices of other stakeholders. Indeed, in the next section I show that their perspectives reveal a very different ethical consideration from the more impartial concerns of the rights to free movement and to health or the economic unfairness of the poor subsidising the rich: that of an ethics of care. Following that I show how more practical concerns remain powerful in migrant nurses' decisions on the specific policy issue of return migration.

Calling to care

Nurse migration is regulated at a professional level (professional nursing bodies regulate training and qualifications) and at a national level

(governments regulate the inflow of migrants at the point of entry). Such regulation determines the extent to which nursing is indeed a global skill and can be transferred with reasonable ease between countries. The importance of this in the context of the 'brain drain' discourse is that the transfer of skills also involves the transfer of professional ethics and a commitment to nursing at a global level. A comment made by one interviewee that 'Nursing is nursing … it's more or less the same as at home' (Female African nurse) supports the idea that the fundamental principles of nursing are transferable across national contexts, despite regulations (such as that of professional bodies that stipulate qualification recognition) resulting in partial, but not complete, transference of clinical skills. The aim of this discussion is to show that in addition to the transference of some clinical skills, an important element of nursing transferred is the element of care, which is often identified by nurses in the concept of 'calling'.

The concept of nurses as community is used by Milton (2007) to address the question of the responsibilities and ethical obligations of the nursing profession in relation to nurse migration and global recruitment. She argues that in the process of migration, the community (individual nurses and as a profession) 'participates in ongoing, ever-changing, indivisible processes' (Milton, 2007: 320). Nurses move not only as individuals but also as part of a nursing community. Each nursing community displays unique patterns but all are 'indefinite webs of interconnectedness' (ibid.). The narratives below show that this interconnectedness is facilitated by an approach to nursing in which calling to care plays a central role and in which nursing as a global commitment becomes apparent.

Calling in the context of nursing is defined as 'a deep desire to choose a task which a person experiences as valuable and considers her own' (Raatikainen, 1997: 1112) and is characterised by attributes such as commitment to holistic care and knowledge of patient's needs. In the rest of this section I will draw on my own research to show the ways in which the concept of calling to care is articulated in the narratives of South African nurses working in the UK.

It is important not to overstate the importance of calling in nursing. Some nurses interviewed chose their profession for instrumental reasons – nursing provides an opportunity to train while earning an income. As one respondent explained: 'I didn't want to do a course where I wasn't going to earn anything – coming from a poor background you know' (Male African nurse). For others, however, the concept of calling formed the basis of their decision to train as a nurse.

This is illustrated in the following narrative that points to the influence that the Florence Nightingale image had on her decision to become a nurse at a very early age – Nightingale is immortalised in the image of the 'lady with the lamp'; a woman who is tender, compassionate and dedicated to her patients (Hallam, 2000: 20).

> I took this job because at the age of eight I was asked to write a composition on what I wanted to do when I grew up. So I said to my Dad 'What am I going to write?' And he said to me, 'what do you want to be – a human rights activist? Do you want to be like Florence Nightingale?' And I said 'Oh, tell me the story of Florence Nightingale!' It just stuck in my head. And ever since then, I wanted to be a nurse – to take care of people. I guess that is why I feel so passionately about my job. I never felt it was a job. I always felt it was a calling.
>
> (Female Asian nurse)

Calling is not lost in migration. Despite the specificity of health-care settings and the challenges that nurses face in adapting to new contexts, the centrality nurses place on aspects of calling such as patient care is transferred in the process of migration, as illustrated in the following narrative:

> I like patients. So when I came to the UK it was easy for me because I've got that feeling – I've got sympathy for patients so I want to make sure that when a patient goes home, he's happy. My main priority is he goes home feeling like he's achieved what he wanted to achieve.
>
> (Male African nurse)

Migration also presents particular challenges to the notion of calling, resulting from the specificity of health-care settings and the cultural contexts in which nursing takes place. For one respondent, working with patients with eating disorders disrupted her sense of calling and challenged her commitment to patient care.

> It was something new to me and the way they were putting food in the bin. … It was so difficult for me because back home people are suffering. It took me months to throw food away. It was against my belief and my morals. But the staff understood that I'm from another country, a different culture.
>
> (Female African nurse)

Despite the challenges, the nurses whose narratives are drawn on here have remained in the profession. As the narratives suggest, a sense of calling plays some part in the decision to become a nurse and it shapes their everyday nursing life. It also plays a part in the decision to remain in the profession.

> People say nursing is a calling. We want to be nurses even though it is difficult and we stay being nurses. You just feel like you want to do it.
> (Female African nurse)

The idea of nursing as a global calling to care adds a further dimension to the ethics debate – a 'dimension from within' which is very much embodied and experiential. Engaging with the issue in entirely different conceptual terms from other ethical and policy perspectives, the idea of a 'calling to care' reveals how nurses may align themselves both morally and practically with their profession in a global arena in a manner that may conflict with the interests of other stakeholders at a national level. As migrants, nurses remain committed to the care of patients, regardless of the national boundaries within which they work. As migrants, they also move as a member of a nursing community, taking with them, and transferring, the notion of care across national boundaries. The migration of nurses makes this distinctly moral sense of a calling to care a distinctly global issue which constitutes an additional and seldom recognised consideration in the dominant ethics discourse on migration.

Intention to return

The nurse narratives also reveal how their employment and migration experience relates to, and may affect, the success of policy choices. This section focuses specifically on return migration. The strain on South Africa's public health system created in part by the loss of nurses through migration has resulted in a focus on return migration as a means of addressing nursing shortages. The South African government and organisations such as the Homecoming Revolution and the Association of South African Nurses in the UK have encouraged return on a permanent or temporary basis, the latter being based on the principle of contribution through the development of ongoing professional links with the nursing profession in South Africa. Return migration is articulated as an objective process in which return will allow South Africa to benefit from the skills nurses have developed abroad through a process of 'brain circulation' (Wickramasekara, 2003).

The problems of accurately recording the outward migration of nurses are in part shared in the recording of return migration in that data on migration flows do not provide information on how long migrants spend away from South Africa, if they move to another country once abroad or if they return to South Africa (Bhorat et al., 2002). Similarly, how 'loss' through migration is defined is a complex matter; nurses working abroad may continue to contribute to their home country in ways that are not easily measurable, for example, by raising the profile of internationally trained nurses (Xu and Zhang, 2005).

Given that an accurate picture of return migration is difficult to ascertain, nurse narratives provide a valuable insight into nurses' perceptions of return migration, the reasons for which they may or may not return and their intention to return to nursing in particular. The narratives suggest that although return is often viewed as desirable, in all cases it is viewed with uncertainty and few intend to go back into the understaffed public sector. The narratives identify four factors that form the basis of this position.

The first is that for some, the experience of migration has led to new ways of thinking about migration and has challenged the idea that migration is a distinct event, engaged with at one point in time. As such, return as a permanent state of affairs (and therefore sustained contribution to the health system in South Africa) is not the dominant view: 'Once I've finished my masters degree here, I would love to work here for six months of the year and in South Africa for six months. A true transnational!' (Female Asian nurse). Another respondent relayed her plans to maintain property ownership in the UK and South Africa 'And then maybe we can have two places to live!' (Female White nurse).

The second is that migrant nurses' children play a part in decision making. For those whose children live in South Africa, the pull of family is strong and is central to their plans to return. For those whose children reside with them in the UK, return migration is made more uncertain if their children wish to remain in the UK. This is especially so for those whose age and/or financial constraints mean that return can only be thought of as an irreversible process. As one respondent explains:

> We are thinking of going back home but I don't think it is going to happen. If my eldest son went back home he would be lost. Education is different for a start. I can't image going back home and leaving them.
>
> (Female African nurse)

Apprehension about reintegrating into the nursing profession is a third factor causing uncertainty about return. This is articulated in terms of opportunities to use new skills acquired abroad and the loss of others:

> I think of going back to South Africa but the problem is: will I use my skills? If I go back to South Africa now, it will be a dilemma because I've been out of management and they don't do the type of nursing I do here.
>
> (Female White nurse)

Others worry that the increased demands on South Africa's public health-care system have created working conditions that do not make return a favourable prospect: 'the conditions have deteriorated so much at home. I don't think I could cope. That's the reason why I left' (Female African nurse). For another respondent, the prospect of increased salaries for nurses opens up the possibility of return: 'If the notches are adjusted, I might decide to leave here' (Male African nurse).

Finally, the narratives point to personal safety and economic security as being important to decision making. 'I would love to go back and always live there but on the other hand, I have to be wise and practical' (Female White nurse). Another respondent has frequently thought about returning to South Africa but has reservations about the level of violence: 'The only thing that keeps me away is the violence in the country. This has been the only negative factor' (Female Asian nurse).

The four factors outlined above suggest conflict between the experience of migrant nurses and the interests of other stakeholders, for whom the return of nurses from abroad would be viewed as a positive step towards addressing the health-care challenges that South Africa faces. It is suggested by Kapur and McHale (2005: 4) that returning migrants have a positive impact on the economy in that they return with 'greater education and financial wealth; different experiences and changed expectations'. In the case of nurses and their potential value to the health system, this depends on if they return at all, but more importantly if they return to nursing (in particular to the public sector) and if they are able to utilise the nursing experience and skills they have gained abroad.

Conclusion

This chapter places nurses within the broad discourse of the 'brain drain' in South Africa and argues that two aspects of their lived experience

(calling and return migration) create an alternative discourse, referred to in this chapter as a 'discourse from within'. It has been suggested that there is some disjuncture between the interests of stakeholders where policy initiatives seek to address the negative consequences of international migration and the interests of nurses themselves – also stakeholders in the migration.

The argument does not propose that nurses are unaware of the consequences of migration for their home country or do not tussle with the dominant ethical debates at the time the decision to migrate is made or at the time consideration is paid to return. For those who contemplate migration but decide not to carry it through, the ethical concerns articulated within the dominant discourse of the 'brain drain' may well play a part in the decision to stay, possibly alongside feelings that their calling to care can be best discharged at home. For those who decide to leave, however, the idea that the calling to care is a global moral concern not restricted only to care of their compatriots, may also form a part of their decision-making process. It is not clear whether or how the disparity in levels of need between patient populations in South Africa and the UK interacts with considerations of calling to care and plays a role in the decision-making process, though this would doubtless prove an important topic for future research. It is likely however, that the equally embodied practical factors revealed in discussions of return migration, such as family commitments, concerns for skill wastage, working conditions and personal safety security, temper and complicate the sense of calling felt by migrant health workers while also potentially limiting the success of government-made policy choices.

This discussion has attempted to widen the debate on the ethics of international migration and health workers by considering where nurses themselves are situated. Their position is influenced by a more complex range of factors than is considered by the dominant ethics discourse. In their 'one size doesn't fit all' argument, Xu and Zhang (2005) suggest that policies developed to address unethical recruitment and the depletion of health personnel from developing countries reflect little knowledge of the everyday experiences of nurses that cause migration from developing countries. Greater awareness of how nurses' experiences engender a particular approach to the question of migration and ethics is important if the impact of policies set out to address the negative consequences of the migration of health professionals are to be adequately assessed.

Notes

1. Life-story interviews were conducted with 18 nurses in 2007 and 2008. The sample comprised of male and female nurses from three population groups in South Africa: White, African and Asian. All nurses had trained in South Africa and had been working in either the NHS or the independent sector for five years or more at the time of interview.
2. Stakeholders are taken to be all those who have a direct interest in the health systems of the UK and/or South Africa: sending and receiving governments, professional nursing bodies, organisations that lobby for the negative effects of migration to be addressed, patients, nurses and the families of migrants.

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13
Global Health, Justice and the Brain Drain: A Trade Union Perspective

Nick Sigler

Introduction

This chapter sets out to identify some of the reasons why trade unions, in particular those operating in the health sector, have an increasing interest in matters related to migration. It looks briefly at some of the history and describes some of the main challenges faced by trade unions both in the UK and overseas. The chapter then goes on to develop some responses to what are often described as the push and pull factors which drive migration, examines how the rights of migrant workers – both employment and human – are often abused in both the sending and receiving countries and concludes with a range of ideas about how some of the more serious impacts of migration on the health sector could be dealt with.

The trade union concern for migration

Trade unions have a unique role to play in issues relating to the international migration of health workers. As practitioners organising migrant workers domestically and in partnership with affected unions in host and sending countries and as advocates to governments, North and South, trade unions have a particular perspective on these issues.

UNISON is Britain's largest public service trade union. It has a membership of some 1.35 million, with the bulk of the members working in local government and the health service, but with members also in education, the utilities, the police service and the voluntary sector. In the health sector the members include, inter alia, nurses – UNISON has the largest representation of nurses of any union – health-care assistants, care workers, cleaners, porters and administrative staff. Two thirds

of the members are women and two thirds the union classifies as low paid, that is, paid the minimum wage or only slightly above. The head of the union's international relations carries a range of responsibilities including the union's relations with sister unions across the world, the oversight of a number of support projects with unions in developing countries and responsibility for developing and presenting the union's policy on a range of international and development issues – trade union rights, public service provision, anti-privatisation and a number of health related issues such as the trade union response to HIV/AIDS.

UNISON, like many other unions in the UK – especially those that organise in the health, local government, agriculture and service industry sectors – has in recent years been faced with the growing challenge presented by the increase in the number of migrant workers. That challenge comes in a variety of forms and comes at a time when unions are facing up to a general decline in membership and pressures to rethink and reinvigorate their complete recruitment and organisation strategy. It also comes at a time when unions are increasingly focusing on their organisation in the international arena, with talk of global unions and streamlined global union federations. While that may not be a direct response to increasing migration it is clearly driven by the increasing mobility of labour and jobs and the impact that that is having on traditional trade unionism.

It is only right to point out that the trade union movement has not always had a good record on migration. In his book on the history of immigration into Britain *Bloody Foreigners*, the author Robert Winder states that, at the beginning of the twentieth century, the Trades Union Congress (TUC) passed several resolutions calling for 'strict legislation against the immigrants who were stealing their members' jobs' (Winder, 2004: 197). Some 50 years later, at the time of the 'Windrush',[1] attitudes, if anything, had hardened. Winder states:

> The trade unions continued to grimace at official pleas to offer jobs to West Indians; some such as the Transport and General Workers Union threatened to strike if forced to take on the men of Jamaica and Barbados. [...] We cannot afford, said the General Secretary, Frank Cousins, that these people should be allowed unrestricted entry into this country.
>
> (Winder, 2004: 267–8)

The general secretary of the Agricultural Workers Union took an even stronger line. According to Winder, in 1947, he said:

> We appreciate of course that these people are human beings but it would seem evident that to bring coloured labour into the British countryside would be a most unwise and unfortunate act.
>
> (Winder, 2004: 268)

However, it is equally right to point out that trade union attitudes at the beginning of the twenty-first century are wholly different from those expressed 50–100 years ago. Changed attitudes mean that the TUC and its constituent unions now regularly pass resolutions and take real, positive, action in support of migrant workers and are at the forefront of defending not only their employment rights but also their social and human rights.

The conflicting ethical challenges migration presents to trade unions

UNISON comes at the issue of labour migration and health from two very different angles. On the one hand its members welcome the arrival of migrant workers. Not only for the diversity and the range of new experiences they bring to the health service but also because without their contribution our health services would be understaffed, thus posing an enormous and unacceptable burden on UNISON members. Without the massive contribution of migrant workers UNISON members would have to work on understaffed wards or in clinics and health centres with unacceptable staff cover. Without the contribution of overseas health professionals the service provided to patients and users would be dramatically diminished. So, as a trade union seeking to represent the greatest possible number of workers in the workforce, the union looks to recruit the increasing number of migrant workers that are being employed in the areas that UNISON organises. Migrant workers present the union with a new and complex series of organisational and representational challenges that officers have often not had to deal with in the past; challenges of language, culture and immigration status alongside a variety of social issues not normally tackled by trade unions but on which UNISON is asked to provide assistance as the only compassionate or sympathetic 'authority' with which the migrant workers come into contact.

On the other hand, and through UNISON's international development work, the union is constantly faced with issues relating to the impact that labour migration has on the delivery of health services in developing countries. UNISON has a major project in southern Africa on developing the trade union response to HIV/AIDS, which serves as

a useful example to put this into context. On any number of occasions in discussions about policies for combating the pandemic with the project's southern partners the union is faced with the question: how can we distribute anti-retrovirals, provide primary health care or provide testing and counselling – all essential components of an effective strategy – when all our nurses and doctors are working in your hospitals in Britain? This seeming dilemma is further complicated by UNISON's (and the wider trade union movement's) general commitment to the free movement of labour which would seem to baulk at any notion of 'managed migration' because it plays directly in to the hands of those who oppose all forms of migration.

We have here a conflict between individual and collective rights. The right of the individual to pursue their fortunes wherever they choose would appear to be undermining the right to a decent standard of health-care provision which we would contend can only be, effectively, provided collectively. It is in looking for ways to overcome that conflict that UNISON has become active in the area of labour migration.

Trade union approaches to some push/pull factors

The problem we are facing is not a British or even a European problem but very definitely a global one. The World Health Organization (WHO) has suggested that there is a worldwide shortage of nearly 4.3 million health workers (WHO, 2006). Alongside that you have the oft quoted – if not properly sourced – statement from the US government that they will have a shortage of some one million health workers over the next ten years, a shortage they intend to meet not through increased training but through overseas recruitment (for example, see Nullis-Kapp, 2005). The 'shortage' manifests itself in a number of different ways and therefore necessitates a variety of responses. It ranges from the pressure in the developed world to meet the ever more specialised health demands of a more health conscious population to the real needs of those in the developing world who do not have even the most minimum of health services.

As a trade union UNISON has to respond to both ends of that spectrum. In working with sister unions in the South in calling for improved health-care provision through the development of adequate public services one consequence of our actions could be to discourage the flow of health workers from the South to the North. Better pay and conditions, improved training and increased incentives to work in remote areas will all help reduce the rate of migration by reducing

the push factors and thus enabling people to stay at home. And to that end we have warmly welcomed the work currently being done in Malawi by the Department for International Development (DFID) which has resulted in a 50 per cent increase in salaries for some health workers, a programme which will hopefully be extended to other countries, will encompass a wider range of health-care staff and which will involve the local trade unions in the decision-making process to ensure a wide worker 'buy-in' to the scheme (see, for example, DFID, 2007a). But we also need to look at what type of training is on offer. Through the contacts that UNISON has developed in the South and elsewhere it would seem that we should be arguing for a new training regime for potential health professionals in the South, a regime that is more targeted to the needs and health conditions in developing countries, rather than one that is targeted at achieving the highest levels of academic excellence. This is somewhat dangerous territory and could lead to accusations of restrictive practice and paternalism. But in the context of facing up to the 'brain drain' would it not make more sense to be training health workers who are adequately equipped to deal with the health specifics of their home countries than to train them so that their skills are immediately transferable to the hospitals of Britain, the US or Australia?

Demands for improved pay and conditions in the North may also help to reduce South/North migration by encouraging more northern health workers to return or remain in the profession thus reducing the demand for workers recruited internationally. Equally, however, those improvements in pay and conditions may also act as a pull factor by widening still further the gap in remuneration for health workers in the South and North. But, as Britain is both a sending and a receiving country, the global shortage has an impact on union members here, an impact that unless resolved could have serious implications for the future of our health service and the people who work in it. With the combination of an ageing population and an increasing demand for health services worldwide the solution cannot be increased labour migration but has to involve a massive increase in training and radical improvements in pay and conditions for health-care workers across the globe.

Given the global nature of the problem, and thus the need for a global solution, the trade unions, with their global networks and structures and their commitment to international solidarity, are ideally placed both to advocate policies to deal with migration related issues and to pursue practical solutions at the grassroots.

Migration, (employment) rights and justice

A recent statement from Gemma Adaba of the International Trade Union Confederation (ITUC), commenting on the Global Forum on Migration and Development, held in July 2007 – and the failure of that approach which took the debate outside the United Nations (UN) framework,[2] made clear the trade union position. She said:

> Governments of sending and receiving countries must incorporate the rights based approach into migration policy both at national level and in the context of bilateral and regional agreements as well as harmonise the rights based approach at global level. Governments must further ensure that the attainment of the MDGs including poverty eradication through quality public services and decent work is not compromised by migration policy.
>
> (Delorme, 2007)

Acknowledging the potential benefits of migration can, paradoxically, reveal some of the injustices created by migration. For example, a 2006 report from the International Labour Organization (ILO) argues that migration is an engine of growth and development for all parties involved:

> In receiving countries it has rejuvenated workforces; rendered economic many traditional sectors like agriculture and services; promoted entrepreneurship, supported pension schemes and met the demands for skills for emerging high tech industries. In the developing regions … positive contributions of migration are reflected in remittance flows, transfer of investments, technology and critical skills through return migration and transnational communities or Diasporas.
>
> (ILO, 2006: 3)

To many this apparently positive account would nevertheless indicate a rather one sided distribution of benefits in which the developed countries shore up their ailing economies, services and pension schemes by poaching skilled workers from the developing world which in return is allowed to benefit from the hard earned wages of the migrant workers themselves. There is here no suggestion that some form of direct compensation should be paid by those countries which have stripped the developing world of their most important assets. In fact the migrant

workers are paying twice – in order to send vital remittances to their families and communities they often end up living at near subsistence level.

To put it another way, there is injustice in a Filipino nurse leaving her children in the care of their grandparents – or an elder sister – in order to come to the UK to look after, often on a very low wage, British children or parents. Improved work-life balance, good health and general well-being in the UK are being purchased – unfairly – at the expense of Filipino or African or Latin American women.

That injustice is deepened by the attitude of developed countries, including the UK, which have adopted restrictive immigration policies that allow and encourage entry to skilled workers while denying access to low and semi-skilled workers – despite surpluses of those workers in developing countries and a demand in receiving countries. In the case of the UK we also have a prime example of a failure of 'joined up' government. On the one hand DFID states quite clearly in a recent white paper that migration is a major route out of poverty (DFID, 2007b), while on the other hand the home office puts insurmountable barriers along that route, denying entry to the UK to those migrants – including health and care workers – who are most in need of the means to improve their economic circumstances. One has to ask though, is this simply a failure of government, or a pandering to those that see any form of migration as a threat?

Trade unions have a critical role in exposing and combating the many abuses that migrant workers face – not just in receiving countries but also in their countries of origin. In receiving countries significant numbers face exploitation in the form of low, often illegally so, wages, appalling working conditions, denial of basic rights such as freedom of association and the lack of any social protection. In addition they often face racial discrimination and social exclusion. In extreme circumstances this denial of rights could be equated with a form of modern slavery. Given that many migrant health workers in the UK work in the National Health Service (NHS) (a public sector employer and thus less likely to breach employment legislation) we are less likely to encounter such gross abuses here – although we have come across many examples of migrants being passed over for promotion, despite their superior qualifications and failures to ensure that they are made aware of their employment rights. But the extreme circumstances mentioned do occur in the private sector and UNISON has had occasion to mount 'rescues' of migrant workers who have suffered terribly at the hands of unscrupulous employers.

Migrant workers are also denied rights and opportunities in their country of origin. If they indicate a desire or intention to migrate

they will often be summarily dismissed. When returning home to visit their families, migrant workers, in countries like Indonesia and the Philippines can be treated differently to other citizens, forced to go through separate immigration queues and made to pay an additional tax on their overseas earnings. On returning home after a period of migration they are often unable to return to their chosen profession because employers perceive them to be 'difficult' employees: they might migrate again, they are over qualified, they can be disruptive because they try to introduce practices – including trade union membership – that they have learnt overseas.

Trade union ideas for dealing with certain impacts of migration in the health sector

Trade unions have faced up to the numerous injustices posed by the 'brain drain'. In advocating the need for strong quality public health services in the developing world we have consistently argued, in evidence to DFID and elsewhere, that they are undeliverable if solutions to health worker migration are not built into development policy at every level (for example, UNISON, 2006). We have worked to overcome some of the injustices by helping to strengthen trade unions and trade unionism in developing countries in the knowledge that strong trade unions will not only ensure that basic rights are upheld but also that, through the negotiation of improved pay and conditions, incentives for workers to leave their homes and families are reduced. UNISON has worked with local unions in receiving and sending countries, through a three year project coordinated by our global union federation, Public Services International, to ensure that potential migrants, particularly women health workers, are well informed about their employment, social and migration rights in both their countries of origin and destination. And the project seeks to do more than simply look at rights but also give a true picture about what potential migrants might expect in their chosen destination, to try and arrange reciprocal trade union membership and to provide networks of support linked with diaspora communities. UNISON's starting point is that we seek to protect people's right to migrate and thus the provision of accurate and timely information empowers the individual. But we recognise that this project might have a double edged impact in that better informed health workers may be more inclined to migrate than those less well informed, thus adding to the problem! Again we have a conflict between the rights of the individual and the need for the collective provision of health services.

Another injustice occurs through the way in which international recruitment takes place. The recent increase in recruitment resulting from the much needed and much welcomed investment by the UK's Labour government in the health service exemplifies that injustice. Given the inability to meet the short-term needs of the service from newly trained recruits, or encouraging former employees back into the service, the NHS filled the gap through a major programme of international recruitment. Most of those recruits come from countries which can ill afford to lose one doctor or nurse, let alone a whole year's output from medical or nursing school. Yes, the government did introduce the 'Code of Ethical Recruitment' intended to promote 'high standards of practice in the ethical international recruitment of healthcare professionals' (Department of Health, 2004: 4), albeit somewhat late in the day, but nonetheless welcome. But the code is fundamentally flawed in three key areas, all of which ensure that the injustices continue. First, it does not apply to the private sector, where much recruitment takes place and where increasingly well qualified people are working below their grade, undermining the worker's own career development and denying their country of origin of the skills they have acquired. Second, it applies only to 'collective' recruitment by the NHS and not to the recruitment of individuals so, despite its implementation there are still significant numbers of health-care professionals being recruited from 'at risk' countries. And third it is flawed because it is a 'national' code and not an 'international' code. Given that we are dealing with a global problem we must have global solutions and thus an international accord on ethical recruitment, brokered between South and North, must be an essential component of any effective strategy.

So a revamped and strengthened code is one of the demands that UNISON is putting forward and arguing for. But there is a wide range of other policy proposals which have been developed from the work that we continue to undertake.

The union believes that there is much to be gained from the idea of circular migration, in which workers, with the full support of the health services in sending and receiving countries, are able to gain from both the financial, career and professional benefits of a defined period spent overseas. Work needs to be done to ensure that such programmes would be able to make the best use of the talents available and that returning workers would be able to return to their profession in their home country and not be lost as they so often are to other businesses or trades. And this of course need not be just a South/North exercise but also one which allows health professionals in the North to share their experience

with those working in the South as well as gaining from a widening of their own professional expertise. Trade unions have a role to play here in negotiating the terms and conditions for such programmes and to ensure that the workers rights are not jeopardised by what could be seen as irregular patterns of employment.

Trade unions have built a range of bilateral partnerships to provide reciprocal rights and support for when members emigrate from country to country. UNISON, for instance, has arrangements with, among others, sister unions in Canada, Australia, Finland and Germany. Sometimes these partnerships develop into 'Union Passports' but all of them are there to ease the process of migration and guarantee that members are not denied the rights to which they are entitled. In some instances these partnerships have developed into twinning arrangements between union branches and regions in different parts of the world. UNISON has twinning arrangements with unions in Cuba, South Africa and Nicaragua. Although more often founded on issues of solidarity these arrangements could, and should, be developed to become another tool in migration policy development – as sources of information and as a forum for joint campaigning and advocacy on issues of mutual concern.

One further and major injustice needs to be mentioned. Britain and other northern countries have benefited enormously from the investment that many southern countries and southern health-care professionals have made in the training of medical staff. It is estimated, for example, that the cash flow from Ghana to the UK represented by the 293 doctors and 1021 nurses registered in the UK in 2003/04 is somewhere in the region of £100m (Save the Children/Medact, 2005). Should not this injustice be righted by some form of compensation payment? While not arguing either for or against such payments it is definitely an issue which needs to be examined. From the workers and trade union perspective it raises the question of who should be recompensed? For in many countries it is not the state that will have made that investment – at least not in its totality – but the health-care professional themselves. And should the compensation take the form of a direct payment or maybe some form of assistance from developed countries in training future health workers? The idea is sometimes floated that the UK and other northern countries should set up training schools in southern countries with some guarantee for graduates to work in the North provided they fulfil some level of commitment to their home country. This is an interesting and potentially valuable idea, but it is fraught with concerns about rights and while trade unions would welcome any idea that led to an improvement in health facilities in any

country, we would also be determined to see that human and employment rights are not infringed. This idea has already perhaps been taken to the point of extremis by the Philippine government which has set up nurse training schools with a clear objective of 'exporting' the graduates to the North in order that the country can benefit from the remittances sent home. Such a trade in nurses may be considered by some as but one step away from human trafficking.

There are a range of legislative changes, including accession to a number of UN and ILO conventions, which UNISON believes would not only enhance and regularise the position of migrant workers in the UK but also set an example to other countries as to how they treat their migrants or potential migrants. These include ratification of the 1990 UN Convention on the Protection of the Rights of All Migrant Workers and their Families, reform of the work permits scheme, legislation to prevent employers holding migrant workers' passports as well as working towards a common European Union (EU) legal framework for third country nationals within the EU as a whole. Implementation is also a major issue. So while many countries have ratified conventions and introduced good legislation, these laws are not being properly implemented and enforced. Trade unions have a key role here in demanding and monitoring compliance. And it would be wrong not to state that a prime objective of the trade union movement is to achieve the regularisation of the vast number of undocumented workers in the UK. Not to resolve this issue will simply store up problems for the future and undermine other efforts to bring about justice for migrant workers.

Conclusion

I hope that through this contribution that I have demonstrated that the trade union movement in general and UNISON in particular have a role to play in developing and implementing policies which will benefit migrant workers and the countries they work in. I hope too that I have demonstrated that while we openly welcome migrants to our communities we cannot and must not ignore the sometimes devastating impact that migration can have on the delivery of health services in countries from which that migration takes place. I hope to have demonstrated that trade unions are committed to ending the dehumanisation of migrant health workers. Too often migrant workers are seen as mere economic units, as nothing more than 'cash cows', relieved of their hard earned money at every turn – underpaid by unscrupulous employers, paying to support families in both their country of origin and their country of work; and

then taxed for the second time on their earnings if they return home. And I hope I have demonstrated that not only are trade unions committed to finding answers to those challenges but we are also in a unique position through our bilateral and multilateral connections to be able to gain support and help implement the kind of radical and progressive ideas that are essential to resolving the sort of dilemmas thrown up by this debate.

Migrants have made a massive and positive contribution to the UK. We owe it to them to have bold thoughts and take bold initiatives so that at least a part of that contribution can be reciprocated through support for their countries of origin. Trade unions are committed to working to make that happen.

Notes

1. The MV *Empire Windrush* docked at Tilbury in June 1948 bringing the first large group of West Indian immigrants to the UK after the Second World War.
2. Adabe claims that holding the GFMD outside the official auspices of the UN and on a voluntary and informal basis (which nonetheless marginalised non-government participants) enabled governments to avoid more rigorous frameworks which could have held them to account on migrant workers' human and labour rights.

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