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GLOBAL JUSTICE AND THE TRANSNATIONAL MIGRATION OF HEALTH-WORKERS

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Abstract

Transnational health-worker migration (or brain drain) is one of the most controversial trends affecting global health inequalities. Trained health personnel are migrating in masses from the developing world fleeing from their dire living and working conditions. The trend is encouraged by active recruitment practices of affluent nations, which are in turn responses to the increased demand for health personnel in ageing populations. While poor regions of the world already face serious health-worker shortages, increasing migration flows further diminish their health care services and their capacity to tackle major diseases. The result of health-worker migration is escalating international inequalities in health.

The aim of this paper is to understand what is exactly unjust about health-worker migration. The dominant view concerning the injustice of medical brain drain holds that insofar as it contributes to severe health deprivations it constitutes a human rights violation of the source population by recruiting nations. The paper seeks to challenge this view and argues that the concept of human rights is unable to capture what is really unjust about health-worker migration and its effects on increasing international inequalities in health. It further argues that a practical political conception of global justice can more plausibly point out where the problem of injustice lies and can, therefore, contribute to a fruitful shift in our ethical outlook on the problem.

Introduction

Transnational health-worker migration (or brain drain) is one of the most controversial trends affecting global health inequalities. Trained health personnel are migrating in masses from the developing world fleeing from their dire living and working conditions. The trend is encouraged by active recruitment practices of affluent nations, which are in turn responses to the increased demand for health personnel in ageing populations. While poor regions of the world already face serious health-worker shortages, increasing migration flows further diminish their health care services and

their capacity to tackle major diseases. The result of health-worker migration is escalating international inequalities in health.

The problem is particularly urgent in sub-Saharan Africa where the burdens of poverty and infectious disease have resulted in the break-down of public health systems. The brain drain of health-workers escalates the already severe health crises in high disease burden regions that already face a critical shortage of health personnel, and results in a negative cycle of declining health services and health outcomes. Sub-Saharan Africa is widely regarded to be suffering the greatest crisis in human resources for health and data suggests that the problem is likely to grow (Dovlo 2007). World Health Organization (WHO) data shows that 36 countries in Africa do not meet the 'Health for All' target of one doctor per 5000 people. On average, there are only 2 skilled health personnel for every 1000 people, compared to 19 in Europe and 25 in the Americas (*World Health Report* 2006). The WHO has estimated that to meet the health-related *Millennium Development Goals* (MDGs) the number of health-workers in Africa would need to triple. Actual trends, however, run contrary to the global policy target. In Ghana roughly half of the graduating doctors and a third of the nurses leave each year, and 40% of the medical jobs are unfilled. At the same time, the number of South-African trained nurses in the UK has tripled in only 5 years (WHO 2004). While domestic political and socio-economic factors in developed and developing countries strongly affect migration trends, health-worker migration has also been encouraged by international policy trends, such as the service sector liberalization fostered by the Agreement on Trade in Services (GATS, WTO 1995) (Bach 2003).

Health-worker migration is increasingly recognized in international policies as one of the most profound problems facing health systems, and the safeguarding of health, in the poorest countries of the world. Global treaties push for international policies that mitigate the effects of international market pressure on vulnerable health care systems and that can achieve worldwide equitable distribution of health workforce (e.g. health-related MDGs; *Kampala Declaration*: *First Global Forum on Human Resources for*

Health, WHO 2008). Despite the urgency of the problem and the intense international debate surrounding it, however, the solution is far from clear.

Ethical reflection on the problem has resulted in a variety of positions concerning the (in)justice of health-worker migration. The prevailing pro-migration view appeals to the right to freedom of movement of professionals and services, and points to economic gains from trade, remittances and knowledge-transfer (see in Alkire and Chen 2006). Others argue that responsibility lies with the migrants who have violated their social contract with the country that trained them (Snyder 2009). Source countries are often charged with domestic injustice and failure to guarantee an adequate level of health to their populations (Keuhn 2009). Receiving countries' active recruitment practices, instead, are blamed for harmful brain drain or violating the human right to health of the poor.

The aim of this paper is to understand what is exactly unjust about health-worker migration. The dominant view concerning the injustice of medical brain drain holds that insofar as it contributes to severe health deprivations it constitutes a human rights violation of the source population by recruiting nations. This paper seeks to challenge this view and argues that a human rights account is unable to grasp what is really unjust about health-worker migration and its effects on increasing international inequalities in health. Besides the traditional view, the paper also discusses two alternative human rights accounts and their implications for the case of health-worker migration. Finally, it argues that a institutionalist conception of global justice with a political foundation can more plausibly point out where the problem of injustice lies and can, therefore, contribute to a fruitful shift in our ethical outlook on the problem.

1. The Human Rights View

The ethics of global health is dominantly shaped by the idea of human rights, the most widely shared standard of political morality in the international society (UDHR, WHO, MDGs, Kampala Declaration, etc; Daniels 2007). The Constitution of the WHO states

that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." (WHO 1946) By now, most countries have ratified international treaties that make the right to health an international obligation. What does it mean to have a human right to health? What kind of obligations they give rise to? What do the different conceptions entail for the case of health-worker migration? While there are numerous accounts of human rights, I believe, they can be meaningfully grouped under three conceptions: the *traditional view* (a) and two different critical views: the *institutional conception* (b) and the *practical political conception* (c).

a) The Traditional View

On the '*traditional view*' (also called the orthodox or the prevailing view), human rights are moral claims that individuals have independently of the relations and institutions in which they participate. People have these rights in virtue of their humanity, and they are necessary conditions of a life lived with dignity, regardless of historical, geographical or cultural contexts. The moral claim can be grounded in different philosophical accounts of human dignity or moral agency that yield a variation in the content of human rights. The moral claim, on a first instance, is addressed to the state. A government's violation or incapacity to fulfil the duty justifies international humanitarian intervention or assistance. (The reconstruction draws on Beitz 2004; Cohen 2004; Wenar 2005, 285; Sangiovanni 2008, pp. 16-17.)

On the traditional view, the problem of medical brain drain lies in its contribution to severe health deprivations in the source population. Brain drain, however, is not the subject of justice or injustice. There is nothing particularly unjust about health-worker migration, as such, since injustice is located in the pattern of health distribution within a (domestic) society; in the fact that certain people do not meet a decent health minimum. Human rights deficits, in general, constitute the injustice and people have moral claims, firstly, *vis à vis* their government, and, secondly, *vis à vis* the international community, on the condition that the former fails to fulfil its duty.

Curbing health-worker migration, then, constitutes a particular instrument to realizing a more general idea of basic justice; namely that all human beings have access to basic health services and acquire a decent health status. Policy approaches target, firstly, source country governments to introduce direct measures to retain health-workforce and indirect measures to promote health, to improve health services, to provide adequate working and living conditions, and to reduce other relevant sources of out-migration, such as poverty and violence. When state guarantees are lacking, international obligations arise, and can vary from a duty to refrain from harmful recruitment, to compensate for the economic losses of the training country, and to provide humanitarian aid.

The traditional account of human rights is problematic in several respects. (i) Primary state duties complemented by a secondary duty of international humanitarian assistance depict a dualist moral universe that is unresponsive to the complex, multi-layered social realities of a globalized world. (ii) Its account of international obligation is silent on the reason that ground responsibilities other than our shared humanity; as such, its motivational force is rather weak. (iii) The requirements of justice are limited to the achievement of human rights and leave unaddressed those international inequalities that prevail even when the human right to health is fulfilled. (iv) The case of medical migration points to an additional problem that calls for a trade-off or priority solution. The human right to health of a population conflicts with the medical professional's human right to freedom of movement.

b) <u>The Institutional Conception</u>

Thomas Pogge's (2002, 2005) *global institutional* account addresses some of the weaknesses of the traditional human rights view. On this account, human rights are moral claims *vis a vis* global institutions and influential political actors that shape them. Pogge has focused our attention on the global order as an additional domain of justice (vs. domestic and inter-national affairs), and has identified the global order as the subject of justice that is to be regulated by principles with a global scope. So doing, he

has been able to specify more clearly the grounds of international obligations. Namely, insofar as health deprivations are the foreseeable outcomes of global regulatory schemes, and there exist a feasible alternative set of institutions under which those deprivations would not occur, individuals have moral claims upon global institutions. Affluent nations and their powerful elites, as protagonists in the design of the international order, have a duty to reform global institutions (Pogge 2002, 26)

The implications of this view for the particular case of health-worker migration are the following. The most influential multilateral agreement affecting medical migration trends is the General Agreement on Trade and Services (GATS, World Trade Organization 1995), which opens up national health care services to international trade and foreign investment. In general, the GATS agreement has rendered national health services vulnerable to global market forces. Regarding professional migration trends, in particular, it has facilitated the adoption of active recruitment policies in affluent nations that try to fill their increasing health-worker shortages with foreign-trained health personnel (Bach 2003).

Studies show (Anand?, Alkire and Chen 2006; Bach 2003) and international treaties affirm (MDGs, Kempala Declaration WHO, African Union, etc.) that health-worker migration is one of the most profound problems facing health systems, and the safeguarding of health, in the poorest countries of the world. If poor health outcomes are, in part, tied to low health workforce density, and the migration of doctors and nurses is encouraged by a global regulatory scheme, then, on Pogge's (2002) account, most of the conditions for a case of global injustice are satisfied. First, *human right deficits* occur: extreme health deprivations. Second, they are *causally traceable to social institutions*: GATS agreement and intensified health-worker migration trends. Third, it is *foreseeable* that the global regulatory scheme leaves unfulfilled the human right to health of large populations. A fourth condition, whether such deprivations are *reasonably avoidable*, or not, is a much more complicated question. The answer requires us to work out a feasible institutional reform under which migration-induced health deprivations would not occur. Insofar as there exist such an alternative institutional scheme, people

who lack access to basic health services due to health-worker shortage have a moral claim upon global institutions and political elites to push for reform. This takes us to the last condition. As Pogge warns, "this avoidability must be *knowable*: we must be able to be confident that the alternative institutional design would do much better in giving participants a secure access to the object of their human rights" (Pogge 2008, 26).

While Pogge's scheme is a major breakthrough in the ethics of global public health, it has its own weaknesses, which I will come back to in the last section. Part of the problem is, that for our (or any) case to satisfy the last two conditions requires empirical data that is often not available, sophisticated social scientific tools to extrapolate policy consequences, and a vivid imagination that can transcend the horizon of the politically possible.

c) The Practical Political Conception

The third conception rests on the idea that human rights are historical products that serve a concrete purpose in international affairs. The conception has two basic components. Firstly, it asserts that human rights have a *practical* role to play in a specific context, as opposed to the timeless and pre-institutional character of the traditional account. Their role is to provide a public standard of international recognition of states. Secondly, given its role as a common standard it must be one that could be reasonably accepted by all members of the international community, regardless of their diverging conception of a good life. Instead of drawing on controversial metaphysical foundations, the third view asserts that a conception of human rights must start from *political* ideals embedded in global public culture. (The view has been developed by Beitz 2001, 2004; Cohen 2004; Wenar 2005, Sangiovanni 2008.) While the terms practical and political are sometimes used interchangeably in the literature, I will use them separately to label the two distinct components: the practical *role* and the political *foundation*.

In contrast to the traditional view that takes human rights to be natural rights that apply across times and places, the practical conception takes human rights as having a specific role and purpose in a concrete historical context and political domain. Once we have understood the function of human rights in the recent historical context of international affairs, we can circumscribe more clearly the content of human rights against this background, and reason about which rights belong to the list in the first place. The different interpretations regarding the practical role of human rights converge on a core idea: they serve as a normative standard for assessing the legitimacy of states in the international community. "Human rights define a boundary of legitimate political action" (Wenar 2005, 285) and "present a set of important standards that all political societies are to be held accountable to in their treatment of their members" (Cohen 2004, 195). When violated, they "justify external interference in a society aimed at changing some aspects of the society's internal life" (Beitz 2001, 273). The deeper rationale behind having such a standard is "to mitigate the worst consequences for human well-being" within an international system of sovereign states (Sangiovanni 2008, 17).

While all of these interpretations work with the idea of equal standing or full membership in the international society, what is more important that they accord with the role assigned to human rights in global public culture. The *Universal Declaration* states, for example, that human rights function as "a common standard of achievement … for all nations." This takes us to the second component, the *political* foundation. Why do we need to retrieve to this minimalist strategy of justification and bracket our deepest moral commitments? And how can we work out what could reasonably be accepted in a highly mediated pluralistic setting where we do not have access to others' moral and religious views? As Wenar argues, in line with the late Rawls' political turn, "under good conditions the most reasonable starting point for determining what people could reasonably accept will be the focal point of that which has already been agreed" (Wenar 2005, 291). We start from fundamental ideals embedded in global public culture taken as the stock of moral achievements throughout the history of

humanity, and on that basis reason about what could be accepted by all. Contrary to what some think about the nature of political justification, however, we do not stop at taking stock of the fundamental ideas embodied in political treaties. Rather, we take a critical stance and present them in their most compelling light through a moral interpretation (James 2005).

When examining the consequences of this view for the case of medical brain drain, we might be surprised to acknowledge that the allocation and the content of responsibilities are very similar to that of the traditional view. The primary duty to safeguard the human right to an adequate level of health is allocated to sovereign states, and unfulfilled human rights justify external intervention (humanitarian assistance) in the internal life of a society. The point of departure consists in the political grounds that justification draws on and its motivational force. By grasping the practical role of human rights as a condition of membership and international recognition we appeal to shared ideals. By appealing to implicitly shared reasons, we provide others with reasons that they themselves have reason to accept (Scanlon 2003).

2. Human Rights vs. Structural Injustice

Both the institutional conception and the practical political conception constitute relevant improvements on certain aspects of the traditional view. While the institutional account has addressed the problem of locating and assigning responsibilities, the political account better grasps the content of human rights and has more motivational force in bringing about the desired outcome. Other weaknesses that remain unaddressed provide the a fruitful ground for further thinking. In the remaining section I will elaborate on the reason why neither conception, in itself, is able to grasp what is really unjust or unfair about health-worker migration. By way of conclusion I sketch an alternative framework, which, I believe, will have a stronger grip on the problem and is able to integrate the advantages of the two. If successful, then this

should make us wary about the dominant use of human rights in forging ethical solutions to medical brain drain.

The political conception provides us with a compelling idea concerning the role of human rights as a normative standard in international affairs. Proponents of the view convincingly argue that as a positive standard, it is a criterion that conditions the sovereign status of states and legitimate political action within it. As a negative standard, it has an "interference-justifying" function. Notice, however, that human rights provide a standard for assessing the internal justice of a (domestic) society. With regard to health deprivations, we can assess the health status of a population and evaluate whether there is any urgent need for international assistance. What is more, it is only suitable for assessing health deprivations as an outcome pattern of distribution, independently of their causes or the relations in which people stand. Quoting Beitz, the political doctrine is "concerned with the interests of the beneficiary of the right, rather than with the relationship in which the right is satisfied" (Beitz 2001, 281). What is more, it relies on a sharp distinction between the domestic and the international realm. As such, it seems unfit for the analysis of certain transnational phenomena increasingly shaped by the complex economic and social forces of globalization and the evolving international institutions that regulate them.

International society provides a whole different terrain of ethical inquiry that must aim at understanding the different kinds of moral relationships in which people stand in the context of evolving multi-level institutions and practices, and the kind of responsibilities they give rise to (Cohen-Sabel 2006, Daniels 2007). Hence, as a first task towards a better understanding of the injustice of medical brain drain, we need to shift the locus of moral assessment from health deprivations to health-worker migration as a complex international practice that occurs within the framework of the global trade regime in health care services.

This points to an advantage of Pogge's focus on global institutions and their effects on human rights deficits that require justification. The remaining puzzle is the reason why Pogge draws the limits of global justice at a human rights threshold. He

might argue that a minimal threshold is a better candidate for reasonable acceptability. On my view, however, such an argument does not take seriously the structure of the political doctrine, and the *role* of human rights. Reasonable acceptability should not aim at the lowest common denominator. It is not concerned with actual recognition by all existing (or dominant) views of morality. We must first understand what the role of a normative standard is in the international practice in question, then, construct the standard that is reasonably acceptable drawing on elements of the global public culture. As argued above, global public culture seems to confirm the idea that human rights have a particular role in the *inter-state* context as a criterion of *state legitimacy*, *sovereignty* or *equal standing*. Do human rights have an equally meaningful function in a global cooperative structural scheme, such as the global trade regime?

The problem of justice in an institutional context is concerned with the distribution of burdens and benefits and the permissible constraints on inequalities arising from the scheme. Does global public culture support the idea that the role of human rights is to limit permissible inequalities that arise from the distributive effects of a global institution? Translating the question to our case. Is the human right to health a suitable answer to the question what we owe to each other in terms of health-expectations in the global trade regime in health services? Would not we need to turn human rights into a threshold egalitarian (sufficientarian) principle of justice, for it to play the role that Pogge would like them to play in his theory? If so, is there enough support for that *role*, in particular, in global public culture?

I do not mean to assert that human rights standard do not have any role to play in addressing global health deprivations. I do claim, however, that due to the structure of the notion based on the dominant interpretation of its role in international affairs, human rights seem to be unfit as principles governing the distribution of socio-economic inequalities. As such, the human right to health does not seem to be particularly useful in grasping the problem of health inequalities arising from medical brain drain.

By way of conclusion: Towards a Political Conception of Fairness in Health-worker Migration

For a better understanding of the injustice of medical brain drain, we need to develop a more nuanced intermediary position that is able to combine the advantages of the two account, while leaving aside their weaknesses. In short, we need to work out an institutional conception of global justice with a political foundation. The theoretical inquiry needs to clarify what is an international practice; in what sense does it constitute the subject matter of international justice; and how does it differ from its social or domestic counterpart. A challenge is given by the rapidly changing and still evolving nature of international institutions, which constitute a moving target, hence a difficult subject for conceptual analysis. The task, then, is to construct a standard of distribution that is responsive to the aim and purpose of the international practice and its suitable role within the practice. On such grounds, we work out a principle of distribution that is likely to pass the test of reasonable acceptability in the context of the global trade regime in health care services. This moral standard will serve as a regulatory ideal in fostering a solution to justice in health-worker migration.

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