



Research Institute for Law, Politics & Justice

Global Health, Justice and the 'Brain Drain'

A one-day interdisciplinary conference on international health worker migration

17th September 2007

Chancellor's Building,
Keele University, UK

Programme and Abstracts



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Programme

- 9.00-9.30 **Registration**
Chancellor's Building Foyer
- 9.30-10.30 **Welcome**

Professor Karen Hassell, University of Manchester
International health worker migration: GB-registered pharmacists
Maureen Strasser Room (CBA 0.060), Chancellor's Building
- 10.30-11.00 **Coffee**
Chancellor's Building Gallery
- 11.00-1.00 **Parallel Session A**
Panel A1: Global Justice and Global Institutions
Maureen Strasser Room (CBA 0.060)
Panel A2: New research directions
Room CBA 1.098
- 1.00-2.00 **Lunch**
Comus Restaurant, Chancellor's Building
- 2.00-3.30 **Parallel Session B**
Panel B1: Work and Exploitation
Maureen Strasser Room (CBA 0.060)
Panel B2: International Approaches and Policy
Room CBA 1.098
- 3.30-4.00 **Coffee**
Chancellor's Building Gallery
- 4.00-5.30 **Parallel Session C**
Panel C1: Philosophy, migration and rights
Maureen Strasser Room (CBA 0.060)
Panel C2: Local approaches and innovation
Room CBA 1.098
- 5.45-7.00 **Professor Thomas Pogge, Columbia University**
Must we exclude the poor from advanced medical treatments?

Conference close
Maureen Strasser Room (CBA 0.060)
- 7.00-7.45 **Drinks reception**
Chancellor's Building Gallery

Parallel Sessions

Parallel session A: 11am-1pm

<p>Panel A1: Global Justice and Global Institutions <i>Maureen Strasser Room (CBA 0.060)</i></p>	<p>Panel A2: New research directions <i>Room CBA 1.098</i></p>
<p>Sanjoy Nayak, Royal Tropical Institute, The Netherlands <i>Explaining the Global Crisis in Human Resources for Health – Political Economy of Migration and Market & Government Failure</i></p>	<p>Lalaine Siruno, University of the Philippines <i>What Keeps the Doctor Away: A Probe into the Filipino Medical Diaspora</i></p>
<p>David Hunter, University of Ulster <i>Global Justice, Luck Egalitarianism & Global Health</i></p>	<p>Tana Wuliji, University of London <i>Migration intentions of pharmacy students – a global study of root drivers</i></p>
<p>Tom Allan, UK Department of Health <i>Highly Skilled Migration from Africa: What Can Game Theory Add to the Debate?</i></p>	<p>Anne Raustøl, University of Reading <i>Brain drain of health care workers in poor countries and self-sacrifice</i></p>
<p>Alex Sager, University of Calgary, Canada <i>Brain Drain, Rights, and Global Institutions</i></p>	<p>Colleen McNeil-Walsh, University of Birmingham Business School <i>Skill transfer and the Discourse of Ethics: the case of South African migrant nurses in the UK</i></p>

Parallel session B: 2.00-3.30pm

<p>Panel B1: Work and Exploitation <i>Maureen Strasser Room (CBA 0.060)</i></p>	<p>Panel B2: International Approaches and Policy <i>Room CBA 1.098</i></p>
<p>Christien van den Anker, University of the West of England <i>The road to nowhere: trafficking of skilled labour migrants in the UK health and care sectors</i></p>	<p>David Benton, International Council of Nurses <i>Emerging Trends, Challenges and Issues in Regulation of Migrating Nurses</i></p>
<p>Jeremy Snyder, Simon Fraser University, Canada <i>Exploitation in the International Migration of Health Workers</i></p>	<p>Sameer Chaturvedi, NTNU, Norway; Linköping University, Sweden <i>Global Justice and Global Health: Exploring 'Migration Threshold' Regulation</i></p>
<p>Nick Sigler, UNISON <i>The role of Trade Unions in the Brain Drain</i></p>	<p>Giulia Greco, London School of Hygiene and Tropical Medicine <i>How can the different approaches to understanding international migration contribute to a multi-dimensional policy framework for the migration of health professionals in both sending and receiving countries?</i></p>

Parallel Session C: 4-5.30pm

<p>Panel C1: Philosophy, migration and rights <i>Maureen Strasser Room (CBA 0.060)</i></p>	<p>Panel C2: Local approaches and innovation <i>Room CBA 1.098</i></p>
<p>Philip Cole, Middlesex University <i>Migration and Human Rights -- The Case of Health Care Professionals</i></p>	<p>MV Lakshmi Devi, R.B.V.R.R.W's College, India <i>Medical Tourism as A Way to Stop Brain Drain –A Case Study</i></p>
<p>Kieran Oberman, St Cross College, Oxford <i>Can Border Controls Be Used To Stem Brain Drain?</i></p>	<p>Staffan Bergström, Karolinska Institute, Stockholm, Sweden <i>Maternal survival and the crisis in human resources for health in Africa: impact of the brain drain</i></p>
<p>Harry Lesser, University of Manchester <i>The free movement of labour</i></p>	<p>Samia Hurst and Nir Eyal, Geneva University Medical School and Harvard Medical School <i>Local Focus in Physician Training to Counter the Brain Drain</i></p>

Abstracts

Parallel session A: 11am-1pm

Panel A1: Global Justice and Global Institutions

Maureen Strasser Room (CBA 0.060)

Explaining the Global Crisis in Human Resources for Health – Political Economy of Migration and Market & Government Failure **Sanjoy Nayak, Royal Tropical Institute, The Netherlands**

Over the past few years, the human resources situation in the public sectors in low-income countries (the South) has reached a point of severe crisis and inability to provide basic health services (WHR 2006 and GHW & GHA 2005). UNAIDS estimates that an additional 3070 medical doctors, 5700 nurses and almost 106000 community health professionals needed *every year* in low-income countries over and above what is currently available in the health sector in order to deal with and scale up present level of care to the HIV/AIDS sufferers. One of the major factors contributing to this crisis is emigration of skilled health professionals (medical brain drain) especially from South and East Asia and sub-Saharan Africa where the problem is very acute.

Research also shows that international migration leads to internal migration: from rural to urban, public to private and from primary to specialist care. Inequitable distribution of human resources leads to inequity in access, utilisation and quality of health care services. This results in unequal impact on health outcomes and health status of the poor and marginalised especially in economically underdeveloped states. Unfortunately, international migration is so far absent from global health equity research agenda and hence no in-depth analytical work is available.

Estimates of the extent and scale of skilled health professionals immigration from developing countries confirm that it is a major phenomenon, e.g., from Ghana, 50% and 75% of each batch of graduates emigrate in 4.5 and 9.5 years, respectively. More than 60% of doctors produced between 1985 and 1994 had already left the country, mainly to the UK and USA. UN-ILO calculated that two thirds of Sudan's professionals had left the country and more than half of Zimbabwe, Zambia and Uganda's high level manpower did the same. In India, it is estimated that 40% of the doctors who work in the private sector migrate outside the country. In a previous paper this author has estimated conservatively that there are at least 100,000 doctors educated in India working abroad representing a transfer of capital value of \$51 billion for those going to the US, \$13 billion to Canada and \$3 billion to the UK *in training costs alone*.

The present paper discusses theories of (i) market failure, externalities, asymmetric information; (ii) global public goods and (iii) political economy of migration and inequitable resource use as the consequences of emigration of health professionals. In order to get a holistic picture, the paper discusses 'unquantifiable variables' by incorporating sociological and cultural theories of migration and global political economy.

Medical expertise like any other professional skill has become an internationally marketable commodity. The persistence of the problem reflects the ineffectiveness of the

policies so far implemented to reduce it. Remittances do not help health development because cost of training from public purse goes to private households or investments, or conspicuous consumption. Relevant international membership organisations, such as WHO, ILO, IOM, UNICEF, UNFPA and WTO, provide a forum for the potentially equitable and optimal information, negotiation and determination of global public goods for health that potentially affect the entire constituency of member states. Development agencies have an interest in ensuring that supply of global public goods is configured optimally for poverty reduction. The paper discusses the interface with global public goods (GPGs) through the international 'institutional architecture' for international collective action to formulate new policies and institutions to restrict migration including international financing of GPGs for health and the effect of recent GATS negotiations on further migration of health professionals.

Global Justice, Luck Egalitarianism and Global Health
David Hunter, University of Ulster

There is considerable controversy about global justice: that is claims about justice between and across the citizens in several countries. These claims about global justice typically entail various claims about global health since the global distribution of resources and wealth affects the global distribution of medical resources and health. There are several competing, broadly Rawlsian egalitarian accounts of global justice, however there are non-Rawlsian egalitarian theories which are little explored in regards to their global implications. A particularly popular alternative egalitarian account is luck egalitarianism which claims something like people ought not be worse (or better) off through no fault of their own. In this paper the implications of luck egalitarianism both in terms of the global distribution of resources and the global distribution of health care will be explored.

Highly Skilled Migration from Africa: What Can Game Theory Add to the Debate?

Tom Allan, UK Department of Health

'Brain drain' is the notion of losing highly skilled workers to developed countries and is considered unsustainable. This is often passively viewed as an unavoidable consequence of push and pull factors emerging from regional inequalities. However, in order to achieve welfare optimising gains from a situation of skilled migration, it is necessary for both developed and developing countries to cooperate. This may result in a more appropriate range of policy options. The difficulty is in the transformation of individual action of skilled personnel from developing to developed countries to collective action, which requires some form of collaboration between the receiving and sending countries, precisely co-responsibility.

Game theory provides a framework in which win-win situations can be sought through various mechanisms and policy options. Firstly information on brain drain, although considered a serious handicap to development, is lacking. Asymmetric information is one of the variables that does not allow both players to arrive at a satisfactory result. Secondly the argument that brain drain is always negative assumes that knowledge is territorial and geographical enclaves bind benefits of such knowledge. Besides the fact that on the global level knowledge increases global welfare, the benefits of African citizens that live and work abroad is considered insignificant.

The policy options given this framework can be grouped as welfare enhancing, and regional spillovers. Data on brain drain should be collected for both the purpose of rational collective action and for State coordination of the migratory process itself. Further, it is necessary to capitalise on the knowledge and skills of the African Diasporas. The coordination of Africans living in the Diaspora, their knowledge and its possible use in African countries should be another policy objective, which could enhance spillover effects of training and experience gained in developed countries. This would require precisely a collaborative effort to facilitate, organise and enhance transfer of knowledge from North to South.

Brain Drain, Rights, and Global Institutions
Alex Sager, University of Calgary, Canada

Critics of open borders frequently cite “brain drain” as a reason for maintaining restrictive immigration policies. Among the most serious concerns is that developed states recruit skilled health workers. These health professionals are badly needed in developing states, which often spend millions employing expatriate doctors, as well as incurring the expense of educating workers who emigrate to more lucrative markets. On the other hand, those who endorse more open immigration policies point to the effect of remittances, technology bridges and the benefits of circular migration, suggesting that the long-term result of migration is likely to help developing states.

I argue that this debate, grounded in consequentialist reasoning, is fundamentally misconceived. Instead, it should be carried out along two different axes. First, it's essential to emphasize migrants' rights and the corresponding duty of institutions at the state and international levels not to violate these rights. Second, an examination of international institutions that systematically disadvantage developing states is needed. Migration is not simply a matter of economic incentives, but is rather structured by social and economic institutions that have international scope.

Migrants' rights include the right to emigrate, as well as the right to freedom of opportunity (including free choice of employment). On this approach, I argue any policy that prevents health workers from seeking better opportunities abroad violates their human rights. It also smacks of hypocrisy and paternalism, dismissing the rights of individuals in the developing world. Brain drain is not limited to the developing world. For example, Canada has programs to keep Canadian trained doctors from migrating to the more lucrative US market. In this case, few would argue that the US should reshape its immigration system to prevent Canadian brain drain, despite the shortage of doctors in their northern neighbor.

At the same time, the focus on individual migrants obscures the more important fact that migration takes place against international and state-level institutions. Instead of engaging in doomed policies to provide incentives and penalties to keep migrants in their place of birth, efforts should be rededicated to structural and institutional factors that lead to their emigration. Root causes include the lack of health care institutions, corruption and insecurity in developing states. 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 IMF, and major political actors such as the G8, there is a moral obligation to reform these institutions. At the same time, developed states have come to rely on cheap, international health care labor and not devote enough of their resources to training professionals (e.g., nurses). Reform of all of these institutions would go a long

way towards addressing the problem of brain drain and guarantee the rights of individual migrants.

Panel A2: New research directions

Room CBA 1.098

What Keeps the Doctor Away: A Probe into the Filipino Medical Diaspora **Lalaine Siruno, University of the Philippines**

The Philippines is now considered as the largest exporter of nurses and caregivers around the world. It is sending medical doctors, licensed engineers, teachers and other professionals to work as nurses to countries which promise them and their family a hefty income and a comfortable lifestyle.

From the armchair, the medical diaspora can hardly be blamed on these people in need and in want of means to live better lives. With meager salaries and deplorable working conditions, seeking greener pastures is not only practical; it even seems to be reasonable. A bigger question however, is whether it is also justifiable from the moral point of view. While a lot of Filipino health workers are doing service in foreign lands, their fellow citizens are left without adequate medical supervision and healthcare provisions. It is estimated that 40% of Filipinos would never see a doctor in their lifetime. Without a medical staff, many hospitals particularly in the provinces did not have a choice but to close down.

With this as backdrop, the paper re-examines the notion of rights vis-à-vis moral duties and obligations on the personal and social levels. It explores philosophical arguments for and against instituting robust limitations to health worker migration, which may be helpful in drawing solutions to this global health crisis and undertaking appropriate courses of action.

Migration Intentions of Pharmacy Students – A Global Study of Root Drivers

Tana Wuliji, University of London/International Pharmaceutical Federation

Co-authors: Professor Ian Bates², Professor David Taylor¹, Dr Sarah Carter¹;

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International migration of health professionals is thought to point towards the widening global inequalities. It is also an indicator for deteriorating health systems, working conditions and opportunities for health professionals. Research and policy debates on the migration of health professionals tend to centre on 'push-pull' theories, supportive of mainstream over-simplification of a complex phenomenon. There is a paucity of research on root drivers of migration and potential opportunities for policy intervention to strengthen human resources and health systems in countries, particularly concerning the pharmacy workforce.

We report on the first international attempt to investigate the migratory intentions of pharmacy students and identify root migration drivers. Responses were gathered from 800 final year students from nine countries: Australia, Bangladesh, Croatia, Egypt,

Portugal, Nepal, Singapore, Slovenia, and Zimbabwe. Analysis yielded three main constructs that correlate with the intention to migrate. These describe attitudes towards the professional practice environment and perceived status of the profession in the home country; perceptions of opportunities for economic and professional development abroad; and attitudes towards the social and political environment in the home country. These represent drivers of migration and together with other demographic descriptors, influence the decision to migrate.

This research together with other emerging evidence, suggests that the 'brain drain' is neither the cause nor the solution to the human resource for health crisis. Given that the country context and environment is critical in determining migration intentions, research and policy should approach migration as being synonymous with workforce attrition and hence symptomatic of wider imbalances.

Brain Drain of Health Care Workers in Poor Countries and Self-Sacrifice
Anne Raustøl, University of Reading

This paper concerns some moral challenges that the individual health care worker faces when being torn between a duty to generate good and a partial concern for oneself and one's family. The duty to generate good may suggest that the health care worker stays in her country and provides health care services to the country's population. The partial concern towards her own good and the good of her family may suggest that she will be able to benefit herself and her family radically more by leaving her country to work as a health care worker in a wealthier country. It is a common view that our duty to help others who suffer is limited by a certain level of self-sacrifice. I will argue that the loss in benefit for one's own if the health care worker stays in her country instead of leaving for a wealthier one is so large that staying can be characterised as a supererogatory act. But some factors complicate the picture. Firstly, if we want to give some priority to the worst off, then it seems problematic to say that it is morally permissible for the health care worker to leave. The loss in benefit for the patients if the health care workers leave is greater than the loss in benefit for the health care workers would be if they stayed. The fact that the consequences of not having access to health care services can be fatal outweighs the potential radical economic and social benefits for the health care workers. Secondly, if we assume that proximity and immediacy of the suffering of other people has moral relevance, then we might favour that the health care worker was staying despite the large self-sacrifice. I will cast doubt on whether these two factors have moral relevance in our case and conclude with that the health care worker cannot be morally expected to stay in the country.

Skill Transfer and the Discourse of Ethics: The case of South African Migrant Nurses in the UK
Colleen McNeil-Walsh, University of Birmingham Business School

The migration of South African nurses to the UK over the last decade has raised significant concerns over the loss of nurses and nursing skill to South Africa's already overstretched public health care sector. Such concerns have been voiced by regulatory bodies and policy makers at national and international level in South Africa and the UK.

This paper focuses on the transfer of skill. The central argument of this paper is that skill transfer is shaped by and takes place within a discourse of ethics that creates a context of complex interactions in which the rights of individual nurses to migrate, the needs and

rights of citizens to adequate health care provision, and the duty of receiving countries to act responsibly and ethically are played out in very dynamic ways. The argument highlights the political nature of skill and suggests that in the real life context, skill is bargained over at a number of levels, involving bi-lateral agreements, ethical codes of recruitment, and the staffing needs of health care settings. The impact of these policy developments on the ability of nurses to migrate is considered in the light of the current decrease in migration of nurses from South Africa into the public health care sector and hence highlights the tension between the rights and needs of individual migrants, the needs of health care sectors, and calls for return migration. To illustrate the argument presented in this paper, life-story interviews with South African nurses and interviews with key informants from South Africa and the UK are drawn upon.

Parallel session B: 2.00-3.30pm

Panel B1: Work and Exploitation

Maureen Strasser Room (CBA 0.060)

The Road to Nowhere: Trafficking of Skilled Labour Migrants in the UK Health and Care Sectors

Christien van den Anker, University of the West of England

In this paper I will set out the specific case of health workers in the wider perspective of the global division of labour and the commercialisation of care. Despite the Skilled labour migration regulations skilled migrants get caught up in trafficking, too. The now famous case of migrant nurses being trafficked in the UK while working within the NHS will be analysed and local cases in the West country will be used to illustrate how due to discrimination of employers and lack of options once the one-year visa expires, exploitative jobs are viewed as the only option. The paper will argue that the restrictive and complex migration regime in the UK is a major contributing factor, in addition to multiple dependency, lack of awareness of rights and structural factors in the global political economy.

Exploitation in the International Migration of Health Workers

Jeremy Snyder, Simon Fraser University, Canada

The migration of health workers from the Developing to the Developed World is often condemned as exploitative. Three charges of exploitation are typically levied. First, exploitation can arise from a misrepresentation of the terms of service for migrants. This form of exploitation is heightened by the distances involved in migration as well as linguistic and cultural barriers to communication between employees and employers. Second, exploitation can occur when members of the Developed World place health workers from the Developing World in dysfunctional health systems that fail to train or retain domestic health workers. The dysfunctional systems, and the poor working conditions they entail for immigrant workers, are perpetuated by the lack of better options for foreign health workers. Finally, exploitation can arise when members of the Developed World take advantage of the educational and health care spending of Developing World nations without a fair return for these expenditures.

In this paper, I will evaluate these charges of exploitation. I argue that the term 'exploitation' can be used to articulate a variety of moral wrongs. I identify four relevant forms of exploitation understood as wrongfully benefiting from another's vulnerability,

including: 1) benefiting from a rights violation; 2) benefiting from global or background injustice; 3) unfairly benefiting from another person; and 4) benefiting from another person without fully discharging one's duty of beneficence. I conclude by assessing which of these forms of exploitation are being faced by migrant health workers and suggesting policies for avoiding exploitation.

The Role of Trade Unions in the Brain Drain

Nick Sigler, UNISON

Trade unions have a unique role to play in issues relating to the international labour migration of health workers. As practitioners – for instance, in partnership with affected unions in the south and organising migrant workers in the UK – and as advocates to governments, north and south, trade unions have a particular perspective on these issues.

This contribution will look, inter alia, at:

- Why a global response is needed to the global shortage of health workers;
- The role that trade unions play in putting the case for effective public services – and how that case can be undermined by labour migration;
- The role trade unions can and must play in developing strategies to protect individual's human rights, their right to migrate and their right to a better life while recognising that these might conflict with certain collective rights;
- The role of trade unions in the protection of labour rights in sending and receiving countries
- The role of trade unions in improving pay and conditions in sending and receiving countries in order to curb some of the factors leading to migration
- The need for changes, and greater coherence, in a range of government policies and international agreements.
- Proposals for new and innovative strategies for dealing with some of these challenges

The contribution will draw on the extensive experience of UNISON's international work, our role as a trade union representing some 1.4 million public service workers and our collaboration with the Global Union Federation, Public Services International.

Panel B2: International Approaches and Policy

Room CBA 1.098

Emerging Trends, Challenges and Issues in Regulation of Migrating Nurses

David Benton, International Council of Nurses

International trade agreements have existed for decades. Today's agreements also influence the migration of workers across borders, in addition to agriculture and manufactured goods. These migrating workers account for millions of dollars in remittances to their families at home. Nations need more than migrant and seasonal workers. No group is in higher demand than nurses. The General Agreement of Trade in Services is one of the World Trade Organization agreements among 140 countries. The goal is that first multilateral rule is to remove any restrictions and governmental regulations in international trade in services. One area of service trade is individuals to

supply services in another country. This “movement of natural persons” includes professionals in specialty occupations, nurses and other healthcare workers. The North American Trade Agreement’s primary focus was to remove barriers to trade and investment among the United States, Canada and Mexico. It allows easier migration of professionals. Those provisions are reflected in the United States Immigration Nationality Act, which governs the certification of healthcare workers and affirms the U.S. maintenance of professional standards and licensure for protection of public health. The European Union applies the EU principle of “free movement” of persons as they also work on a system of mutual agreements. Participation in these trade agreements, which promote professional migration, may be an incentive for economically strapped nations. The emphasis of this lecture/paper is to address the development of international markets in healthcare service as a result of international commercial policy, such as trade agreements.

Global Justice and Global Health: Exploring ‘Migration Threshold’ Regulation

Sameer Chaturvedi, NTNU, Norway; Linköping University, Sweden

Migration of people from one place to another has been an age-old phenomenon. Since time unknown, the quest for security and advancement has lead people to leave for strange as well as distant destinations. But the recent advent of specific patterns of migration has emphasised the need to theorize and deliberate such movements. On the one hand the matter of concern is to regulate the movement of unskilled people who yearns to enter better-off and more promising countries with or without legal channels. This is important for receiving side. On the other hand, when it comes to skilled and highly skilled personnel, it is the sending side which gets affected more in terms of loss which can be referred to as brain drain.

In this light, this paper explores the ways to deal with the challenge arising of out-migration of health professionals. It is divided into three parts. The first part begins with outlining some trends in the movements of health professionals globally. In the later part, it shows why these trends have to be conceived of as global problem. The second part analyses the extent to which the literature pertaining to global justice theory suffices in coping up with the problem. In brief, there are global egalitarian thinkers who call for either relaxing the immigration policies of the well-off countries, or facilitating global distribution of wealth. But the current problem remains untouched. The third part assesses the need and feasibility of certain global institution to deal with the problem in such a comprehensive way that the gap arising out of incoherence in the demand-supply of health services could be curtailed. The idea of facilitating ‘reverse migration’ has also been mooted so as to encourage brains of the developed countries to serve in developing countries for certain duration. On the whole, the paper endeavours to link the regulation of such ‘migration threshold’ with global aid reforms in such a way that the ongoing trend can be universally checked. It also takes up some ethical issues which might come in the way of putting up such global regulatory framework.

How can the different approaches to understanding international migration contribute to a multi-dimensional policy framework for the migration of health professionals in both sending and receiving countries?

Giulia Greco, London School of Hygiene and Tropical Medicine

The present paper attempts to provide 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 presents an overview of the patterns and scale of the international migration of health professionals and its major impacts on the health systems of developing countries. It is crucial to investigate the variables that influence this global phenomenon in order to develop ad hoc policy responses.

Analysis and policy recommendations start from three different analytical frameworks of international migration: the economic approach (including the “push and pull” theories); the historical-structural approach; and migration systems theory.

The proposed models function at different level of analysis. Even though the assumptions, hypotheses and arguments resulting from each theory are not intrinsically clashing, they lead to different implications for policy making. Depending on which theory is used and under what conditions, different policies are put forward to cope with the problems created by the migration of health professionals.

It is argued that the analysis of the factors influencing health professional migration must go beyond only the individual or household perspective and beyond the responsibilities of the sending and receiving countries. It is necessary to widen the perspective through different levels of analysis so as to create a multidimensional framework for policy analysis and implications.

Parallel Session C: 4-5.30pm

Panel C1: Philosophy, Migration and Rights

Maureen Strasser Room (CBA 0.060)

Migration and Human Rights – The Case of Health Care Professionals **Philip Cole, Middlesex University**

This paper asks what happens if we attempt to balance the human right to health with the human right to migration. Although international law – and most liberal political theory – is reluctant to accept a human right to inward migration, the right to outward migration is held to be fundamental. On the face of it, then, medical professionals have a fundamental right to leave their country of origin (and medical training), to seek employment elsewhere. However, under international law, states can derogate certain international rights, including the right to leave, in critical circumstances, and one such circumstance is public health. Given that most agencies would agree that the provision of health services in developing countries is being thrown into crisis by the emigration of health professionals, do those states have the right to prevent their health workers from leaving? One consideration here is, firstly, that developed states claim that their right to prevent inward migration is justified by hypothetical and marginal threats to their people’s welfare, and secondly, that the liberal theorists’ claim that there is a real moral difference between immigration and emigration that justifies state control over the former and not the latter is often assumed, rather than explicitly argued for. Given that the people of developing world face a very real and serious threat to their medical welfare, is the position taken in liberal political theory and by the practice of developed liberal states merely a case of hypocritical special interest pleading, rather than a principled and defensible strategy? As well as outlining the position in international law (in particular the important role of the Siracusa Principles), this paper explores the complex and difficult relations between the right to health and the right to migration.

Can Border Controls Be Used To Stem Brain Drain? **Kieran Oberman, St Cross College, Oxford**

The conventional answer to this question is that the poor state itself cannot prevent its skilled citizens from leaving as this would violate the right to exit but rich states can prevent them from entering and thus reduce the incentive to leave. My paper argues against this conventional view. I argue that no state, whether it is the poor state of origin or rich state of destination, can restrict the freedom of skilled workers to travel overseas unless (a) these workers are above a minimal welfare threshold, (b) those restricting the borders have met their duties of distributive justice towards the workers and (c) that every reasonable effort has been made to enable the workers to meet their duties towards their poor compatriots without the use of border controls.

My argument for condition (a) is that no one has a duty to assist another if it would thereby imperil themselves or their families. Condition (b) is supported by the claim, which even some border control advocates have accepted, that states cannot exclude those they have denied their due. My argument for (c) is more controversial since it relies on the claim that people have a human right to international freedom of movement that entails not only a right to exit one's own state but also a right to enter other states. I nevertheless defend this claim against a number of objections. I conclude that states must try other measures, such as an emigrant tax, to ensure skilled workers meet their duties to their poor compatriots before they stop them from travelling overseas.

The Free movement of Labour **Harry Lesser, University of Manchester**

A major ethical issue regarding the migration of skilled medical personnel from the developing to the developed world is the question whether there should be a right to sell one's skills and labour wherever one can, so that one has no right to interfere with movements of this kind. Two arguments for this can be given. One is that the consequences of this freedom are beneficial, having the consequence that skills both go where they are needed and get their appropriate reward. But empirically this is often the case, but not always: harm can be done to the "hosts", as when imported labour results in loss of jobs and/or depressed wages, and to the people left behind, who may, as here, be deprived of badly needed skills. So the utilitarian argument may fail.

But the case for free migration can then be argued on the ground that one owns one's skills and has an absolute right to decide where to sell them, if there is a buyer. To this one may reply that property rights are not always absolute, and two considerations should limit this property right: the harm done by the migration and the duty owed to the country that gave the person their training, especially if people are making sacrifices to bring this about. The reply to these points may be that 1) only the doing of direct harm should limit a property right, and 2) no formal contract was made at the time of the training. And the reply to this is that 1) whether the harm is direct or indirect is irrelevant, if it is serious enough, and 2) there is an implicit contract being made, that the cost of training should be repaid. As a conclusion, one may suggest 1) that this suggests there is no injustice in limiting the free movement of labour when necessary, and 2) that, though training may create an implicit contract, it would be better to have formal agreements requiring a period of time to be spent in one's home country, or even some specific part of it, as in Sri Lanka. It may indeed be that justice positively requires this.

Panel C2: Local approaches and innovation

Room CBA 1.098

Medical Tourism as a Way to Stop Brain Drain –A Case Study **MV Lakshmi Devi, R.B.V.R.R.W's College, India**

For its [World Health Report 2006](#), the *World Health Organization* (WHO) noted that there is a global shortage of 4.3 million doctors, midwives, nurses, and support workers. Although the total shortage of health professionals worldwide is estimated at around four million, most of the demand is concentrated in industrialized countries, due to largely demographic reasons.

Many studies on migration of health workers and doctors identified certain trends. The majority of the migrating health workers come from the world's least developed countries, especially in Africa and Asia, where health professionals typically earn low wages and have little prospect for advancement in their careers. Other reasons for emigrating are a poor working environment and lack of motivation.

The other side of the coin is seen in industrialized countries, which have ageing populations and declining birth rates, making it difficult to replace retiring health workers, and creating a large proportion of people with special healthcare needs. This is illustrated by two of the countries with the "oldest" populations, Japan and Italy. By 2050, Japan will have 77 pensioners for every 100 workers, compared to 30 for every 100 in 2005. And in Italy, the ratio will have risen from 30 per 100 to 75 per 100.

By contrast, the developing countries have reduced infant mortality in recent years, and while fertility rates are slowly declining, the future is expected to bring an explosive increase in the number of young people entering the labour market.

These trends in the developing countries created opportunities to control brain drain of health workers from developing countries particularly India. India has developed medical tourism. The present study is an attempt to examine the role of medical tourism as a way to stop brain drain. The objective of this paper is to understand the role of health policy in promoting medical tourism so that health workers' migration could be reduced. Data is collected from the government officials, doctors and other health workers to analyze the impact of the health policy on brain drain of health workers.

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

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In the absence of doctors many African ministries of health have decided to train midlevel health workers to execute tasks traditionally assigned to doctors. In Mozambique a new category of surgically trained assistant medical officers ("técnicos de cirurgia") were created in 1984. In Malawi "clinical officers" have been trained also in surgery for several years. In Tanzania "assistant medical officers" are trained since the early 1960s. We have shown that the postoperative outcomes of caesarean sections by non-physicians versus physicians in Mozambique are almost identical. There we also

followed three graduated groups of physicians and three graduated groups of non-physicians (same years), trained for surgery. Seven years after graduation zero per cent of the physicians were at district hospital level, against 88% of the non-physicians. We have also found that the cost-effectiveness of non-physicians in performing caesarean sections is three times better than for physicians. The population's perceptions of non-physicians in major surgery are overwhelmingly positive.

Though the brain drain has a devastating impact on maternal survival in most African countries there is a clear trend to train non-physicians to perform tasks and duties conventionally handled by physicians. The consequence of this task-shifting scenario may be that we have to redefine which category of health care provider is most cost-effective to save mothers' lives and best retained in areas where maternal mortality and other emergencies are predominant. The need of medical doctors is, however, paramount in training of the non-physicians and in supervising the quality of care provided by them.

Local Focus in Physician Training to Counter the Brain Drain

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Assuming that the basic health of the world's poorest and least healthy populations takes the first ethical priority, reducing physician brain drain is urgent. However, to do so ethically and efficaciously is no easy matter. We propose that, in resource-poor countries that lose physicians from medical migration, reforming medical training could help increase doctor density. Suppose that local medical schools trained physicians mainly for locally endemic diseases, practice in conditions of scarcity, and the use of "brain-based" technologies such as epidemiology, teaching skills, and decision analysis. They would not train them for expensive Western-style practices. Rather than falling into a demeaning "barefoot doctor" model, true local focus would actually improve care. Doctors' skills would chime in with local needs because graduates could offer poor local patients specialized care. It could also help decrease graduates' emigration rates in five ways. First, training for local practice would make that practice more in tune with graduates' expectations, and thus less frustrating. Second, these graduates would be less attractive for Western employers. Third, they would find it more difficult to secure licensure in the West. Fourth, training students for local practice would require mentoring by experts in local practice, writing and review of locally adapted guideline, and special health research—avenues for regional career development options that could attract doctors to stay. Fifth, it could enhance the professional prestige of local practice in the eyes of former mentors and fellow graduates, as well as international colleagues, increasing its allure. Local focus in training avoids several pitfalls that threaten other strategies to counter physician brain drain. It does not require antagonizing regulatory constraints against migration; the cooperation of disinterested Western governments; prohibitively expensive work incentives; or harm to the quality of medicine in source countries. Five specific worries about it can be addressed.

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