An Ethical Analysis of the Global Medical Brain Drain

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INTRODUCTION

The 'medical brain drain' refers to the mass movement of health care workers from low and middle-income countries (LMICs) to high-income countries, resulting in gross shortages of health care workers in LMICs.1 Strong notions of medical workers' duty-to-stay in their home country and of equal rights to the life and health of citizens in source countries are important arguments in emphasizing the unethicality of the medical brain drain. I spent part of my childhood in Lagos, Nigeria, and I witnessed some of the detrimental health outcomes individuals experienced when they did not have access to health care.

ANALYSIS

Current statistics show that there are 1.95 medical workers per 1,000 individuals in Nigeria.4 Lagos is a major city, but in the midst of the daily movement of millions, no reliable network of emergency care exists. As a result, fatalities from car accidents and other medical emergencies are frequent. When individuals sick with chronic or communicable diseases are able to reach one of the few major public hospitals, there are long lines to receive care. There are no policies regulating the distribution of workers, so public agencies deploy workers at their own discretion, which complicates the shortage because these agencies often have conflicting interests in where to assign workers.4

Driving forces such as poverty and political instability intensify the mass emigration of health care workers from LMICs, resulting in critical shortages of remaining workers to meet the basic health needs of citizens in these countries. Medicals workers emigrate for better employment opportunities, to earn higher wages, and to secure the future of their family.3, 6 Other factors include a desire for safer working conditions with greater resources. This is relevant especially in Sub-Saharan African countries whose immense burden of HIV/AIDs and resource limited settings overburden medical staff, who work long hours in conditions often lacking proper protective medical equipment.3, 7, 9 Paradoxically, the emigration of these medical workers further exacerbates the problems that served as the initial driving forces for their migration. Political instability and war are other significant factors that spark high migration rates from medical workers.

Widespread agreement exists that the medical brain drain severely undermines the capacity of LMICs to develop competent health care systems.2-4 Efforts at the national and international levels to impose policies

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encouraging against the medical brain drain have lacked implementation and remain largely ignored.2 As LMICs increasingly suffer the harmful effects of the medical brain drain, a debate continues over the morality and legality of international health care workers migration and of the policies used to address this phenomenon. A number of important questions are raised in this debate including: Who is to blame for the recruitment of skilled medical workers to high-income countries such as the United States? Is it wrong for medical workers to emigrate or are they rightfully exercising their human rights? Do migrating medical workers have a responsibility to remain in their home country?

The migration of medical workers is part of the current global-health workforce crisis characterized by the severe shortage of health care workers in countries suffering from high burdens of disease.5 The World Health Organization (WHO) estimates that over 4.3 million health care workers are needed to effectively combat HIV/AIDs and other diseases, reduce child mortality and improve maternal health.3, 6-7 The WHO's estimate only accounts for shortages of health care workers in 57 countries experiencing "critical shortages," and does not account for countries experiencing shortages in the capacity to provide basic health services (see Figure 1).5-6,8 36 of the 57 countries are in Africa, a continent experiencing 25% of the global burden of disease yet possessing far less of a capacity to provide care to its inhabitants (see Table 1).6 The far-reaching realities of the medical brain drain are not entirely captured by existing data.

The conflicting fundamental moral units (FMUs) of important stakeholders contribute to differing views held about which policies are morally justifiable to address the medical brain drain and is cause for the objections of some against viewing the medical brain drain as an unethical (see Table 2 for further elaboration). 9

Objectors claim that medical workers have the right to leave their country and to choose their profession (see Article 13, UDHR). 16 But the effects of these individuals' decisions raise significant ethical issues when aggregated at the societal level. One of the questions frequently raised in this debate is whether the freedom of movement of health care workers to migrate for professional reasons should be limited. It is important to acknowledge the conflicting fundamental moral units of two stakeholders involved: that of the health care worker is at odds with that of the source country and its inhabitants.

Least restrictive means approaches should be used to limit the migration of health care workers. These approaches are ethical on the grounds that when healthcare workers emigrate from source countries, thousands of individuals are left without access to adequate health care, which is a violation of their right to life and well-being. Rawl's justice theory offers the *Veil of Ignorance* as a thought experiment that allows us to consider what principles to govern life individuals would choose if we were all in an original position of equality to make this decision.14 From this position, all would choose principles that guarantee equal basic liberties for all, to avoid later ending up in the oppressed minority. The injustice evident in the context of the medical brain drain are grounds for employing non-restrictive policies, such as a compulsory service requirement, to curb the emigration of health care workers while preserving everyone's liberties.5

Source and destination countries disproportionately experience the distributions of benefits and burdens of the medical brain drain. Destination countries experience numerous benefits of added medical workers to strengthen their health systems without undergoing the cost of training these professionals. These benefits include: less need to meet the growing demand of health care workforce, added stability of health systems, and less need to invest in national medical education.9 The medical brain drain has been referred to as "reverse foreign aid" because it is a movement of health care workers from LMICs to support high-income destination countries.5 Others have described the medical brain drain as a sort of "theft" from poor countries by rich countries.

Objections have been raised against these claims, stating that destination countries long stopped actively recruiting health care workers and thus have no obligation to address the effects of the medical brain drain. Though these destination countries may not participate in active recruitment of health care workers from LMICs, they participate in "passive recruitment" of health care workers. Passive recruitment occurs when health care workers indicate their interest to emigrate due to attractive factors in the destination country that make the emigration process easier: the creation of new points systems for immigrants and the establishment of entrance exams in LMICs to medical schools in destination countries.21, 22 Passive recruitment still has detrimental effects on the capacity of source countries to meet the health needs of its inhabitants, and this makes destination countries obligated to rectify the effects of their passive actions.

Others point to the difficulty of documenting the effects that migration of healthcare workers has on health systems and outcomes. They believe that the effects of the medical brain drain are difficult display and slow to perceive.5 They provide alternative factors, such as internal geographical misdistributions of medical workers, as "better" reasons for the poor health outcomes in source countries.23 Fixation on alternate factors distracts from the fact that passive recruitment actions of destination countries results in a disproportionate distribution of health care workers to destination countries. This inequality is an issue of distributive justice, in which the policies and programs of destination countries exist as a pull for foreign health care workers to emigrate. Source countries have not received any remuneration for the losses in human and social capital experienced, thus destination countries are obligated to rectify these losses.

CONCLUSION

The international community has taken an important step in adopting the WHO Global Code to tackle worker shortages in LMICs by acknowledging that ethical norms must be used to guide cooperation on the issue of the migration of health care workers. The code has been ineffective though because of its non-binding nature and lack of incentives to guide destination countries to adopt national policy changes consistent with the code.12 When asked about the impact of the code, a Sudanese official remarked that, "*as far as the WHO Code is voluntary and as far as beneficiary countries in the region do not have media or civil groups pressures, they will not be part of this code, I do not think there is hope!*" 2 The WHO must employ pressure through the media to mobilize national civil groups as a tactic to prompt destination countries to employ policy changes that address these countries' roles as passive recruiters of foreign health care workers.2

*Figure 1. Expatriation Rate of Doctors*8

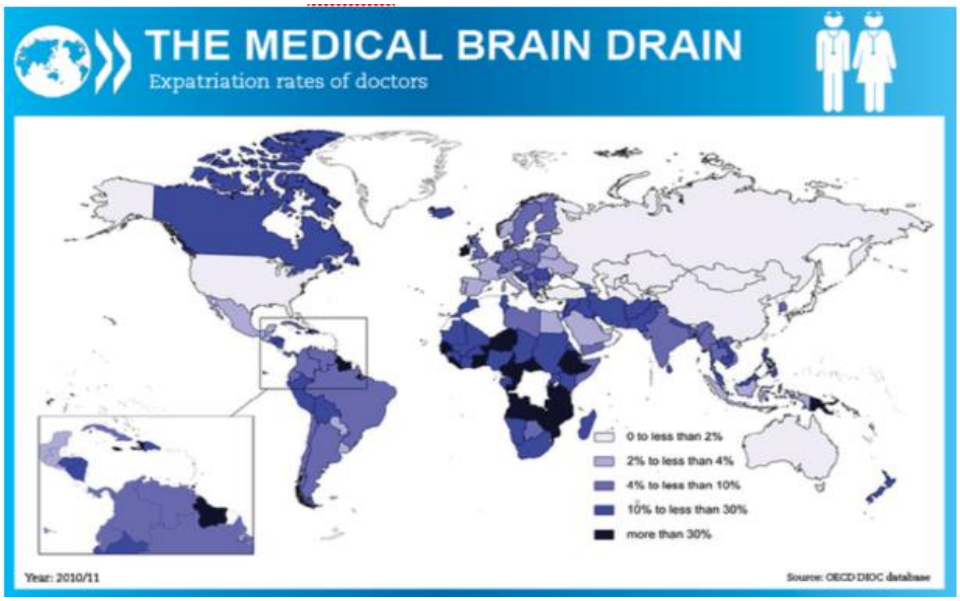

*Table 1. Global Health Workforce by Density*6

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WHO region	Total health workforce	
	No. (millions)	Density (per 1000 population)
Africa	1.6	2.3
Eastern Mediterranean	2.1	4.0
South East Asia	7.0	4.3
Western Pacific	10.1	5.8
Europe	16.6	18.9
Americas	21.7	24.8
World	59.2	9.3

*Table 2. Specific Ethical Challenges in the Medical Brain Drain*9

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Stakeholders	Fundamental Moral Unit	Harms	Burdens	Benefits
Source Country & Inhabitants	○ Relationship between persons ○ Community integrity	Direct Harms: ○ Deprivation of access to health care ○ Worsened burden of disease and death of inhabitants lacking access to care ○ Worsened structural systems due to increased burden of disease Indirect Harms ○ Neglected by destination countries who refuse to sign/adhere to WHO Code of Practice	○ Shortages in domestic healthcare service capacity ○ Financial loss in investment of training and educating the workforce ○ Decline in morale and commitment among remaining workers ○ Loss of social and human capital ○ Knowledge spillover losses ○ Undermining institution building and development as a whole ○ Loss of expert knowledge in academia and education centers	○ Improvement in skills of returnees ○ Remittances received from people working abroad ○ Collaborative partnership between diaspora and local professionals
Destination Country	○ Individual rights to emigrate	--	○ Some administrative costs involved ○ Enhanced local competition	○ Relief of supply shortages ○ Improved quality of healthcare
Health Care Workers	○ Individual right to emigrate and to pursue employment opportunities	--	--	○ Increased employment and wage opportunities ○ Political stability ○ Future security of families

Source: Adopted from Stewart, Clark, and Clark (cite) and Aluttis et al and further enhanced by Christiana Oshotse.
"—" Denotes that no information is applicable to this position

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