THE MORAL PARADOX OF THE “BRAIN DRAIN”

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INTRODUCTION

THE BRAIN DRAIN

In the 1960’s the British Royal Society coined the term ‘brain drain’ to describe the migration of scientists, physicians, and engineers from Britain to North America (Cervantes). Over the past three decades, the “brain drain” of educated professionals from less affluent to more affluent nations has become a widely discussed global phenomenon. This thesis will focus on the migration of physicians from developing to developed countries. In the thesis, I will offer a description of the brain drain in health care and an analysis of the moral and social problems it poses.

Chapter 1 of the thesis will provide an overview of the brain drain in health care. The developing countries from which physicians emigrate face serious consequences as a result of this brain drain. As physicians depart, these “donor” countries may make an attempt to train more physicians to provide health care for their citizens. If emigration continues, however, a low physician-to-patient ratio may persist. The number of physicians needed to maintain an effective health care system may not be sustained, and those physicians who do remain will confront deteriorating working conditions, fueling a vicious cycle of emigration. As physicians migrate to the developed world, hospitals and clinics become understaffed, the overall standard of care declines, and the national burden of untreated disease increases. A stark example of this is the spread of tuberculosis and HIV/AIDS in the sub-Saharan region of Africa (Mukadi). The exodus
of physicians also causes broader economic problems for developing countries. The departure of physicians who sustain the nation’s health care infrastructure can undermine prospects for economic development for the affected countries. Because developing countries often use public funds to educate physicians who eventually emigrate, those countries receive little return from their education investment.

The remainder of the thesis will examine the moral implications of the brain drain in health care, focusing on the major stakeholders in this global phenomenon. Chapter 2 will evaluate the role of individual physicians who leave their home countries to practice elsewhere. Chapter 3 will consider the role of more affluent nations whose health care systems recruit physicians from abroad. Chapter 4 will focus on the role of less affluent nations that experience a loss of physicians through emigration. In each of these chapters, I will discuss the reasons underlying individual and collective decisions and assess the justifiability of those decisions. A final chapter, Chapter 5, will be devoted to a review and evaluation of proposed strategies to address the problem of the brain drain in health care.

Chapter 2 will begin with an investigation of the reasons why physicians leave their home countries. In doing so I will argue that it is the physician’s choice to leave his or her home country. This argument is supported by a study of physicians trained in South Africa, 93% of whom had been motivated to emigrate by a wish to leave South Africa (Arnold). A complex interplay of political, social, and economic factors can cause the flight of physicians from their home countries. Better pay, working conditions, career prospects, and educational opportunities for individuals and their families are all “pull” factors that encourage physician immigration.
After reviewing statistical evidence based on comparisons of economic and social factors in developed and developing countries, I will evaluate the moral grounds for physicians’ decisions to emigrate. It is difficult to criticize the desire of individuals to seek a more satisfying quality of life for themselves and their families. Hundreds or thousands of individual physicians’ decisions to emigrate, however, can create a major social problem for a developing nation. These nations may claim that physicians have a moral obligation to practice in the nation that has subsidized their professional education. May nations then restrict the freedom of movement of physicians, or is this a violation of individual autonomy?

Chapter 3 will examine the role of developed countries in recruiting foreign physicians. I will first describe in depth the “pull” factor of recruitment that the developed countries actively use. Despite an increased number of medical graduates, developed countries still lack sufficient doctors to meet their needs, especially in poor and underserved areas. Recruitment of foreign medical graduates relieves these continuing physician shortages, without the financial burden of training more physicians at home (Bundred and Levitt). The UK’s National Health Service, for example, has become dependent on health professionals from the developing world (Martineau). Along with the individual choices of physicians, the recruiting practices of developing nations require moral evaluation. I will examine the following questions: Is it unethical for wealthier countries to recruit foreign medical graduates away from their home countries? Are these foreign medical graduates receiving fair treatment, or are they being exploited? Is recruitment of physicians permissible from some foreign countries, but not others, and if so, on what grounds?
Chapter 4 will focus on the plight of developing countries affected by the physician brain drain. Low pay and poor employment conditions in the source countries are “push” factors that entice physicians to emigrate. Unstable economic conditions in these countries restrict job security, limit opportunities for career development, and do not allow increases in physician remuneration. Many of the donor countries also bear a heavy disease burden with little prospect of relief; this may stimulate physicians to cross national borders in pursuit of better working environments that are not overwhelmed with illnesses such as HIV/AIDS. Another internal problem in some developing countries is political instability and turmoil. Concern about personal security in areas of conflict puts pressure on those who can leave to do so. All of these factors may make it difficult for developing countries to take effective action to prevent the emigration of native physicians.

Chapter 5 will examine proposed solutions to the problem of the physician brain drain. I will identify and evaluate strategies that can be adopted by both developed and developing countries. Among the strategies that recruiting countries might adopt are international agreements to reduce reliance on recruiting foreign medical graduates, linked with efforts to increase the number of locally trained physicians. An example of this strategy is the British government’s ethical guidelines to reduce the dependence of its health system on foreign immigrants (Hooper). Another strategy would be to have the recipient country reimburse the “donor” country for the cost of an emigrating physician’s medical education. A third strategy would focus on modifying the geographical distribution of doctors inside of the developed country to increase the number of physicians working in underserved areas. A final strategy would focus on assisting less
developed countries in modernizing their medical education systems, emphasizing basic clinical skills rather than advanced technology.

Strategies available to donor countries include directing resources towards improving pay and working conditions of their physicians. Another strategy would be to require physicians to repay their medical education costs themselves before emigrating, or begin paying as soon as they begin work in the recipient country. Another strategy would be to increase the number of graduates produced annually, or to tailor the education of physicians or mid-level health professionals to address the health needs of their home country and to limit training in areas in demand in other countries. Other educational strategies would be to increase the time needed for a graduate to be fully registered or train clinical officers who may not be qualified in medicine, but are trained to do procedures traditionally done by doctors.

In summary, this thesis will examine the moral paradox of the brain drain in health care, that is, the fact that multiple, apparently defensible individual moral decisions can result in a major problem of global justice. I will argue that individual physicians may make decisions to improve their lives by emigrating, but that these decisions may also be limited by the country that finances a physician’s medical education and by the adoption by developed countries of fair recruiting practices.
CHAPTER ONE

INTERNATIONAL MIGRATION OF PHYSICIANS

The migration of health care professionals has occurred for as long as medical services have existed. Whether from village to village, city to city, state to state, or country to country, this migration has enriched the professional and personal lives of practitioners and the health of their patients. Although professional migration is not a new phenomenon, various factors have led to its steady growth over the last few decades. In the 1960’s the British Royal Society coined the term ‘brain drain’ to describe the migration of scientists, physicians, and engineers from the United Kingdom to North America (Cervantes & Guellec, 2002, p. 1). Over the past three decades, the ‘brain drain’ of educated professionals from less affluent to more affluent nations has become a widely discussed global phenomenon.

Early studies of the migration of educated professionals viewed it primarily as a solution to the growing demand for skilled workers in developed nations. A study headed by F. J. Van Hoek of the Institute of Social Studies concluded that scientific and technological developments in developed countries caused a shift in emphasis from labor-based to science-based capital formation (Van Hoek, 1970). This shift increased demand for skilled workers, such as health care personnel, in richer nations. A study conducted by the Committee on the International Migration of Talent (CIMT) recognized that the popular use of the term ‘brain drain’ suggested wrongdoing, as the results of migration were not beneficial for all those affected (The Committee on the International Migration of Talent, 1970). Speaking positively of the "supply of talent" in other
countries, the CIMT study suggested that health professional emigration was not a serious problem in countries like India, one of the leading donor countries at the time, where the annual output of that country's education system was sufficient to replace physicians leaving for other parts of the world. The study concluded that in African nations such as Tanzania and Kenya, which did not have as strong an education system in place, the depletion of health professionals was a much more serious matter (The Committee on the International Migration of Talent, 1970).

In the middle 1970s, the World Health Organization (WHO) conducted a multinational study of the migration of physicians and nurses (Mejia, Pizurki, & Royston, 1979). This study found that the flow of physicians from developing countries was almost entirely to developed countries, while the emigration of physicians from developed countries was primarily to other developed countries. As a result, nearly 90% of the world’s migrant physicians were absorbed by developed countries. These migration patterns resulted in a significant net loss of physicians in developing countries.

More recent studies of international physician migration from developing to developed countries identify multiple causal factors, including several factors that “push” physicians out of their home country and several other factors that “pull” physicians toward other countries (Muula, 2005, p. 22; IOM, 2007, pp. 18-24). The main push factors stimulating physicians and other health care workers to emigrate include low pay, poor economic conditions, the risk of contracting HIV infection and AIDS, and concerns about personal security in areas of conflict. Pull factors encouraging migration of physicians include a shortage of physicians in developed countries, recruitment efforts from developing countries, new and more attractive living conditions for physicians and
their families, family or social connections in developed countries, political stability, good public services such as schools and health care facilities, and more job satisfaction. There is, in fact, a kind of inverse relationship between push and pull factors related to the relative levels of pay, career prospects, and working environments available in donor and recipient countries.

Although statistical sources (censuses, surveys, administrative registers, immigration visas, work permit data, and border statistics) provide some useful data about the international migration of health workers, a global summary of this phenomenon is difficult to achieve (World Health Organization, 2003, p. 12). There is no standard measure or overall estimate of health worker emigration. One can interpret each component of the phrase in multiple ways. A “health worker” could be someone who was trained as such or someone who currently works in the health sector. How one defines ‘emigration’ can also vary depending on how long one must stay outside of the country for it to be labeled as ‘emigration’. In many countries, there are significant information gaps and a considerable proportion of migration is undocumented, making it difficult to compare data between countries. Despite these difficulties, there are a number of striking examples of the physician brain drain in individual nations.

Over 60 percent of doctors trained in Ghana in the 1980’s emigrated overseas (Stalker’s Guide to International Migration). In 2002 in Ghana, 47 percent of doctors’ posts and 57 percent of registered nursing positions were vacant (Alkire & Chen, 2004). The World Health Organization has calculated that about 34% of Zimbabwe’s nurses and 29% of Ghana’s doctors work abroad (World Health Organization, 2006). Some seven
thousand expatriate South African nurses work in the wealthy countries of the Organization for Economic Cooperation and Development (OECD), while there are thirty-two thousand nursing vacancies in the public sector in South Africa (Daniels, 2006, p. 30). In all, the WHO estimates that 25% of doctors and 5% of nurses trained in Africa are working in OECD countries (Hooper, 2008, p. 684). In a 1997 article published by the Journal of Public Health Medicine, author Peter Sims described the number of doctors needed for a country such as Zambia. He cited a World Health Organization estimate that Zambia would need one doctor per 5000-10,000 people to make its health care system workable. With a population of 9 million, Zambia would need between 900-1800 doctors, with the support of clinical officers, nurses, and other health professionals. However, in 1997 only 800 doctors were registered with the Zambian Medical Council (Sims, 1997, p. 137). In Uganda, where the per capita expenditure on health care is US$9, there was only one doctor per 24,700 people in 2000 (Bundred & Levitt, 2000, p. 245).

A “medical carousel” has been described by author Daniel Ncayiyana, in which doctors seem to be continually moving to countries with a perceived higher standard of living (Ncayiyana, 1999). Pakistani doctors move to the UK, UK doctors move to Canada, and Canadians move to the USA. Currently 600 South African doctors are registered to practice in New Zealand, which is one of the world’s most affluent countries (Bundred & Levitt, 2000, p. 245). The estimated cost to the South African taxpayer of educating health care professionals who have emigrated is in the region of $37 million, money that South Africa can ill afford to waste. This cost is roughly equal to one third of the development aid South Africa received between 1994 and 2000 (Bundred & Levitt, 2000, p. 245).
As physicians from developing countries migrate to the developed world, hospitals and clinics in these countries become understaffed, and as a result the overall standard of care declines, while the national burden of untreated disease increases. A stark example of this is the problem of caring for patients with HIV infection and AIDS in sub-Saharan Africa, despite a severe shortage of doctors and health facilities. A UNAIDS/WHO 2009 AIDS epidemic update reports that sub-Saharan Africa has the world’s highest prevalence of HIV and AIDS. In 2008, sub-Saharan Africa accounted for 67% of persons with HIV infection worldwide, 68% of new HIV infections among adults, and 91% of new HIV infections among children (WHO, 2009, p. 21). The region also accounted for 72% of the world’s AIDS-related deaths in 2008. In Swaziland, average life expectancy fell by half between 1990 and 2007, to 37 years. In 2008, more than 14.1 million children in sub-Saharan Africa were estimated to have lost one or both parents to AIDS (WHO, 2009, p. 21). The heavy burden of AIDS-related illness, disability, and premature death has had an enormous impact on households, communities, public services, and national economies in the region.

Despite this grave situation, the ratio of doctors to patients in sub-Saharan Africa is now estimated to be 17.1 physicians per 100,000 people (IOM, 2007, p. 10). By comparison the United Kingdom has 230 physicians per 100,000 and the United States has over 256 physicians per 100,000 (IOM, 2007, p. 10). The emigration of physicians and resulting physician shortage, coupled with the high prevalence of HIV infection and AIDS, puts a severe burden on the patients and healthcare workers in the sub-Saharan region. The result is diminished access to and quality of care, and significant limits on the
provision of all health care services, from routine immunizations to tuberculosis treatment to specialized anti-retroviral therapy (IOM, 2007, p. 11).

The example of AIDS in sub-Saharan Africa shows how the emigration of physicians is the loss of a valuable resource for developing countries. One example of the gain of these same resources in developed countries can be seen in the United States. An article examining strategies for providing medical care to underserved sections of the USA reports that many inner-city hospitals in the USA rely almost exclusively on graduates of foreign medical schools to provide services to America’s poor (Mullan, 1997). According to some estimates, 10% of hospital doctors in Canada are South Africans, while the countries whose nurses got the most British work permits in 2001 were South Africa and Zimbabwe. The IOM says that more Ethiopian doctors are practicing in Chicago than in Ethiopia (African Migration: Home, sweet home -- for some. How can Africa move from brain drain to brain gain, 2005). This gain can also be shown in other developed countries, as 25% of doctors trained in Africa are working in OECD countries (World Health Organization, 2006, p. 2).

Recipient countries thus reap a variety of benefits from the immigration of foreign physicians, including increased access to health care for their citizens, increased economic productivity, and savings from limited public support for medical education. The immigrant physicians also benefit by making the transition from the developing to the developed world. They can improve their general standard of living dramatically and look forward to a better life for themselves and their families. For example, according to the World Bank as of 2008, the average life expectancy at birth in Sierra Leone is only 47.6 years, compared to over 78.4 years in the United States (The World Bank, 2008).
Finally, at least some people in the donor countries benefit because they receive financial remittances from relatives working in rich countries, they develop professional contacts in the developed world, or they gain access to significant skills and expertise when (or if) the emigrant workers return home.

With growing recognition of the significant benefits and burdens of international migration of physicians, debate has surged in recent years regarding the moral implications of this phenomenon. One proposed idea is that foreign medical graduates are perceived by receiving countries to be dispensable commodities, a supply of physicians that can be spontaneously accessed by the wealthier countries who can afford to employ them for their own needs (Wright, Flis, & Gupta, 2008, p. 7). Others accuse developed countries of purposefully under-producing medical professionals and filling the void with foreign medical graduates because it is more economically expedient (Bohl, 2008, p. 3). In contrast, defenders of international physician migration argue that it would be unethical to restrict the free movement of skilled professionals, and it would be difficult to enforce a ban on emigration. Physicians, they argue, have as much right to safe working conditions and decent pay as anyone else does (Bundred & Levitt, 2000; Saravia & Miranda, 2004; Klein, Hofmeister, Lockyer, Crutcher, & Fidler, 2009; Watkins, 2005). One author has even argued that the poor public health conditions in Africa are "a result of factors unrelated to international movement of health professionals" (Clemens, 2007). The remainder of this thesis will be devoted to an examination of these arguments and to the conflicting claims of the major stakeholders in the international migration of physicians.
CHAPTER TWO

INVESTIGATING THE ROLE OF PHYSICIANS IN THEIR MIGRATION

The decisions and actions of individual practitioners are obviously a major factor in the international migration of physicians from developing to developed countries. Unlike the slave trade of the 18th and 19th centuries, physicians are not kidnapped from their homes and forcibly transported to another continent, but rather choose to emigrate from their home countries. This chapter will describe and evaluate the role of individual physicians in the physician brain drain.

Physicians choose to relocate in a new country for various reasons; as noted in Chapter 1. Some of these reasons “push” physicians out of their home countries and others “pull” them towards developed countries. Much of the recent literature about the brain drain focuses on the pull factor of active recruitment of physicians by developed countries (Dauphinee, 2005; Hooper, 2008; Scott, Whelan, Dewdney, & Zwi, 2004; Watkins, 2005). This narrow focus, however, disregards other reasons for individual physicians’ decisions to migrate. Two recent studies examine multiple reasons why physicians choose to leave their home countries. The first study explores the personal side of migration and transition experiences of international medical graduates who settled in Alberta, Canada (Klein et al., 2009). The second study examines reasons why more than 2000 doctors have migrated from South Africa to Australia since 1948 (Arnold & Lewinsohn, 2010). Review of these two studies provides a clearer picture of major factors behind physicians’ decisions to practice in a foreign country.
The first study used telephone interviews with 19 international medical graduates to determine their reasons for migrating to Alberta, Canada. The 19 respondents ranged in age from 27-60 years old; 11 came from Africa, and the others were from South America, Europe, and Asia. All of the physicians interviewed were currently practicing and had held restricted or temporary practice licenses for less than seven years. The international medical graduates were first asked “What helped you decide to come to Canada and Alberta?” and “What major differences are there between practicing here and practicing in your home country?” The study identified common push and pull factors and also proposed a new factor called ‘plant’ to describe those phenomena that influenced physicians’ decisions to stay in their new home (Klein et al., 2009, p. 199).

The study found that personal safety is a major push factor—physicians want to escape from areas of high criminal activity. Of the 19 physicians, 12 expressed negative comments about their home environments. One physician was quoted as saying “From the non-professional side the whole society—you can see there’s no future for your kids … The society is against white people there. It’s black apartheid in reverse and you see this huge AIDS problem, crime problem unsolved, the country getting unsafe so you can’t leave your kids there” (Klein et al., 2009, p. 199). Major pull factors were new opportunities for employment, new places to live for spouses and families, and family or social connections. The ‘plant’ factors identified in this Canadian study included a good quality of life and good public services like schools and universal health insurance (Klein et al., 2009, p. 200). The study concluded that individuals migrate to a new location for improvements in quality of personal life, better professional opportunities, and security. It also described a new ‘plant’ factor, explaining why physicians decide to remain in a new
community, as an important aspect of physician migration and transition (Klein et al., 2009, p. 201). The acknowledged limitations of the study were its small number of respondents and single geographic location.

The second study focused on South African-trained doctors living in Australia; it included reports from the spouses or adult children of deceased practitioners who had emigrated from South Africa. The final participants were a sample of doctors identified by an e-mail “snowball” technique and through advertising in alumni and professional journals. Subjects were sent a questionnaire about reasons for migration. A total of 469 responses were received (Arnold & Lewinsohn, 2010, p. 288). The study examined the reasons underlying the migration of South African doctors to Australia since 1948. The results were divided into two categories, reasons for migration prior to 1990 and reasons for migration from 1990 onwards. The primary reason for migration before 1990 (cited by 62% of this group of respondents) was objection to apartheid. When concern for the future, including fear of violent backlash and civil war, were added to the previous percentage, the number rose to 79%. Other reasons cited were safety, professional opportunities, and army service. 59% of respondents who emigrated after 1989 gave as primary reasons the level of violent crime, safety issues, and concern for own and their children’s future. Only 5% before 1990, and 11% after 1990, stated that the primary reason for leaving South Africa was their attraction to Australia. One respondent stated “with all respect to Australia, it was not so much the positives of the country that pulled us towards it, but rather a push from the negatives of South Africa” (Arnold & Lewinsohn, 2010, p. 289). Respondents also reported that, had Australia not accepted them, they would have migrated elsewhere, citing Canada, the United Kingdom, New
Zealand, or the United States as preferred locations. Whether it was during the apartheid era or after due to violence and crime, South African doctors were emigrating due primarily to personal concerns and their home country’s issues rather than the lure of Australian recruitment. Data from the Alberta and Australia studies also suggest that physicians decide to relocate not solely for their own benefit, but rather for the benefit of their entire family.

A recent anthology, *The International Mobility of Talent: Types, Causes, and Development Impact*, includes a chapter on the issue of the physician and nurse brain drain, using Ghana as a case example to detail the popular reasons given for migration. To fully understand the migration in the health sector as an international phenomenon, the author begins by examining the relationship between changes in the global economy and health sector labor markets (Bach, 2008, p. 202). He cites the integration of physicians from Ghana into the global labor market as a process that begins with potential migrants making informed comparisons of wages and working conditions across countries; increased private investment in employment agencies to facilitate international recruitment; information on immigration processes becoming widely available; and the existence of feedback effects putting upward pressure on wages and conditions in the countries of origin (Bach, 2008, p. 215).

The wage differential between source and destination countries is another commonly cited reason for migration. A 2004 article reports that the physician wage in the USA is about 25 times the physician wage in Zambia, about 22 times the physician wage in Ghana, and about 4 times the physician wage in South Africa (Vujicic et al., 2004, p. 7). In Ghana, a major concern expressed by a group of doctors interviewed in
2003 who were intending to migrate was unrealistic salaries, a reason cited by every
doctor interviewed (Mensah, Mackintosh, & Henry, 2005, p. 20). Remitting money and
investing in property in Ghana were the primary goals for most nurses interviewed in
2004, prior to migration; for doctors interviewed in 2004, these were of secondary
importance, after career development and training (Mensah, Mackintosh, & Henry, 2005,
p. 28).

Access to professional development and training is an important feature of a
successful career. As noted above, doctors in Ghana identified professional development
as a reason for migration. In a study of migrating Indian physicians, responding doctors
reported that, to make rapid advancements in their professional career, they would need
better academic exposure and better professional infrastructure that are “not easily
available in India” (Khadria, 2004, p. 21). These opportunities, including access to
specialist training and the chance to use technologies that are not available in the home
country, can entice physicians to migrate to countries where they are available (Bach,

The freedom of physicians to emigrate is a matter of increasing ethical debate.
Advocates of international health mobility emphasize the benefits for individuals in
enhancing their careers and earnings opportunities by moving to other countries, benefits
to host countries of improved health care, and benefits to source countries produced from
remittances and other components of knowledge transfer (Bach, 2008, p. 203). Moreover,
actions taken by the industrialized nations to inhibit the immigration of healthcare
professionals may violate these people’s rights to move freely from place to place
(Hooper, 2008, p. 686). The free movement of labor is a fundamental and inalienable
right of individuals, irrespective of the circumstance that they leave behind (Bach, 2008, p. 203).

Arguments for the right of physicians to migrate may appeal to international documents like The Universal Declaration of Human Rights adopted by the United Nations General Assembly in 1948 (United Nations General Assembly, 1948). The Universal Declaration of Human rights represents the first global expression of rights to which all human beings are entitled; it is also incorporated into the International Bill of Human Rights. The Declaration contains several statements on the right of human relocation. Article 3 of the declaration reads “everyone has the right to life, liberty, and security of person.” Article 13 says that “everyone has the right to leave any country, including his own and return to his country.” Another Article, 23, addresses the issue by granting “everyone the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment”. Lastly, Article 25 declares “everyone has the right to a standard of living adequate for health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…”. The right to leave any country is also recognized in the International Covenant on Civil and Political rights, Article 12.2, and the African Charter on Human and Peoples Rights, Article 12(2) (United Nations General Assembly, International Covenant on Civil and Political Rights , 1966; Organization of African Unity, 1986).

Though there is the potential for physicians, developing, and developed countries to benefit from international migration, using migration as a long term answer to physician shortages in developed countries may not be effective. Although foreign
medical graduates are often placed in underserved areas in developed countries, it is not clear whether doctors will remain in these areas their entire careers, move to more affluent areas, or return to their home countries. Thus, it remains to be demonstrated that use of foreign physicians in these areas is a good long term solution to regional physician shortages. Claims that developing countries benefit from migration as a way to enhance their economy or medical knowledge may also be overstated. Remittances by health workers are not directly reinvested as a monetary gain for the health system in developing countries. Nor do they provide sufficient compensation for the loss of human resources resulting from the exit of experienced health personnel out of the donor countries (Stilwell et al., 2003, p. 6).

The force of human rights based arguments for migration may also be limited. A coercive approach through policies to restrict the freedom of movement would essentially violate the rights previously referred to, but the rights that the declaration and articles state would be difficult to enforce. If read with strict adherence, the rights referenced allow for the free movement of anyone in all circumstances. Though interference with migration can be considered a violation of rights, allowing one to migrate at any time or for any reason could prove costly if the migrating individual is a criminal, owes a debt to their society, or is instrumental to a nation’s government and its development. Countries have a right to protect their borders and the inhabitants of their nations. Preventing the entry of physicians can protect potential patients of developed countries from being harmed by unqualified doctors, while restricting the departure of doctors can help developing nations provide a better quality of care for their patients. The human rights
declarations adopted by the United Nations advocate for human freedom, mobility, and development, but are also practically and theoretically limited.

Another prominent argument against physician migration asserts a societal right to inhibit migration of healthcare workers because they are trained using taxpayers’ money. In return for this investment in their education, this argument claims that physicians have an obligation to provide health services to those who financed their medical education (Hooper, 2008, p. 686). Those who receive benefits from a community have a moral duty not to take a “free ride” from their community (Hooper, 2008, p. 686). These same critics argue that free riding is immoral, as it involves treating others as means to an end rather than as ends themselves. Further this concept of free riding is unfair because the principles of justice and equality require that members of the community receive a share of the benefits as well as the burdens of the investment they have made in physicians through taxes (Hooper, 2008, p. 686). Thus, healthcare professionals who have had the costs of their training paid for by their communities should not emigrate after graduating unless they have repaid their debts to society (Hooper, 2008, p. 686). This claim, however, relies on the questionable claim that receiving benefits from one’s society creates a debt to society that must be repaid. Robert Nozick challenges this notion of a general debt to society. Nozick argues that "...the fact that we partially are 'social products' in that we benefit from current patterns and forms created by the multitudinous actions of a long string of long-forgotten people, forms which include institutions, ways of doing things, and language..., does not create in us a general floating debt which the current society can collect and use as it will" (Nozick, 1974, p. 95).
Without a general debt to society, I contend that, unless medical students have entered into explicit contractual obligations to practice in return for subsidization of their medical education, emigration after receiving a subsidized education should be allowed. Current and potential patients may hope and expect that physicians will remain in their home country after medical school, but unless there is a clear agreement about what is expected in return, the public subsidization of medical education does not establish specific duties of repayment. In other words, one is not a “free rider” unless one fails to fulfill an established duty. Though potentially limited, the declarations adopted by the United Nations and particular African Countries express the rights to which all humans are entitled. With these rights, physicians should be able to migrate in order to better themselves and their families.

The studies referred to throughout this chapter illustrate how physicians’ decisions to migrate are personal decisions based on a complex interplay of factors, including personal security, an improved standard of living, higher pay, and opportunities for professional development. The push and pull factors that physicians encounter are reasons why I believe it is morally acceptable for migration to occur. If migration is disallowed, then physicians’ human rights are denied solely because of their profession. However, this act of migration may become immoral when developed countries become active participants in enticing foreign doctors to migrate. This role of developed countries in physician migration through recruitment or under-production of health care professionals will be analyzed in the next chapter.
CHAPTER THREE

THE ETHICS OF INTERNATIONAL RECRUITMENT

As physicians migrate from their home nations to wealthier countries, they are attracted to factors such as more training opportunities, higher living standards, and better practice and research conditions. Until now, this thesis has focused on physicians’ individual decisions to migrate. Though these physicians make autonomous choices, their decisions are inevitably influenced by potential destination countries. Many developed countries allow foreign doctors to practice in their health care systems. In 2005, the General Assembly of the World Federation of Public Health Associations noted that while developed countries have 33.4% of the world’s population, they contain 74% of the world’s physicians and 89% of the world’s migrating physicians (World Federation of Public Health Associations, 2005, p. 1). The Organization for Economic Co-Operation and Development published a health data report in 2009 comparing health statistics across OECD countries. The data indicated that countries are hiring more foreign-trained doctors, a trend that reflects the demand for more doctors. The percentage of foreign trained physicians nearly doubled in Switzerland and Sweden and tripled in Ireland and Finland between 2000 and 2007. In the U.S. and the U.K., international medical graduates accounted for about half the increase in the number of doctors in practice (Organization for Economic Co-Operation and Development, 2009). Policy-makers in high-income countries face dilemmas, as there are strong economic and political pressures in OECD countries to recruit health workers from overseas (Forcier et
al 2004, Stilwell et al 2003). As I will describe in this chapter, the response of developed countries to these pressures stimulates individuals’ decisions to migrate.

The activities of a committee of the Alberta Health Ministry provide a helpful example of these government recruitment efforts. The Ministry hired a professional recruiter to find doctors to fill the many vacancies for physicians in Alberta’s rural communities. The committee chair and the recruiter travelled to South Africa in March of 1997 and interviewed doctors who had been pre-recruited through the press. The two then arranged for these doctors and their families to visit rural communities in Alberta and, as a result, the Ministry was able recruit more than 40 South African doctors (Bundred & Levitt, 2000, p. 246). Recruiters use a wide variety of strategies, including advertising in national newspapers and journals, text-messaging health workers, sending personal e-mails, and creating internet sites (Attaran & Walker, 2008, p. 265). “Active” recruitment also includes listing openings with recruitment agencies known to operate primarily in developing countries, placing recruiting stations at conferences that primarily attract health professionals from developing countries, and onsite recruitment in developing countries (World Federation of Public Health Associations, 2005, p. 5). The international health care labor market has become commercialized in recent decades. Technological developments, notably the advent of the Internet, have increased knowledge of jobs and working conditions abroad. Active recruitment by health care employers via commercial recruitment agencies and advertising, particularly in the U.S. and U.K., has also facilitated this knowledge (Mensah, Mackintosh, & Henry, 2005, p. 13).
The active recruitment of physicians by governments of developed countries is perhaps the most controversial contributor to the brain drain. In Australia, for example, the Government’s Medicare Plus policy initiatives in 2003 included a promise to increase the number of available physicians, in part by foreign recruitment efforts (Australia Department of Health and Aging, 2003). Another example is the November 1998 issue of the *South African Medical Journal* (SAMJ). That issue included 23 pages of employment-related ads, 11 of which offered jobs in Canada, the United Kingdom, New Zealand and Australia. Among the 10 Canadian ads were a family practice position in Prince Rupert, B.C., and a post in Kindersley, Saskatchewan, that offered a $25,000 "practice establishment grant." South African doctors were also invited to practice among the "craggy cliffs, deep fjords and snow-capped mountains of Newfoundland and Labrador" (Sullivan, 1999).

Two countries that are widely criticized for their roles in physician migration are the United Kingdom and the United States. The United Kingdom’s dependence on overseas-trained physicians to fulfill its needs is nothing new. Over one third of registered doctors are not originally from the U.K. (Mensah, Mackintosh, & Henry, 2005, p. 7). One notable critic of the NHS’ reliance on healthcare professionals from developing countries is Dr. James Johnson, former Chairman of the British Medical Association. In his keynote address during the Association’s 2004 annual conference, Johnson observed that “as the fourth largest economy in the world we are still … taking doctors and nurses from the Philippines who need them more than we do. It’s a shameful record of exploitation. Surely after over half a century of the NHS we should be producing enough doctors to look after our patients” (Kmietowicz, 2004).
In response to protests from African governments and non-governmental organizations about the impact of health professional recruitment from sub-Saharan Africa, the United Kingdom in 1999 adopted a Code of Practice for NHS employers involved in the international recruitment of healthcare professionals. The Code is an explicit recognition of the impact of the active recruitment of physicians by the NHS and the U.K. private sector. The Code states that no active recruitment will be undertaken in developing countries by U.K. commercial recruitment agencies, or by any overseas agency sub-contracted to those agencies, or any healthcare organization, unless there exists a government-to-government agreement that healthcare professionals from that country may be targeted for overseas employment (Department of Health, 2004, p. 10). The Code seeks to limit UK health employers’ recruitment of physicians from countries of concern. It also attempts to reduce the flow of international migrants from those countries into the U.K. health services (Mensah, Mackintosh, & Henry, 2005, p. 26).

As the primary response to this problem, however, the Code may be both ineffectual and misdirected. It is an advisory statement, not a mandatory policy, and there are many ways around this Code of Practice. Recruitment for “medical international fellowships” is one indirect recruitment method that has undermined the Code of Practice. In 2002 The British Government offered medical international fellowships for up to two years to English-speaking specialists overseas. The fellowship included a consultant salary for two years, plus up to €55,682 to assist with relocation and housing. The invitation, including a letter from Prime Minister Tony Blair, was addressed to anesthesiologists, psychiatrists, clinical oncologists, radiologists, pathologists and thoracic surgeons (Watkins, 2005, p. 241). These international fellowships were marketed
primarily as an opportunity for doctors to experience one of the world's best healthcare systems, but it is obvious that the NHS was trying to fill vacancies in specialties where there is a shortage (Patel, 2003). The NHS circumvented the Code in another way by employing doctors who had already migrated to other European countries but originated from African countries. Because they were not directly recruited by the NHS from their home country, these actions technically did not violate the Code of Practice. These methods enabled the NHS to continue to recruit physicians from countries that have severe physician shortages and are on the list of countries from which recruiting is proscribed by the Code of Practice (Watkins, 2005, p. 241).

While the U.K. has a centralized health system to address physician staffing issues, the United States, in contrast, has a decentralized health system that is less able to engage these issues at the national level. Agencies of the U.S. government have been reluctant to impede free-market-driven physician migration (Hagopian et al., 2004, p. 2). United States policies have been friendly to physician migration, even though the US has toughened its medical licensing examinations and tightened immigration rules. The U.S. welcomes foreign medical graduates for two reasons. First, as a form of foreign aid, it provides specialty training that physicians can take back to their home countries for the benefit of residents of those nations. J-1 visas are used for graduates of overseas medical schools to gain access to graduate medical education through residency programs in the U.S. This type of visa requires that foreign physicians return to their home country for two years when their residency training is completed. The two-year home residency requirement may be waived, however, if a U.S. government agency claims that the person’s departure would be detrimental to the interests of that agency. Though United
States government agencies do not directly participate in recruitment of foreign physicians, policy initiatives have allowed for more migration. In 2002 Congress expanded the number of foreign physicians who are granted favorable immigration status by increasing the number of J-1 visa waivers allocated to state health departments from 20 to 30 (Hagopian et al., 2004, p. 2). The Department of Health and Human Services took over the role formerly played by the Department of Agriculture in handling applications for J-1 waivers, which gave additional foreign physicians access to waivers (Hagopian et al., 2004, p. 2).

The second reason the U.S. welcomes foreign medical graduates is because these physicians fill positions in specialties and locations that are less attractive to American doctors, and so may help to correct physician maldistribution in some rural or underserved areas (Hagopian et al., 2004, p. 8). In an article examining strategies for providing medical care to underserved sections of the U.S., Hagopian states that many inner-city hospitals in the USA rely almost exclusively on graduates of foreign medical schools to provide services to America’s poor. International medical graduates (IMGs) have significantly expanded America's physician workforce since World War II (Hagopian et al., 2004, p. 1). The dependence of the United States on international medical graduates is displayed in various policies. One specific example is Medicare's financial support for significantly more residency positions than there are domestic medical school graduates (Iglehart, 1996). The United States also waives the exchange visitor requirement that would otherwise return foreign medical graduates to their home countries after residency training in exchange for agreements to practice in underserved
USA settings. This is another indication that the United States grants permanent residency status to IMGs under a variety of conditions (Hart et al., 2007, p. 1169).

The reliance of the United States healthcare system on foreign physicians puts a tremendous strain on the healthcare systems of developing nations. At the same time, by relying on IMGs rather than American medical school graduates, the policy prevents a significant number of Americans who desire to practice medicine from doing so (Bohl, 2008, p. 1). Developed nations save millions of dollars by relying on foreign-trained physicians to fill the gap between the number of physicians they need and the number they train. Future physician migration studies forecast physician shortages of as much as 20% in the developed world by 2020 or 2025 (Cooper et al., 2002, p. 148). The recent U.S. federal health care reform legislation may expand access to health care and further exacerbate the shortage of physicians. While decisions on how to manage these shortages have not yet been made, two choices are available to developed nations to address the issue. Either nations must expand their physician training programs or increase their reliance on IMGs (Bohl, 2008, p. 3). In 2006 the Association of American Medical Colleges called for a 30% increase in medical school enrollment in the U.S. Almost five decades ago, the Education Assistance Act of 1963 funded a major increase in physician training and a doubling in medical school seats. However, it took fifteen years after the act was passed before the number of practicing physicians increased. Experts doubt that this process could occur any more quickly (Bohl, 2008, p. 8). Based on data in a 2009 AAMC report, a 30% increase in medical school enrollment will not be achieved until 2017 or 2018 (Association of American Medical Colleges, 2009, p. 9). Because medical schools need time to expand and because of the long residency and
fellowship training period before physicians are eligible for independent practice, current efforts to increase medical school enrollment will not reduce U.S. reliance on IMGs in the near and medium term future.

With demand for physicians high in both developing and developed countries, the ability of wealthier nations to provide a higher income gives them a clear advantage. Are developed nations justified in using recruitment and immigration policies to capitalize on this advantage? In times of shortage, developed nations may be justified in allowing foreign physicians to fill their gaps, even if it means drawing from more needy developing ones (Bohl, 2008, p. 3). Recruitment could be mutually beneficial and thus ethically appropriate if it leads to a short-term transfer of health personnel from low- to high-income countries. This experience would allow physicians from developing nations to gain useful skills for their practice back home. Recruitment could be founded on agreements between the source and receiving countries to adhere to ethical recruitment principles (Physicians for Human Rights, 2004, p. 33). This short-term recruitment practice can be further supported if a nation recognizes that a right to correct workforce shortages by using IMGs is justifiable only if it is not a premeditated practice that permanently “robs” developing nations of physicians.

Though this method of addressing unexpected short-term needs may be justified in certain situations, most developed nations do not recruit and employ IMGs in this way. First, the physician shortages developed nations have experienced and are likely to experience in the future are not unexpected. Rather, a number of studies have estimated the number of physicians needed in these countries and predicted future physician shortages (Weldon, 2008; Center for Workforce Studies, 2009). Second, developed
nations generally employ IMGs as part of a long-term cost-saving strategy. No country wants to assume the considerable expense of expanding medical education if the demand for physicians can be met with doctors from foreign countries. The employment of these foreign-trained doctors, in the United Kingdom for example, represents a direct subsidy to U.K. health service users, since their training costs have not been borne in Britain. It is estimated that it costs approximately €260,000 to train a doctor in the UK (British Medical Association, 2008). In 2004 there were 293 Ghanaian-trained doctors registered in the UK. This would imply a saving to the NHS in current training costs of about €76,180,000 from the employment of those 293 Ghanaian-trained doctors. These calculations are only estimates, but they do give a glimpse of the magnitude of savings involved for the UK (Mensah, Mackintosh, & Henry, 2005, p. 35).

Defenders of IMG recruitment by developed nations may claim that these nations should be free to pursue their financial interests in this way. The benefits enjoyed by developed nations are not without their costs, however. Using IMGs as a long-term solution to physician shortages causes direct harm to the health systems of developing nations and thus makes this dependence morally suspect (Bohl, 2008, p. 3). A prolonged stay by foreign physicians represents a loss to developing nations of the physicians educated to care for needy patients in their understaffed health care systems. Unlike the free trade of goods, developed nations do not pay developing nations upon acquiring their physicians. When developed nations recruit the physicians of developing ones, they deprive developing countries of a return on their investment in medical education.

The international physician brain drain thus creates serious disadvantages for developing countries and their citizens. Few would deny that this is an unfortunate
outcome for these countries, but does it also represent a moral transgression? This is a controversial issue, but I believe that a strong case can be made that recruitment of IMGs by developed nations violates a duty of nonmaleficence. The ancient principle of nonmaleficence in medical ethics asserts an obligation by physicians not to inflict harm on others (Beauchamp & Childress, 2001, p. 113). I contend that this duty not to inflict harm applies not only to physicians, but more broadly to moral agents generally. Moral agents have a duty to do what is required by one’s role in society, particularly by one’s occupation, profession, relationship as family member, or one’s special circumstances (Gert, Culver, & Clouser, 2006, p. 119). Like the actions of individuals, the practices and policies of nations can inflict harm on others. In spite of the benefits for physicians, developing, and developed countries described in Chapter 2, physician recruitment practices harm medical services and patients in developing countries. The emigration of physicians causes a direct and immediate harm to patients because physicians are direct caregivers. When physicians are in short supply, individuals who desperately need treatment often go without the services they need. Weighing the risk versus benefits, nations should not recruit international medical graduates for self-interested benefits because the risks imposed upon the developing country through a lack of health care providers far outweigh the benefits the developed country receives by using foreign graduates instead of future potential physicians. Thus, recruitment by developed countries that removes health personnel from developing countries and consequently impairs their health systems, violates a duty of nonmaleficence.

The argument for the ethical appropriateness of recruitment by developed countries can invoke the principle of double effect (Doctrine of Double Effect, 2009). According to
the Stanford Encyclopedia of Philosophy, the doctrine of double effect is often invoked to explain the permissibility of an action that causes a serious harm as a side effect of promoting some good end. In our case the good effect of providing health care to the citizens of developed nations, is what recruiting countries intend. The bad effect of depriving members of another community of physicians to provide health care is foreseen but not intended. But, in order for the doctrine of double effect to justify an action, the good and bad effects of the action must be proportional to one another. I contend that this is not the case, however, in the recruitment of physicians away from many developing countries, because the adverse health consequences to the source countries are much greater than the benefits to the developed countries.

The argument takes a different perspective when one tries to apply the principle of nonmaleficence to individual physician choices. The resulting harm that can occur to patients once physicians migrate cannot be seen as a violation of the duty of nonmaleficence by physicians because one must take into consideration the potential harms physicians confront within their home country. Though one’s profession requires that they provide care for others, it does not mean the well-being of others always comes before their own. If harm is present for both physicians and patients, one cannot blame physicians for first wanting to protect their families and themselves from harm, due to disease or violence, before protecting a stranger.

One recent commentator argues that the practice of recruitment of IMGs may also be viewed as a violation of international law. In recent years, international law has developed the notion of international crime to strengthen the accountability of individuals for serious violations (Mills et al., 2008, p. 687). One indication of acts that deserve
treatment as international crimes by the International Criminal Court is that they create social alarm. Although the active recruitment of health workers from developing countries may lack the heinous intent of other crimes covered under international law, the resulting degradation of health infrastructure contributes to a measurable and foreseeable public-health crisis (Mills et al., 2008, p. 687). The active recruitment of health workers from African countries is seen by some as a systematic and widespread problem throughout the continent and a cause of social alarm.

Thus far we have analyzed the ethical arguments for and against a physician’s personal choice to migrate as well as the debate surrounding the practice of physician recruitment by developed nations. The recruitment aspect of physician brain drain receives the most attention by nations, hospitals, and doctors; it is easy to blame developed nations for their lack of physician production, self-interested cost-saving strategies, and widespread use of foreign medical graduates as short-term and long-term solutions to their physician shortages. However, though recruitment by developed countries can lead to physician migration, the developing countries must also recognize the need to take action to improve their own practices in regards to the brain drain. This issue will be examined in the following chapter.
EXAMINING THE ROLE OF SOURCE COUNTRIES IN MIGRATION

The neoclassical economic model can be used to analyze the mobility of health professionals. This model would explain migration by the location and intensity of push-pull factors (Bach, 2008, p. 214). The push factors include pay, working conditions, and broader management and governance factors that encourage health professionals to exit their own health systems. Chapter Two reviewed these various reasons physicians cite for their decision to migrate. Further analysis incorporates factors that push health professionals to shift from rural to urban areas, from public- to private-sector employment, and at times out of the profession altogether (Bach, 2008, p. 214). Chapter Three examined factors that pull physicians toward particular destinations, especially the recruitment efforts of developed countries. The resulting migration has been a contributory factor to the problems faced by African health systems, as signified by the shortage of physicians in these developing nations (Bach, 2008, p.210). The extent of the migration is suggested by the fact that the proportion of health workers to the population has stagnated or declined in nearly every African country since 1960 (Physicians for Human Rights, 2004). Though it may be reasonable for poor countries that are losing their health professionals to richer countries to complain about recruiting, they must also accept their own responsibility to improve strategies for attracting and retaining physicians and other health care professionals. Some have suggested that the neglect of these responsibilities has caused much of the migration from poor African countries such as South Africa and Ghana (Martineau, Decker, & Bundred, 2004, p. 6).
When physicians emigrate, there is an impact on the education and overall intelligence of the countries they leave. Physicians and their families comprise an educated sector of a country's population, and the migration of physicians depletes this pool (Aluwihare, 2005, p. 16). As physicians emigrate, undergraduate, postgraduate, continuing medical education institutions also suffer. These educational forums need physicians who have the time and energy to share their knowledge and skills; physician shortages do not allow this to happen. Continuing medical education also needs input from senior, highly experienced physicians, but many of these senior physicians either no longer work in the community or are too busy to give time to teaching their junior colleagues (Aluwihare, 2005, p. 19). An example of the impact migration may have on the quality of continuing medical education can be seen in the country of Ghana (Martineau, Decker, & Bundred, 2004, p.4). A large-scale migration of Ghanaian doctors to the Middle East in the 1980s left the local academic ranks severely depleted. Policy initiatives, such as the provision of extra incentives, eventually restored the number of medical teachers to a reasonable level. However, most of the health research capacity in Ghana, an important ingredient of academic medicine in terms of quality and retention incentives, was said to have been lost (Martineau, Decker, & Bundred, 2004, p.4). Research, specifically clinical research, requires vigilant physicians, a large volume of patients, and an audit process that is sufficient to allow for proper design and retrospective analysis of results. The first two requirements can be met under many circumstances, but the vigilance of physicians is reduced when coupled with the additional burden of analyzing results. Supervision of research technicians by physicians is necessary to audit the research properly, but busy or unavailable physicians cannot or
will not do this, thus resulting in inadequate research (Aluwihare, 2005, p.18). The system of medical education in developing countries may in fact contribute directly to the problem of physician emigration. It is argued that the medical school culture in many African countries encourages graduates to practice abroad, not least because it affirms the standard of training and is prestigious for the local institution (Physicians for Human Rights, 2004, pp. 47-51).

Health professionals also want a decent living wage, something that publicly funded health care delivery systems in many developing countries frequently cannot provide. That financial disincentive is often a principal factor that convinces physicians to work overseas. The chairperson of Africarecruit, an African-based recruitment company that tries to bring African physicians back to their home countries, stated that "At the end of the day it is where people will get maximum returns on their skills that they will go. If the UK is going to pay a nurse a lot higher than what she will get in Africa, then she is going to go to the UK. People will go to where the highest bidder is. . . if you look at the figures there are more Nigerian doctors operating in the US than in Nigeria and up to 65% of Ghanaian doctors are not in Ghana" (Price, 2004). Salary levels are important to staff retention, along with working and living conditions that make it possible to do a good job in a reasonably safe working environment or to provide reasonably safe care for patients (Mensah, Mackintosh, & Henry, 2005, p. 23). Families of Ghanaian migrants report that migrants remit funds for family support and to invest in property. Many migrants express plans ultimately to return and settle in Ghana, even if it is after retirement abroad. This suggests that raising salaries in an effort to provide financial support to health workers that enables them to invest, especially in owning a
home, and to save for basic personal and family commitments, could be an effective tool that developing countries could offer to reverse the tide of migration (Mensah, Mackintosh, & Henry, 2005, p. 23).

Economics is part of the motivation to emigrate, but other factors such as clinical frustration also exist in developing countries. One argument is that poor working conditions, including heavy workloads, and a lack of medical equipment in developing countries are factors that impel health professionals to seek employment outside their country. Health professionals need workplaces that are adequately equipped to take care of patients and to prevent illness (Farmer, 2007, p. 1065). Health professionals working in poor countries often do not have the tools they have been trained to use to do their jobs. They lack the diagnostic and therapeutic equipment and supplies that their patients, many of whom live in poverty, need in order to receive decent care. Low staff numbers coupled with an increasing number of patients lead to heavy workloads for health professionals (Bach, 2008, p. 217). These factors produce frustration in the work environment and, coupled with war, civil unrest, and crime in their home countries, become common factors that encourage health professionals to seek employment abroad (Bach, 2008, p. 217). This leads one to wonder whether government efforts to alleviate crowding and equipment shortages or civil unrest and crime as it relates to the provision of healthcare would convince more qualified and trained professionals to stay in their home countries.

Developing countries also contribute to the brain drain when they fail to provide opportunities for professional development. In addition to creating employment opportunities, providing continuing education is important for the development of professional communities and of the country as a whole. Whether it be medical, political,
or business education, it is in the best interests of these developing nations to provide educational resources so the country can further develop. The absence of these opportunities reinforces the attractiveness of overseas employment. A difficulty arises in determining whether professional education or direct patient care is more important. Developing countries have limited financial resources and should focus first on providing adequate patient care. However, as medical needs become more complex these countries will need professionals who have received more advanced continuing education. In South Africa, for example, nurses have complained about the lack of opportunities for promotion within hospitals (Bach, 2008, p.217). If health care professionals become frustrated at the lack of opportunities to utilize their training and knowledge in their local circumstances, they are more likely to seek employment abroad (Bach, 2008, p.217).

Using Ghana as a case study for the impact of physician migration and the role of developing countries, one can observe how a specific developing country can contribute to the phenomenon through mismanagement of government spending. Ghana is a low-income country with a rising shortage of health care professionals due in part to increasing emigration of these professionals. The government is making efforts to improve its health care and economy. However, the country still spends too little on health care to provide adequate care for its citizens. Ghanaian health spending was $12 per person in 2002, of which $7 was public spending. The WHO’s Commission on Macroeconomics and Health estimated the cost of a set of essential interventions at $34 per capita per year, much of which would need to be public spending (Mensah, Mackintosh, & Henry, 2005, p. 9). The government has made other expenditures in education, rural development, infrastructure, water, and sanitation that all seem to be a
priority for the country. As the government tries to stabilize a struggling economy, cuts in expenditure have an effect on how much the government can spend per person. As the elected officials of the nation, it is the government’s responsibility is to provide basic health services to its citizens, a duty which the Ghanaian government has failed to discharge.

Policies implemented by finance ministries, as well as new government programs that are designed to stabilize a country’s economy, have been blamed for restrictions in health care spending (Bach, 2008, p. 216). These restrictions impede the development of good human resource systems that are essential for developing countries. In one attempt to address the lack of funds for human resources, schemes such as “additional duty hours allowed” (ADHA) were created in Ghana. The ADHA provides additional pay to health professionals exceeding normal working hours of 160 per month. This measure initially slowed emigration, but its effectiveness was undermined by poor governance (Mensah, Mackintosh, & Henry, 2005, p.23). Arbitrary local decision-making led to grievances, especially among nurses, and provoked a ten day country-wide strike (Mensah, Mackintosh, & Henry, 2005, p. 23). The difficulty is that many source countries have a limited ability to increase salaries when severe budgetary constraints on their economy already exist (Physicians for Human Rights, 2004, p. 39).

Raising salary levels is a necessary but not a sufficient condition to eliminate migration (Bach, 2008, p. 224). It is acknowledged that poorly designed and operated human resource management systems reinforce low morale, foster migration, and make it difficult for returnees to have job satisfaction. The lack of opportunities for further education and development along with traditional teaching methods are often mentioned
as symptoms of poor human resource systems (Padarath et al., 2003, p. 21). Therefore, poor human resource management practices remain a constraint on the ability of a health sector to be effective, further contributing to migration ((Bach, 2008, p.218, Price, 2004).

Policy responses to international mobility of health professionals have been directed at managing migration in conjunction with measures to improve the workforce shortages and poor working conditions that promote migration. These measures are designed to improve pay, working conditions, and career prospects of health professionals in source countries. In source countries, reforms also focus on the structure and training of health professionals to establish new roles in the health care community (Bach, 2008, p.223). Along with experimenting with positive incentives to retain staff, many countries use financial penalties to deter health professionals from migrating. One example of a system of financial penalties is the practice of bonding. Bonding requires new graduates from health professional schools to post bonds of variable amounts which they forfeit if they leave the country before a certain number of years have elapsed. Alternatively, they may be required to pay back their training costs if they emigrate. This restrictive policy has been subject to considerable criticism in countries such as Ghana. There it has been argued that bonding policies that have poor enforcement and monitoring encourage evasion strategies and have proved ineffective (Mensah, Mackintosh, & Henry, 2005, p.21). A strategy such as bonding can be a useful tool as long as there are enforcement measures that require graduate health professionals to practice in their countries of training as a way of repaying their government-funded education. However, if policies are not enforced, as seems to be the current situation in Ghana, then a program such as bonding proves to be ineffective. In general, restrictive
measures by developing countries to inhibit mobility have only limited effects or support, and consequently direct attention towards issues of recruitment (Bach, 2008, p. 224). Critics also argue that bonding does not effectively serve its intended purpose of retaining health care professionals. Students may prefer to forfeit their bonds and break their community service obligations in order to emigrate. This is a frequent choice in countries where high inflation reduces the real cost of paying the fine. For example, in Ghana doctors are bonded to serve for five years or to pay back their training fees. However, high inflation and currency depreciation made this bonding scheme ineffective because a Ghanaian bond worth 13 months’ salary changed to five months’ salary in a five year period (Mensah, Mackintosh, & Henry, 2005, p. 21).

Insufficient health personnel form one of the main constraints that limit the ability to deliver basic health services. In Ghana, as in many other low-income countries, many people lack access to basic health care, and this problem is worsened by physician migration. In 2004, the Ghana Health Service was suffering as a result of declining staff numbers and the worsening of health indicators (Mensah, Mackintosh, & Henry, 2005, p. 10). Developing nations, such as Ghana, have overwhelming tasks of correcting a variety of economic and social problems. As a result they can only provide only very limited resources to provide health care to their patients. The Ghanaian government has ratified international human rights treaties that include rights to decent health care and safe working conditions, but without the resources and personnel to satisfy these human rights treaties, the treaties seem futile (Mensah, Mackintosh, & Henry, 2005, p. 10). There is widespread agreement on some of the reasons for health worker migration from low-income countries. Developing countries need to recognize that migration cannot be
simply prevented, as it is influenced by a variety of factors such as living conditions, access to education, politics, wages, working conditions, and knowledge of opportunities. Therefore, countries of origin have no choice but to focus on developing better management of migration and providing better incentives and opportunities for professional development to encourage return. These approaches can be an integral part of increasing their human resources for health care (Mensah, Mackintosh, & Henry, 2005, p.20). The strategies suggested for developing countries to reduce the brain drain, as well as for all participants in this phenomenon, will be further evaluated in the next chapter.
CHAPTER FIVE

POLICY SOLUTIONS & CONCLUSIONS

As discussed in this thesis, physicians who decide to migrate are influenced by a variety of factors in both developed and developing nations. Along with the controversial issue of whether it is morally acceptable for developed nations to recruit foreign medical graduates at all, debate centers around what policies, if any, should be implemented to allow ethical recruitment and migration that does not undermine the health care systems of developing countries. These policies must also allow for physicians to exercise their own individual rights of free movement. The key policy issues should be approached with national and international cooperative strategies.

National strategies addressing the ethics of skilled health professional migration to developed countries include the following: First, developed nations can formulate and implement national codes of conduct for ethical recruitment. These codes can identify countries from which recruitment would be less harmful, encourage more acceptable forms of recruitment within poor countries, and apply other elements of good practice (Scott et al., 2004, p. 175). Second, developed nations can recognize and respect the significant differences between countries as potential sources of physicians; for example sub-Saharan African countries are unable to recover from the loss of health personnel as well as China, India or the Philippines (Scott et al., 2004, p. 175). Third, providing an adequate supply and distribution of health professionals within a developed country’s own professional education and health system would be useful. If human resources within developed countries were better deployed, areas of need would be fewer and the
search for skilled migrants to fill the gap would be less common (Scott et al., 2004, p. 175). Fourth, developing nations can selectively limit proactive approaches by recruiters in recruiting skilled health professionals. This involves restricting proactive approaches made by some governments and recruiting agencies to remove physicians from the developing world through advertising and recruitment visits (Scott et al., 2004, p. 175). The appropriate methods of recruitment could also be coupled with paying compensation to source countries for their loss of trained personnel.

The issue of reparations to counter losses to source countries has long been a proposed solution to the Brain Drain (Muula 2005, Martineau et al. 2004, Mensah et al. 2005). Designing and implementing a system of compensation, however, requires difficult decisions about who makes the reparations, to whom, and how. A hospital in an industrialized country will probably not be best equipped to provide appropriate assistance to institutions in resource-poor countries (Muula, 2005, p. 26). Should compensation be financial, or direct provision of materials and technical assistance such as expertise? When the public health care system has lost a physician, it would make sense to compensate that system, but the health care system may not have contributed to the training as much as the physician’s parents or guardians (Muula, 2005, p. 26). It is also not clear when and if the government gets part of the compensation and which department should be compensated. Should it be the department of health, department of education, or both (Muula, 2005, p. 26)?

In a competitive labor market, all organizations that recognize the value of their staff will have some kind of attraction and retention strategies that revolve around pay, conditions of service, working conditions and job satisfaction (Muula, 2005, p. 31). The
governments of developing countries could invest more in human resources by developing and providing targeted incentives and more realistic salaries to retain medical graduates. There has been reluctance to fund salaries on a wider scale (Muula, 2005, p. 8). The most common reason for the drain of health professionals is the poor salaries that characterize many health systems in Africa. Though this is a known push factor, not much has been done to curb this aspect of the brain drain. One reason for this is that many African governments receive grants and loans from international financial lending institutions such as the International Monetary Fund and the World Bank (Muula, 2005, p. 25). These sources of funds dictate how the money should be spent in order to continue receiving financial assistance. One of the requirements for receiving the loans is reduction of public spending. One way of reducing public spending is limiting payment of public workers and, because many health professionals in African countries are public employees, they end up being poorly remunerated (Muula, 2005, p. 25). Though this aspect will not be further discussed in this thesis, it makes one wonder whether the brain drain is caused by injustices due to international economic inequities.

Beginning with strategies that focus on training institutions, African health training institutions can “indigenize” their curricula so that their graduates will be trained primarily to care for common health conditions in Africa and not for health conditions in developed countries (Muula, 2005, p. 24). The indigenized curriculum would focus on creating health providers who can attend to the needs of that region. This would be similar in some respects to specialization of physicians. This strategy would make it less attractive for the developed countries to recruit from Africa. Africa does not need highly trained and sophisticated health workers, but instead front-line primary health care
workers. It is argued that most of what Africa needs is not physicians trained on the European model but rather health workers on the level of clinical officers and medical assistants (Muula, 2005, p. 24). The major problem with this proposal is that it must be accepted that this type of curriculum is not synonymous with inferiority and that relying on lower level health care professionals will not promote mediocrity.

When human resources become constrained, governments and health care institutions must brainstorm new strategies to train and retain health professionals. One national strategy for developing countries to combat personnel losses through international migration includes the use of staff whose qualifications are not internationally recognized. These staff members would provide basic services that many physicians provide, but are not trained as doctors (Martineau, Decker, & Bundred, 2004, p. 7). The problem with this approach would be that the quality of care may be poor, as providers with lower levels of training and experience are left to staff the health system (Muula, 2005, p. 23). The solution of training more health professionals is also naïve as it assumes that the resources for training are readily available. The training of health professionals requires highly skilled tutors and specialists at different levels who are not available in adequate numbers due to migration. To enable the development of these “mid-level” health professionals, additional investments in finances, personnel, and time would be required (Muula, 2005, p. 23).

If the resources are readily available and increased training becomes possible, another important issue is selection of appropriate candidates for training. Judging by the number of health care professionals who do migrate, the current trend appears to be that
professional schools are not recruiting persons who are likely to remain and serve in their own countries. Various studies show possible recruiting strategies to identify those who would stay. For instance, the findings in a study of South African medical graduates suggest that recruiting larger numbers of rural origin graduates may alleviate shortages of doctors in rural South Africa. Students of rural origin were more likely to work in rural areas than students of urban origin (de Vries & Reid, 2003, p. 92). Another study suggests that the background of medical students may determine who is likely to work in a particular setting after completing training (Ward, Kamien, & Lopez, 2004). If the intention of a health system was to train more physicians for rural areas, for instance, one could suggest considering the origin of the potential medical student at recruitment (Muula, 2005, p. 23). This solution raises the question of whether it is ethically appropriate to deprive one of graduate education based upon the prospective student’s potential use of their degree. However, this is done in many developed nations, as a student may not gain acceptance to particular medical schools if their future career goals do not align with the curricular goals of the medical school.

Since the pull towards overseas employment will likely remain very strong in these countries no matter how well designed the strategies are for attracting and retaining health personnel, it may be appropriate to accept that in such a situation, migration is inevitable and should be actively yet responsibly managed (Muula, 2005, p. 27). At this point the policy debate should move on to ensuring that the needs of medical graduates in source countries are met. This would require flexible employment to enable people to work abroad temporarily and then return to their employment at home without the risk of losing their job. A good example of programs for encouraging return is the program of
the Fogarty Institute that offers African researchers and academics incentives such as research funding to return to and then remain in their country of origin (Muula, 2005, p. 27). Such actions may provoke resentment among other local staff as the income differences between researchers supported by Fogarty and local researchers may be huge.

Responsibly managing migration can also mean setting up bilateral agreements with recipient countries as a national strategy. These agreements should promote time-limited positions, to ensure that the health professionals return and also that others get their chance to work abroad (Martineau, Decker, & Bundred, 2004, p. 7). A properly managed agreement would also protect people from deceitful recruitment agencies and ensure that people are employed in jobs that make use of their skills. Agreements should be made so that temporary migrants gain skills relevant to their country’s needs, thus providing a win–win situation for the recipient and source countries, as is done with the Fogarty Institute training programs (Martineau, Decker, & Bundred, 2004, p. 7). While this form of managed migration appears to be a good option to cope with the brain drain, it does carry risks. Many governments do not have the discipline or the ability to manage that type of process. However, without better alternatives it is a plan that should be considered.

Another possible solution would be not only to have agreements with recipient countries, but also with medical students. In some African countries where the training of health professionals is fully funded or subsidized by the government, individuals do not receive a diploma upon completion of their training (Muula, 2005, p. 27). These are withheld by the government until the training costs are repaid financially or through service, a method referred to earlier in this thesis as bonding. However, bonding can
provide controversy between personal autonomy of health professionals who may feel they have the right to decide where to work and need not to be restricted by the government (Muula, 2005, p. 27). In response the government may feel that the health professional has a duty to serve his or her society as his or her training was financed from public funds. The idea of bonding raises moral questions of how one’s rights should be balanced by responsibilities and social obligations (Muula, 2005, p. 27).

The problem of the brain drain cannot be solved by merely blaming recruiters in developed countries. Problem solving will require identification of the responsibilities of each stakeholder and acceptance of responsibilities by those stakeholders. On an international level better monitoring of migration patterns by all countries is needed to create effective policies. Dialogue between source and recipient countries should lead to agreements that are guided by ethical codes of practice on international recruitment. Source countries must work on improving staff attraction and retention and development assistance, while recipient countries should focus on improving their health services through domestic solutions, rather than contribute to the drain of health professionals from developing countries (Martineau, Decker, & Bundred, 2004, p. 9). When all sides concentrate more on their own responsibilities, progress and policies can be made.

The analysis of the brain drain in this thesis has challenged some of the popular perceptions regarding who is to blame, who needs to take responsibility, and whether the brain drain is in fact an ethical problem and a major cause of poor health in developing countries. One author has criticized the viewing of physician migration as a moral problem and suggested that the word “brain drain” be removed (Loefler, 2001). I believe that the loss of health human resources from the developing to developed countries is
indeed a moral issue, as the defensible moral decisions of individuals result in a major
problem of global justice. Many of the issues generating debate on the migration of
health personnel include balancing rights of workers, communities, patients, and
countries, while avoiding unfair inequalities that may result due to migration. Notions of
fairness imply a need for moral debate on rights and obligations around movement and
migration of health personnel and how it affects the personnel themselves, their
employers in developed and developing countries, users of health services, and training
and labor market institutions (Padarath et al., 2003, p. 36). This thesis has attempted to
highlight the varying areas of focus for policy development and to provoke thought about
effective and sustainable measures that can be reached to ameliorate the adverse
consequences of the brain drain. Initiatives should be adopted at regional and
international levels by governments, private health institutions, and potential health
professionals themselves to limit the effects migration has on poor healthcare systems.
However, these initiatives should not unduly limit health workers’ rights to migrate to
secure personal wellbeing for their family and themselves, even if it has costs to the
health systems of their home countries.
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EDUCATION

*Wake Forest University*, Winston-Salem, NC

**Bachelor of Arts in Biology**, May 2009

**Master of Arts in Bioethics**, December 2010

WORK EXPERIENCE

*Lord & Taylor*, Sales Associate, Gaithersburg, MD, Winter 2006

- Processed sales, exchanges, and returns in various areas of the department store
- Organized Sales floor and setup displays
- Greeted customers as they entered the department store and assisted customers with locating merchandise and suggested related merchandise the customer might be interested in

*Camp Counselor*, Mercersburg Adventure Camp, Mercersburg, PA, Summer 2003 – Summer 2008

- Instructed campers on the importance of fitness through sports and outdoor activities
- Collaborated with fellow counselors to organize weekend social activities
- Completed objectives and skills evaluations in accordance with the curriculum of the AHA for Heartsaver AED program.
- Supervised children ages eight to sixteen while attending a sleep away camp

*Teaching Assistant*, English Secondary Language Camp, Mercersburg, PA, Summer 2007 & 2009

- Assisted students with the development of a personal portfolio to show progress of learning a new language.
- Developed and implemented extracurricular activities for students to participate in outside of schoolwork
• Worked with faculty to focus and follow through with enrichment activities to facilitate the process of teaching a new language to students.
• Provided help to students who struggled with their homework assignments

**Health Center Liaison**, English Secondary Language Camp, Mercersburg, PA, Summer 2007

• Administered medicine to campers daily at lunch and bedtime
• Recorded necessary information about camper injuries such as location, medical history, details of the accident, and precautionary measures taken.
• Reviewed medical forms with the student health services center to ensure parents had submitted the proper paperwork in case of emergencies


• Contacted Wake Forest alumni, parents, and friends and updated constituent records accurately
• Helped foster goodwill with alumni, parents, and friends and brought Wake Forest constituents up-to-date on current events regarding university
• Increased awareness of The Wake Forest Fund and programs at Wake Forest and raised funds for Wake Forest over the phone

**Peer Counselor**, DC College Success Foundation, Washington, DC, Summer 2009

• Mentored male and female high school seniors from two of the economically neediest sections in Washington, DC to support college goal-setting and planning
• Assisted university professors and instructors in presenting academic sessions focused on SAT level Math and English
• Provided a support system for these students of low income background outside of the high school environment

**Student Assistant**, Z. Smith Reynolds Library, Winston-Salem, NC, Summer 2010

• Greeted library patrons in person and on the telephone
• Prepared materials to be placed on reserve, responded to requests, answer questions and make referrals
• Checked out materials, searched for missing items, took inventory, did shelf reading, kept circulation statistics, checked in, arranged and reshelved returned items

**Assistant Medical Coordinator/Instructional Therapist**, Community Services for Autistic Adults and Children, Fall 2010 - Present
• Responsible for providing one-to-one direct care and support to children in their home settings.
• Provides residents with the training in skills areas to enable them to live in less supervised environments and become active members in their communities.
• Provides smooth transitions to and from caregivers, reporting all relevant transitions to families and staff.
• Plans and implements daily activity schedule; collects data as specified in a behavioral or instructional program.
• Maintains a respectful interaction with the child at all times; maintains a good rapport with the individual's family.
• Prepares and disseminates a monthly calendar of medical, dental and lab appointments; prepares and disseminates pre-appointment written notification to Residential Support Coordinators and Employment Managers.

EXTRACURRICULAR ACTIVITIES

Volunteer, Rehab ABI, Wake Forest University Baptist Medical Center, Spring 2008-Spring 2009
• Transported, observed, and assisted with patients in rehabilitation areas for acquired brain injuries.
• Documented patient behavior for nurses and physicians while supervising the patient.
• Inventoried and assembled medical supplies.
• Delivered patient paperwork to appropriate departments and labs located in the medical center.

Volunteer, Campus Kitchen, Wake Forest University, Fall 2007 - Fall 2008
• Prepared meals and delivered them to senior citizens and drug rehabilitation programs in the nearby community.

Event Chair, Kappa Sigma Fraternity, Wake Forest University, Fall 2007 - Fall 2008
• Coordinated with Event Chairs of other fraternities, organizations, and sororities to organize over 50 events.
• Helped organize the Mark Pruitt Charity run for cancer research by contacting Fraternity member alumni & families, businesses of the Winston-Salem community, and members of the Wake Forest University community to accumulate donations.
• Scheduled a St. Baldricks charity event for children's cancer research.

Student Advisor, Student Orientation, Wake Forest University, Fall 2008 – Spring 2009
• Assisted new students with transition issues, student life issues, and campus resources
• Provided support system for incoming students making transition to college
• Teamed with a faculty adviser to form an academic advising network for a small group of first year college students