Ethics in Migration and Global Health Delivery: Issues of Justice and Integrity

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Abstract

This paper examines two sets of ethical issues relating to the health of human migrants and the delivery of healthcare across the globe. The first set pertains to the access of migrants to health care services in their adopted (or adopting) countries. The second set of issues arises in connection with the migration of healthcare professionals from low- and middle-income countries to high-income countries. In the final section the paper looks at these two sets of issues as interconnected concerns within a broader global justice framework of healthcare delivery. We show how the justice issues in the first set relate to the justice issues in the second set. In the end, we propose the adoption of that broader framework, making reference not only to issues of justice but also to the question of the integrity of medicine and the noble objectives of healthcare delivery.

Keywords: Health Migration Ethics, Global Justice, Integrity, Human Resources

I. Introduction: HRH Migration

Human resources for health (HRH) consist of healthcare professionals and technicians. As with other human resources, they migrate internally (in-country) or internationally. “Brain drain” is a term commonly used to refer to such movement. The term suggests a negative impact that covers economic, social cultural, political and ethical dimensions. This paper focuses on ethical dimensions while recognizing that ethical issues are very closely tied up with economic, social, cultural and political concerns. Hence this is not merely about brain drain but also about broader concerns that may be overlooked when the focus is on the geographical movement of persons.

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We consider two types of issues that have been discussed in the literature. One set has to do with the access of migrant (healthcare or otherwise) workers to healthcare in their countries of work. Fairness issues arise when these workers are not able to access the same level of healthcare services that are granted to those who are citizens or long-term residents. This could happen when access to healthcare or other basic services is made to depend on citizenship or different levels of residency corresponding to workers’ varying contractual conditions. For instance, migrant workers who serve as nannies or perform other domestic work may have working contracts that (because of limited wages) will not enable them to access or purchase relatively low-cost healthcare. We question the fairness of applying these different levels of entitlement as well as the ethical foundations of what we consider to be unjustifiably discriminatory criteria. We also argue that the issues discussed in this connection ought to be seen in relation to the migration of healthcare professionals in the same general direction.

The second type of issues arises more directly from the migration of healthcare professionals from low- and middle-income countries to high-income countries and is more closely related to brain drain. This paper seeks to show why an exclusively brain drain-focused framework fails to provide a satisfactory rendering of the ethical issues, especially because governments have tended to accept economic formulae showing that gains from HRH migration outweigh the economic losses. There are overriding considerations more important than the economic ones.

In the end, this paper looks at these two sets of issues as interconnected concerns within a broader framework of global healthcare delivery. Seeing the interrelatedness, we argue that one ought to be concerned not only with issues of justice but also with fundamental questions about the noble objectives of healthcare delivery and the integrity of medicine and the medical profession.

II. International Migrants: Access to Healthcare

The number of international migrants throughout the world today is at the greatest level it has ever been. The rate of increase has been observed to be proportional
to that of the overall growth in the global population. As a consequence, the total number has become extremely difficult to manage. Agencies and authorities trying to address migrants’ health issues find that their work has been rendered more complex because of differences among population groups they have to deal with. While many migrants continue to search for work or education, there are now huge numbers of migrants who are rendered more vulnerable to abuse and exploitation by being asylum seekers and refugees. Thus, there is a rising concern about meeting migrants’ health needs in their new surroundings.

Apart from having to contend with unfair healthcare policies, migrants often have to deal with obstacles to access health services in the host country, including language issues, uncertainties in migration status, unreliable information about health services, reluctance of employers to provide health coverage, or unsuitable health facilities’ opening hours.

It can be useful if source countries provide health insurance coverage for their citizens who migrate for work — as in the case of migrants from the Philippines who are covered under the Philippines Health Insurance Corporation — for overseas hospitalization and confinement of legal dependents back home. However, these perks can only account for a small portion of the total cost of healthcare.

Pre-departure health assessments in both source and destination countries can help identify conditions that can be treated if that is part of the plan. However, this can have the effect of restricting citizens’ freedom of migrating, considering that many countries still have restrictions on the entry of people with HIV.

Taking cognizance of the health of female migrants, the UN Economic and Social Commission for Asia and the Pacific observes that in many countries, foreign female workers’ dependency on their continuation of work is affected largely by whether

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3 Eckenwiler, “Care Worker Migration and Transnational Justice,” 171-183.

they are pregnant or not. It cites Singapore as an example of a country where migrant domestic workers “must have a semi-annual check for infectious diseases and pregnancy. Those found to be pregnant are subject to termination of work and immediate repatriation.”

This should remind us of the need to focus also on migrants’ sexual and reproductive health rights.

**A. Financial Constraints and Health Care Access**

It is understandable — but not necessarily acceptable — that financial constraints have led many countries to restrict access to healthcare for certain migrant groups. Some countries have completely excluded migrants from routine health services. Among those that have been known to provide good healthcare access to migrants, some have tried to scale back on non-nationals’ entitlements. In 2012, when the Spanish Government approved the transition from a National Healthcare System (NHS) to an insurance model, it effectively abolished universal healthcare access and non-citizen residents lost their right to healthcare, except in the area of emergency services and maternal health.

On another front, Canada has sought to reduce medical entitlements of new-comers, in apparent violation of rights enshrined in its constitution.

There is a tendency to look at migrants simplistically as non-nationals taking advantage of better living conditions within a host country. In part at least, this has been the reason why international migrants do not have fair access to healthcare in many countries. Among the most vulnerable to such policies are irregular migrants and asylum seekers. According to a 2006 study, asylum seekers were legally entitled to emergency care in only 10 of 24 European countries. Undocumented migrants continue to be restricted

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6 Eckenwiler, “Care Worker Migration and Transnational Justice,” 171-183.
in their access to healthcare in many countries.\textsuperscript{10} While Australia admits 13,500 refugees a year and refugees are entitled to free medical assessment on arrival, asylum seekers have difficulty accessing medical care and are not eligible for free medical treatment under the national insurance scheme. Lacking financial resources, they have to find services that are offered for free.\textsuperscript{11}

In Denmark, emergency care is available to undocumented migrants as a matter of right but additional care is restricted and may be subject to payment. In Sweden, such migrants have the right to emergency care only. Asylum seeking children are considered as an exception as they are recognized to have the same rights as Swedish citizens. In the Netherlands, undocumented migrants have access to primary, secondary, and tertiary care.\textsuperscript{12}

B. Healthcare Access: Rights of Nationals and Non-Nationals

The entitlements mentioned above are granted in the context of these countries’ ratification of international human rights treaties that provide for the right of access to healthcare services. Nevertheless, outstanding barriers to health care access persist. In Denmark, a study of undocumented migrants and emergency room nurses found that entitlements are not always availed of because of the lack of knowledge about the healthcare system, the fear of being reported to the police, language difficulties, inadequate referral systems, uncooperative practitioners, and a lack of recognition of specific health requirements. These factors may lead to delays in seeking treatment and the use of less effective or even illegal health-seeking strategies such as self-medication, informally contacting doctors in home countries for advice, and borrowing health insurance cards from Danish residents.\textsuperscript{13} A study among Danish health professionals reveals a perception that undocumented migrants experience inequities in accessing


primary care, and that primary health practitioners are uncertain how to respond to this patient group.14

The barriers to universal healthcare access also constitute an impediment to the implementation of international human rights law, as reflected in the Universal Declaration for Human Rights, the International Convention of the Rights of the Child, the International Convention on the Elimination of All Forms of Racial Discrimination, and the Constitution of the World Health Organization. These international legal instruments are anchored on a human rights framework consistent with the idea that human beings deserve to be treated equally and are entitled to the same basic human goods, whatever their nationality or citizenship. Also pertinent are United Nations treaty provisions including Article 12 of the International Covenant on Economic, Social, and Cultural Rights,15 which establishes the “right to the highest attainable standard of physical and mental health.” The details and implications of this provision are expressed in General Comment 14 of the ICESCR.16

International migration involves a dynamic and interdependent interaction among communities, countries and regions, as well as various sectors of society. Addressing ethical concerns in international migration and health requires close cooperation and collaboration among countries, as well as among sectors and related institutions involved in the migration phenomenon.17 The dialogue needs to transcend national boundaries as well as the nationalities of the full range of stakeholders, from the most powerful to the most vulnerable. Studies have documented how, for various reasons, vulnerable migrants are denied access to an appropriate level of healthcare. Hence, it is important “to explore and document models of best practice in the developed-world context for delivering services to various migrant groups, and their impact on health outcomes.”18

Policies that withhold healthcare entitlements from migrants on account of their

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17 Oberoi, “International Migration, Health and Human Rights.”

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nationality fail to take into account the different reasons that migrants have for moving or the variable circumstances in which migration is taking place. Such policies ignore the often overlooked fact that, in the first place, many migrants start off being recruited by agencies of the adopting countries because of an urgent need for work skills that local citizens or residents are not in a position to provide. Migration is such a complex phenomenon that trying to understand it only from the perspective of nationality constitutes an oversimplification that engenders unjustified appeals to false nationalism and xenophobia. It also fails to give due recognition to the magnitude and significance of the contribution that migrants make to the destination country’s economic, political and social growth. In general, it fails to recognize “the fundamentally dynamic character of migration.” 19

The exclusion of migrants from a rights-based approach to health magnifies the inevitable vulnerability of migrants by creating and amplifying discrimination and health inequalities, resulting in higher health costs for migrants. On the other hand, looking after the health of migrants effectively promotes integration, social development and the observance of human rights. 20 In order to promote these ends, “institutions have to be reformed on a philosophy of social inclusion — that it is a human right to have equal access to health-care services…You can have discrimination simply by failing to include people.” 21

Brock 22 elucidates a cosmopolitan ethics perspective that transcends the kind of nationalism that excludes non-nationals from healthcare access. According to this perspective, every person has global stature as the ultimate unit of moral concern and is therefore entitled to equal respect and consideration no matter what her citizenship status or other affiliations. This global justice framework helps to define a mandatory level of healthcare for migrants, and a corresponding moral duty to provide healthcare that is not based on charity. This is important as charity can be regarded as optional. Cosmopolitanism entails a willingness to address the vulnerabilities that non-nationals

20 Oberoi, “International Migration, Health and Human Rights.”
bear. The suggestion is that this can be done concretely by looking after the health “of non-compatriots who are residents of our community.”\textsuperscript{23} This view of providing help to non-national migrants is determined by several “ethical frameworks, including those associated with Good Samaritanism, Obligations of Mutual Aid or the Duty to Rescue and that those who take the opposite view must bear the burden of proof.”\textsuperscript{24}

\textbf{C. Summary}

The main point of this section is to illustrate the discrimination that is being perpetrated against migrant workers by government systems directly or indirectly through policies being implemented by governments. As we move forward, we re-examine the economic card and argue that the discrimination described here ought to be seen as being intimately related to the more specific phenomenon that is the migration of healthcare workers. The phenomenon takes HRH away from the migrants’ countries of origin and brings them to destination countries where their compatriots have difficulty of access to the healthcare services that they help provide. One can speak of double jeopardy characterized by the diminishing capacity to provide universal healthcare in a source country because of outward HRH movement and at the same time by the failure of migrants from the same source country to access necessary healthcare in the destination country of their HRH compatriots.

The following section takes up issues arising in connection with the migration of healthcare professionals from low and middle-income countries to high-income countries. We examine the concomitant problems from a brain drain framework and move on to show that a purely economic assessment is unwarranted. A myopic brain drain framework has a tendency to treat HRHs as mere instruments for economic prosperity. It also fails to recognize the essential significance of medicine and healthcare in support of human life and human flourishing.

\textsuperscript{23} Id.
\textsuperscript{24} Id.
III. HRH Migration: Ethical Implications

The migration patterns that negatively impact healthcare are understandably those that move from the poorest regions to the richest cities within a country, from low-to high-income countries, and from a poorly funded public sector to private. Analyses show push and pull factors that drive HRH migration. Push factors that drive HRH away from source institutions or jurisdictions include low salaries, no overtime and hazard pay, poor health insurance coverage for workers and their families, work overload or stressful working environment, slow promotion or lack of professional incentives, limited employment opportunities, decreased health budget, socio-political and economic instability, and inadequate health system planning. “Pull” factors attract health workers from less endowed institutions or jurisdictions. These include higher income, better benefits and compensation packages, lower staff to patient ratio, flexibility in working hours, the possibility of upgrading professional skills, chances for the entire family to migrate, opportunities to travel and learn about other cultures, influence from peers and relatives, advanced technology, and socio-political and economic stability.

A. Right and Obligations

As in the case of efforts to deal with the negative impact of worker movement in general, efforts to address the negative impact of HRH migration have to be undertaken in a manner that respects the rights of workers and takes into consideration the obligations of governments. One’s assessment has to be guided by the interlocking rights of workers and obligations of governments. The Universal Declaration on Human Rights\(^\text{25}\) recognises “the rights of individuals to a decent standard of living, health, education, safe work and work environment, as well as the right to migrate, among others.” Many health workers in low-income nations are unable to enjoy rights pertaining to living standards. They find their governments unable to guarantee enjoyment of those rights. The inability to enjoy minimum living standards, as well as the resultant frustration of health workers have encouraged the latter to consider migrating to countries with

better conditions.

Measures implemented by governments from low-income countries to avoid losing domestic health workers to migration have ranged from the dangling of incentives to the use of coercion. Incentives have included increased salaries, allowances, provision of personal vehicles, and scholarships for further studies. On the other hand, coercive measures have taken the form of withholding training certificates, charging exorbitant prices for documents needed for registering abroad, repaying subsidies given by government for their education, and even withholding their passports.

Some of these measures have generated controversy because of the claim that they infringe on the basic human rights of health workers. On the other hand, some steps taken by destination countries to control or reduce the migration of healthcare workers from low-income nations have also been opposed for being infringements on their rights to migrate and pursue comfortable lives. These rights infringements have been encountered to varying degrees in different countries. It is necessary to adopt a global framework for improving conditions that seeks to eliminate these infringements because the issues transcend global boundaries and national loyalties.

B. Global HRH Migration Imbalance

Contributing to the lopsided migration cycle are the HRH shortages in developed countries. Such shortages are due partly to a growing aging population and exacerbated by the emerging features of global health — increasing burden of chronic diseases and the ever-growing options for high-technology and expensive healthcare. All of these features require highly-trained health professionals who developing countries are quickly challenged and encouraged to produce. By 2012, deficits in workforce in the developed world had resulted in imbalances in migration: 1.5 million health worker shortage in Africa; 2.4 million health worker shortage in the world’s 57 poorest nations; and more than 95 million of 232 million migrants coming from the Asia-Pacific region.26

The United States and Canada combined have the highest share of HRH throughout

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the world at 37% even as they only account for 10% of the global disease burden. Europe has 28% of the global health workforce to deal with its 10% share of the global disease burden. On the other hand, Africa has 24% of the world’s disease burden but the entire continent only has 3% of the world’s HRH. One can see in these imbalances in health workforce capacity, health financing, health spending, and corresponding disease burden that the poorest countries, who have the worst shortages and health outcomes, contribute the greatest percentage of physicians and medical graduates to high-income countries.\(^\text{27}\)

The following tabulation of physician density further illustrates the global HRH imbalance:\(^\text{28}\)

<table>
<thead>
<tr>
<th>Density of Physicians (per 1000 population)</th>
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<tbody>
<tr>
<td>USA</td>
</tr>
<tr>
<td>UK</td>
</tr>
<tr>
<td>Canada</td>
</tr>
<tr>
<td>Australia</td>
</tr>
<tr>
<td>Singapore</td>
</tr>
<tr>
<td>India</td>
</tr>
<tr>
<td>Ethiopia</td>
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</tbody>
</table>

High-income countries with low disease burdens have more physicians per 1000 population than low-income countries with high disease burdens. For the nursing workforce, the same contrast between high and low-income countries is apparent:\(^\text{29}\)

<table>
<thead>
<tr>
<th>Density of Nursing / Midwifery personnel (per 1000 population)</th>
</tr>
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<tbody>
<tr>
<td>USA</td>
</tr>
<tr>
<td>UK</td>
</tr>
<tr>
<td>Australia</td>
</tr>
<tr>
<td>India</td>
</tr>
<tr>
<td>Costa Rica</td>
</tr>
</tbody>
</table>

\(^{27}\) Mackey and Liang, “Rebalancing brain drain,” 66-73.


\(^{29}\) Id.
Almost 25% of doctors in the United States and 30% of those in the United Kingdom have been trained outside the country. The figure for Israel is even higher at more than 58%.\textsuperscript{30}

<table>
<thead>
<tr>
<th></th>
<th>Domestically-trained</th>
<th>Foreign-trained</th>
<th>Percentage of foreign-trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>640,199</td>
<td>211,771</td>
<td>24.857%</td>
</tr>
<tr>
<td>UK</td>
<td>119,171</td>
<td>48,766</td>
<td>28.26%</td>
</tr>
<tr>
<td>Australia</td>
<td>51,626</td>
<td>26,617</td>
<td>32.668%</td>
</tr>
<tr>
<td>Canada</td>
<td>70,021</td>
<td>22,228</td>
<td>23.976%</td>
</tr>
<tr>
<td>Israel</td>
<td>10,729</td>
<td>14910</td>
<td>58.117%</td>
</tr>
</tbody>
</table>

Developed countries also draw heavily on foreign trained nurses for their healthcare needs:\textsuperscript{31}

<table>
<thead>
<tr>
<th></th>
<th>Domestically-trained</th>
<th>Foreign-trained</th>
<th>Percentage of foreign-trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA (2012)</td>
<td>3,858,563</td>
<td>246,291</td>
<td>~6%</td>
</tr>
<tr>
<td>UK (2014)</td>
<td>596,902</td>
<td>86,668</td>
<td>~12.678%</td>
</tr>
<tr>
<td>Australia (2014)</td>
<td>213,655</td>
<td>48,279</td>
<td>~17.796%</td>
</tr>
<tr>
<td>Canada (2014)</td>
<td>353,426</td>
<td>29,530</td>
<td>~7.69%</td>
</tr>
<tr>
<td>Israel (2014)</td>
<td>42,819</td>
<td>4,277</td>
<td>~8.943</td>
</tr>
<tr>
<td>New Zealand (2014)</td>
<td>34,382</td>
<td>11,170</td>
<td>~24.511%</td>
</tr>
<tr>
<td>Switzerland (2012)</td>
<td>27,574</td>
<td>11,536</td>
<td>~18.725%</td>
</tr>
</tbody>
</table>

The following summary highlights the lopsided imbalance pertaining to HRH production and HRH utility:

1. The United States, United Kingdom, Canada and Australia combined use 23-28% of all international physician graduates, highlighting the dependence of developed countries on foreign medical training and education.
2. 40-75% of medical school graduates from lower-income countries migrate to serve the HRH needs of developed countries, with the UK and the USA representing the first and second largest recipients.
3. Sub-Saharan Africa, the Indian subcontinent, and the Caribbean, where some of the world’s most severely challenged economies are situated, have the highest

\textsuperscript{30} Id.
\textsuperscript{31} Id.
healthcare worker emigration.\textsuperscript{32}

Zooming in on the example of the United States, one could see that severe care worker shortage is due to high turnover rates and a reluctance on the part of individuals to enter the field. Compared to 2005 figures, the growing elderly population is set to double in 2030. Given the increased needs for more complex biotechnology-enabled care, the demand for healthcare workers will continue to rise, thus increasing the pressure for more aggressive migrant HRH recruitment. Eckenweiler has observed that:

The percentage of foreign-trained nurses entering the US labor market have increased at a rate faster than that of US-educated new nurses … Perhaps especially important is the point made above, that new foreign-trained nurses in the United States are increasingly likely to come from low-income countries with a low supply of nurses … [and] a high burden of disease.\textsuperscript{33}

C. Economic Impact of HRH Migration

HRH source countries often depend on their care workers for economic survival. The Philippines, for instance, is known to anchor its economic growth and stability on its huge service sector and is reputed to be the largest source of registered nurses working overseas. The skilled nursing workforce of the Philippines is “migrating faster than it can be replaced, threatening the viability of the country’s health services.”\textsuperscript{34} This has already led to the closing of hospital wards or even of entire hospitals. The most highly trained nurses are the ones that recruiters poach, setting in motion a train of local migration from rural and suburban hospitals to highly urbanized institutions. The local healthcare system remains unable to replace skilled HRHs in a timely manner.\textsuperscript{35}

In general, migrants are responsible for a significant portion of host countries’ GDP growth, while sending back home (usually developing nations) about $435 billion

\textsuperscript{32} Mackey and Liang, “Rebalancing brain drain,” 66-73.
\textsuperscript{33} Eckenwiler, “Care Worker Migration and Transnational Justice,” 171-183.
\textsuperscript{34} Mackey and Liang, “Rebalancing brain drain,” 66-73.
\textsuperscript{35} Id.
in remittances. 36 Although money sent home by migrant healthcare workers help in a way, “the adverse effects of losing them is not likely compensated by remittances, for they tend neither to contribute to the development of health systems specifically, nor to compensate for the overall economic consequences of losing educated workers.” 37

The World Migration Report 38 has pointed out that, globally, USD 77 billion had been sent back to countries of origin in the form of remittances in 1997. In 2012, that figure had risen to an estimated USD 529 billion. 39 For Lesotho, remittances from migrant workers represented about 50 per cent of the GDP. 40

While the migration of care workers offers certain benefits for both developed and developing world, the net effect could still be lopsided against developing countries. The fact is that the health care situation in source countries has not improved enough, even if remittances from migrant HRHs have increased and the global balance of migrant HRH and burden of disease continues to deteriorate.

As Eckenweiler maintains, “social and economic norms and processes serve systematically to undermine or constrain some people’s abilities to develop their capacities … and to threaten their equality while at the same time enhancing and expanding others’ prospects.” 41

It is expected that the brain drain will persist for some time, in irreversible mode, as demand continues to outstrip supply. In addition to general concerns about the unidirectional movement of HRHs globally, there are specific developments in various countries or regions that hit resource-poor countries when current push or pull factors are allowed to prevail by mere inaction. For example, the expansion of the European Union (EU) has given rise to more porous boundaries associated with reduced barriers that encourage greater HRH migration from less developed countries. In the USA, a massive healthcare reform has been undertaken that purportedly provides wider healthcare access for uninsured persons. The resulting increased demand for healthcare

36 Id.
37 Eckenwiler, “Care Worker Migration and Transnational Justice,” 171-183.
40 Id.
41 Eckenwiler, “Care Worker Migration and Transnational Justice,” 171-183.
services is likely to attract even more international health workers.42 While such developments can be attributed to the general processes of globalization,43 we maintain that destination countries cannot allow the expected poaching of HRHs from developing countries to take place without assuming responsibility for their consequences related to the ability of the source countries to maintain their own healthcare systems. It is a moral obligation of developed countries to redress brain drain at least by remedying net losses in the developing world and by taking proactive measures to prevent further brain drain.44

D. Summary

By most accounts, HRH migration has brought about economic amelioration to individual migrants concerned, their families, and, with remittances, their sending countries. It also upholds freedom of movement. Ultimately, however, current HRH migration arrangements produce a net negative in terms of human rights, and also possibly in terms of long term economic outcomes. The migration of healthcare professionals from low and middle-income countries to high-income countries is not necessarily in the best interests of these HRHs and the health systems they leave behind. It perpetuates a vicious cycle of want for migrant labor, without governments and institutions assuming responsibility for the deleterious effects of the migration imbalances on the healthcare systems of sending countries. The “addiction” of high-income countries to migrant labor tends to breach the “floor” set by the Universal Declaration of Human Rights and other international legal instruments vis-a-vis discriminatory practices against migrants and the resulting risks to the health and well-being of sending countries. Migrant workers cannot ethically be treated as mere means to the healthcare goals of high-income countries without compromising the integrity of medicine and healthcare in a global scale.

IV. HRH Migration: A Challenge to the Ends of Medicine

WHO’s “Global Code of Practice on the international recruitment of health personnel”\(^{45}\) (hereafter abbreviated as “WHO Code of Conduct”) provides the foundation for regional or bilateral agreements to “promote more equitable resource sharing between countries.”\(^{46}\) While the WHO and other agencies have proposed ways of addressing the problems arising from HRH migration, it is not very clear that the parties involved have acted harmoniously in this effort. An overarching ethical framework is required. A global justice framework should be capable of bringing together viewpoints that are not initially aligned. It ought to be global in order to encompass not only individual health migrants and recruiters but also state actors and regional leaders. This paper takes the position, along with Pogge,\(^{47}\) that agents have a stronger moral reason to make sure that people are not harmed through their negligence than they have to ensure that people are not harmed through causes that are outside those agents’ control. Applied to HRH migration, governments can be said to have stronger moral reason to ensure that people are not harmed through their inaction. By inaction of governments in protecting the health and well-being of migrants, HRH migration harms migrants through causes that are not within their control.

The responsibilities of national governments are readily indicated in international covenants. For example, the International Covenant on Economic, Social and Cultural Rights (ICESCR) states that nationality must not be used as a ground for discrimination in relation to healthcare and other rights in the Covenant.\(^{48}\) Still, quite often, governments


\(^{48}\) Oberoi, “International Migration, Health and Human Rights,” 16.
use nationality or legal status as a basis to draw a distinction between persons who may and may not enjoy access to healthcare facilities, goods and services. This contravenes international human rights law providing that all persons, without discrimination, must have access to all fundamental human rights provided in the International Bill of Human Rights.

Thus, the states these governments represent must be held responsible for the harm to migrants that they are unable to prevent. Such states can even be said to cause harm directly if they limit healthcare access of non-nationals on the grounds of “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.” It is an accepted principle that a state’s responsibility for ensuring non-discrimination includes ensuring equal protection and opportunity under the law, as well as in policies, programmes and everyday practices for the enjoyment of rights, such as the rights to health and social security. Additionally, states are obliged to monitor the effects of their social policies, public health policies and actions to ensure that there are no inequalities in the enjoyment of human rights. Based on information and data mentioned earlier in this paper, one can see that there have been many failures on the part of states. These failures represent injustices in the world that have been perpetrated by the states, mostly on account of economic reasons.

On account of these failures, this paper argues that the integrity and inherent value of medicine acquires relevance.

A. HRH Migration and the Inherent Value of Medicine

The primary end of medicine and healthcare follows from the definition of health as the “state of complete physical, mental, and social well-being.” The practice of medicine and healthcare must be dedicated to the pursuit of that end. That end ought to guide the pursuit, especially because health is also considered as “a fundamental

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49 Assembly, “International Covenant on Economic, Social and Cultural Rights (1966),” Art. 2.2
50 Oberoi, “International Migration, Health and Human Rights.”
51 Id.
right of every human being." It helps to understand the significance of medicine further, including the ends it must pursue, if we look back at the origins of the World Health Organization itself and the definition that is now attributed to it. In 1945, the United Nations Conference on International Organisations voted to establish a new international health organisation. The following year, the constitution of the World Health Organization was approved by the International Health Conference held in New York. For the next two years, an Interim Commission, composed of 18 states, took over the work of L'Office International d'Hygiene Publique, the Health Organisation of the League of Nations, and the Health Division of the UN Relief and Rehabilitation Administration until the WHO Constitution came into force in 1948 after getting enough country signatures.

Crucial to this paper’s argument concerning the ultimate end of medicine and the essential significance of medicine in relation to other human good is the idea that “the animating spirit behind the formation of the WHO was the belief that the improvement of world health would make an important contribution to world peace; health and peace were seen as inseparable.” There was also the conviction that health was “intimately related to economic and cultural welfare; in turn, that welfare, so it was assumed, had a direct bearing on future peace.” Memoranda submitted by participating countries further shed light on the idea of health as an essential human good:

A number of memorandums submitted to a spring 1946 Technical Preparatory Committee meeting of the WHO capture the flavor of the period. The Yugoslavian memorandum noted that “health is a prerequisite to freedom from want, to social security and happiness.” France stated that “there cannot be any material security, social security, or well-being for individuals or nations without health … the full responsibility of a free man can only be assumed by healthy individuals … the spread

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53 Id.
56 Id.
of proper notions of hygiene among populations tends to improve the level of health and hence to increase their working power and raise their standard of living.” The United States contended that “international cooperation and joint action in the furtherance of all matters pertaining to health will raise the standards of living, will promote the freedom, the dignity, and the happiness of all peoples of the world.”

Taken altogether, these views about the definition and significance of health amount to a confirmation of the idea that health is vital to human life and that good health must be regarded (as most of us do) as inherent to the good life. Hence, health should be considered not merely as a human good that can be sacrificed for economic gains. While HRH migration does result in economic losses for source countries, and could be addressed by measures transforming those losses into economic gains, the process would still be ethically compromised because it makes a mere instrument out of health status and the entire practice of medicine and healthcare.

Undeniably, economic crises can have an impact on access to healthcare. Extreme situations can require triage-like measures. Suess et al. cite findings of Médicins du Monde about an increasing lack of access for the analyzed population groups to primary care, prevention and vaccination services, complicating health care continuity, especially in case of chronic diseases and pregnancy.” Médicins du Monde also write that “In some cases, a refusal of health care is stated, despite the formal health care entitlement. While observing increased access barriers, a higher need of health care is detected, related to the impact of the economic crisis on previous situation of social exclusion.”

Economic difficulties can present handy excuses for sacrificing healthcare access, even when these are supposed to be protected by human rights legal instruments. Cost-saving measures violate the integrity of the medical enterprise if they discriminate

57 Id.
on the basis of nationality, race or creed, especially with reference to migrant workers. The pursuit of the ends of medicine cannot be compatible with discriminatory measures. If at all, an argument for reverse discrimination would even be in order, given that migrant HRHs from low-income source countries have been rendered vulnerable to the impact of economic crises by their having been recruited to provide healthcare to destination country nationals. Appealing to the ends of medicine and the integrity of the health care profession enables us to put in better perspective the policy proposals that have been put forward by WHO and other migrant advocate organizations. The proposals also acquire much stronger appeal that cannot be diminished by citing economic issues.

**B. Policy Proposals**

Adopted by the 63rd World Health Assembly on May 21, 2010, the WHO Global Code of Practice on the International Recruitment of Health Personnel is a ground-breaking instrument in that it marks the first time that WHO Member States have used the constitutional authority of the organization to develop a code in thirty years. It provides guidelines for recruiting international health personnel, with a view to maximizing benefits and minimizing negative effects of HRH migration, protecting the rights of individual HRH migrants, and strengthening health systems.60 Up to this point, however, the Code is still only a “soft law,” with no binding enforcement mechanisms.61 The lack of enforcement is reflected predominantly in higher-income destination countries (Australia, Canada, UK, and USA) that continue to benefit from HRH influx from resource-poor countries without making meaningful progress in terms of Code-compliant policies.62

Addressing the HRH migration imbalance ethically on a global scale can be expected to benefit from global resource or staff sharing and exchange programs.63 For example, programs have been proposed for “reverse” resource sharing arrangements where

62 Id.
63 Id.
countries that hire from resource-poor countries “should be subject to mandatory
cost-sharing and reallocation of resources in an attempt to mitigate disproportionate
losses borne by developing countries and subsidized gains by developed ones.”64 There
have also been proposals for Health Exchange Programs (HEPs) to allow domestic
and foreign HRHs from the source countries to return to their native countries and
provide services for extended periods of time. These programs can be supplemented
by technology sharing and transfer to resource-poor nations in order to increase impact.65
We maintain that the ends of medicine and the integrity of the health professions
can only be supported if the goals of these programs are driven by developing source
country needs instead of by destination country priorities.

Other proposals for addressing HRH migration issues focus on economic retribution.
For example, taking into account the “major transfer of riches from poor societies
to the affluent,” it has been argued that “the only appropriate redress is a bilaterally
managed scheme of direct reimbursement of the value lost.”66 The view is that trying
to enforce ethical recruitment policies is misguided because these policies are difficult
to enforce, characterized as they are by exploitable loopholes.67 Thus:

The only sure way forward is to compensate in full the value of transferred
wealth via direct financial and technical support to the affected health
systems. Money given could be earmarked for health spending, building
up health-system capacity, and facilitating progress on a host of other
development indicators. The cash would be channelled to the roots of
the problem, to treat the cause and not just the symptoms.68

While we support such initiatives, we are afraid that the kind of reasoning on which
these are based, taken in isolation, could be interpreted as offering a purely economic
solution that does not take sufficient notice of the ends of medicine as elucidated.

64 Id.
65 Id.
66 Kwadwo Mensah, Maureen Mackintosh, and Leroi Henry, “The ‘skills drain’ of health professionals
uk/8532/1/.
67 Id.
68 Id.
The proposal to earmark the money received for health spending makes the proposal nearly acceptable. Stipulating that the money received is going to be used exclusively for health spending makes the proposal even more appealing. It gives us an opportunity to highlight what this paper’s argument is all about—pursuing the ultimate ends of medicine and preserving the integrity of the health care professions.

In the first section of this paper we examined issues that pertain to the access of migrants to health care services in their adopted (or adopting) countries. We noted the unfairness of allocation policies that recognize different levels of entitlement, especially those that are based on nationality or residency. In the second section we examined ethical issues arising in connection with the migration of healthcare professionals from low- and middle-income countries to high-income countries. We highlighted the unsuitability of using a purely economic analysis to provide solutions to the ethical concerns. We find the need to look at these two sets of issues as interconnected concerns within a broader framework of global healthcare delivery. Seeing the interrelatedness, we argue that one ought to be concerned not only with issues of justice but also with fundamental questions about the noble objectives of healthcare delivery—the ultimate ends of medicine—and the integrity of medicine and the medical profession.

Received: October 3, 2016
Revised: November 14, 2016
Accepted: February 10, 2017