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# Human Resource for Health Migration: An Analysis from the Perspective of Utilitarianism

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# **Human Resource for Health Migration: An Analysis from the Perspective of Utilitarianism**

## **Introduction**

Medical brain drain or health-worker migration is a part of what has been labeled a global health workforce crisis and is characterized by the migration of trained and skilled health workers (doctors, nurses, and midwives) from low-income countries to high-income countries. It leads to loss in human capital for the developing countries, uneven distribution of those professionals between the affluent and poor countries and more severe suffering for the latter, due to the heavy disease burden (Kollar & Buyx, 2013; WHO, 2006). According to an estimate by WHO, a healthcare system is considered unable to deliver essential health services if it operates with fewer than 23 health workers (doctors, nurses, or midwives) for every 10,000 members of its population (WHO, 2006). There are 57 countries, mainly in Sub-Saharan Africa (SSA), whose health systems are operating below this threshold level, a problem exacerbated by a much higher disease burden compared to countries that have far better availability and distribution of health (Kollar & Buyx, 2013; WHO, 2006).

The Anglo-American countries are the major recipients of health workers from developing countries with 22.5-39% of their registered physicians coming from outside. The USA alone gets 47% of the total migrant doctors coming into the Organisation for Economic Co-operation and Development (OECD) countries (WHO & OECD, 2010). Forty-five percent of medical doctors and 61% of nurses in the world have been practicing in North America and Europe while the world population share of these regions is 21%. On the other hand, the share of doctors and nurses for the SEA region, which accounts for 26% of the world population, is only 20.2% and 7.9% respectively. In total, the global shortage of health workers has been pointed out to be as much as 4.3 million (WHO, 2006).

## **Reasons Behind Medical Brain Drain**

War and civil unrest, inadequate to no opportunity for further education, less relevance of the training knowledge and skills in the rural community settings, heavy patient loads, low

compensation for service under poor working conditions, absence of good schools for educating children, absence of adequate support and development at the workplace, and desire for better life among others have been pointed out as the common reasons behind medical brain drain (Blacklock, Ward, Heneghan, & Thompson, 2014; Poppe et al., 2014).

At the system level, the factors responsible have been pointed out as under-funding of human resources for health and overall health systems, owing to the harsh economic policies like Structural Adjustment Programs (SAP), leading to collapsed health systems and unsafe working conditions for health workers (WHO, 2006).

### **Implications of Medical Brain Drain for the Developing Countries**

It is well-appreciated that the availability of health workers and the health outcome indicators are closely correlated (WHO, 2006). As a result of the migration of the health workers, some of the general losses the developing countries face include fewer numbers of health workers available for consultation especially in the rural areas, less consultation time available for the patients due to heavy patient load, and consequently more health inequities. The shortage of health workers leads to overburdened public health systems and at the same time reduces the country's capacity to invite external support and implement international interventions for health assistance (Dreesch et al., 2005; Gupta et al., 2011). Supporters of brain drain argue that it contributes to the economy of poor source countries through the gain in remittances. (MSF, 2007; Ratha, 2005). However, closer analyses have shown that an individual migration always represents a huge loss in terms of human capital. The remittances sent home hardly compensate for the public investment in medical training and expected return over a medical career from a professional (Aluwihare, 2005; Packer, Runnels, & Labonté, 2010).

### **Brain drain and Utilitarianism**

Utilitarianism is a part of the broader view of consequentialism which has the idea that the morality of an action (if it is act-utilitarianism) or a rule (in case of rule-utilitarianism) is defined by its consequences (Henry R. West, 2014). It advocates for the need to produce the greatest amount of good (referred in terms of utility) for the greatest number. It means that the good consequences of our actions (and not just the decisions to act) as individuals should outweigh the

bad consequences or harm and thereby result in maximum happiness or benefit for the most people involved.

Medical brain drain examined through the lens of utilitarianism helps us understand the effects of the health professionals' choice to emigrate in terms of utility, as this action is bound to have varying effects on the lives of not just the émigrés and their families but also the source countries' health systems (Baker, 2002; Dreesch et al., 2005), the service recipients of those émigrés in the source countries, and also the destination countries (AMA, 2010; Gupta et al., 2011).

When analyzed from the realm of individual choice of the health professionals, their decision to migrate in pursuing better life can be adjudged to have been guided by their choice to do whatever maximizes their utility. By doing so, the health professionals have taken care of self-interest, not just for utilizing their rights as human beings but also for performing the duty of looking after their self-interest and taking care of their happiness (Bohl, 2009). However, when the same issue is viewed from the different perspective that people have a moral obligation to help, serve, or benefit others in need, even at the cost of self-interest in order to maximize the happiness for the majority, the decision made by the medical personnel to migrate from the poor home countries to affluent countries, leaving behind the broken health systems and the ailing fellow compatriots, could be judged to be unethical (Sanders, 1988).

Another way to look at the ethical dilemma associated with the migration of health professionals is linked with practices adopted by the developed countries in attracting (or in many cases actively recruiting) the medical graduates from developing countries instead of training more native health professionals in order to meet the increasing demands for such cadres of professionals. The argument could also be made that the developed countries have done nothing wrong by welcoming the foreign health professionals, as the former are merely guided by the motive of helping their citizens who are deprived of enough health care providers and thus acting to maximize the utility for those communities in developed countries. Furthermore, arguments have also been put forth that the medical brain drain has not been proven with evidence to have had any significant effects on health systems and outcomes of the developing countries (in contrast to the evidence presented earlier in the article of how medical migration has been affecting the developing countries' health systems and general populations) (Mastin L, 2008).

This justification would mean the developed countries are assuming that their priorities of maximum happiness for the majority come before that of any other country and they don't necessarily care about the harms brought by their actions in inflicting the influx of foreign health professionals into their country, leaving behind the suffering population in their home countries.

From this discussion it follows that this issue can be examined from the utilitarianism perspective in two ways:

- 1) If the decision to migrate leads to a high level of personal gains for the migrating health professionals in terms of earning and better living conditions, can it be considered moral to limit their free movement on the grounds of the greater good of others dependent on their technical expertise? Taking the stand of utilitarianism in this context, the greatest amount of good for the greatest number means that the health workers need to be made to sacrifice their aspirations for the sake of their compatriots. This raises a question: whose utility is to be maximized? That of the source countries and the residing inhabitants or that of the ones who want to leave their country for maximizing their personal preferences?
- 2) And how can developing countries move towards building a skill base comprising highly-qualified human resources in an extremely competitive globalized world when the brightest of their human resources for health are actively lured by the wealthier countries after they become competent enough to work? Whose utility should get more value here? That of the resource-limited source countries who spent many years and a lot of money in training the health workers, or that of the destination countries who want to fulfil the health-worker shortages and thereby maximize the happiness of their citizens?

According to an estimate made by the United Nations Commission for Trade and Development, each professional leaving Africa costs the continent US\$ 184,000 (Hidalgo, 2013). And in return, the recipient rich countries always benefit from the importation of qualified health workers. The United States, for example, is believed to benefit with the entry of almost 6,000 international medical graduates annually, contributing a few billion dollars to its economy which is almost equal to the output of 50 more medical schools (Marchal & Kegels, 2003). Not requiring to invest for training local medical doctors due to easy availability of fully-trained

foreign doctors is yet another way of saving money and the financial saving made thereof has been found to be substantial, for countries like the UK and Canada (AMA, 2010; Eastwood et al., 2005). This is an indication of the benefit being outweighed by the harms of an action when viewed from the perspective of the developing countries. The harm inflicted on the population due to the shortage of doctors and nurses is beyond the scope of monetary calculations, but it presents a strong enough case for the explanation that the harm of brain drain outweighs the happiness gained by the émigrés.

However, the debate does not end here. The arguments for brain drain -condemning the term itself as outdated and carrying a negative sense and rephrasing it as skill flow or wisdom gain in its role to maximize utility for all the parties involved- have been put forth as a source of remittance, means of brain circulation, diaspora knowledge exchange, skill transfer, and an increased bargaining power of the counterparts who decide to stay in the country (Clemens, 2009; Packer et al., 2010). Arguments have also been made that when graduates start leaving in droves, the younger ones who grow up seeing their elders prosper abroad start preparing themselves for the competitive global market and thus become very skillful, but not all of them end up migrating. Those who stay back contribute to human capital development in the country (Dodani & LaPorte, 2005). In addition to it, the supporters of brain drain further argue that the emigration of health professionals does not have a role in producing the harmful effects on health outcomes of the population left behind in the developing countries, and they can continue to fulfill their obligations of serving their compatriots even after leaving the country (Mastin L, 2008).

These arguments put the case that more benefits than harm are produced by the phenomenon of brain drain.

## **Discussions and Conclusion**

Brain drain as an idea and a phenomenon originated in the Western world when the skilled professionals started leaving the countries of their origin to more prosperous countries despite the source countries themselves not being poor. But this phenomenon started being recognized to have serious consequences only when the highly educated professionals from the developing

countries started leaving their countries for the more prosperous ones. This article discussed the issue with regard to the health workers representing the emigrating groups.

The proponents of medical brain drain justify it with reference to personal freedom of the health professional about what s/he wants to do with life associating it with their human rights. The supporters have pointed out that brain drain produces maximum happiness for the majority (the émigrés, the health system of source countries and the population living there) in the form of remittance, skill exchange, overall improvement of human capital, and the like. On the contrary, others have argued that medical brain drain has resulted because of well-meditated unethical practices adopted by some developed countries, and it has brought serious implications on the health systems of developing countries, producing more harm to the majority as opposed to the little happiness gained by a small section of emigrating health workers. Others consider medical brain drain as a reflection of global injustice, as a violation of human rights of the population of developing countries, and as a practice infringing the notion of health professionals' responsibility in protecting people's health as a special entity (Kollar & Buyx, 2013).

Given the shortage of health-care professionals and the fact that it is directly associated with the human right to get a decent minimum level of health care, the brain drain resulting from recruitment of doctors and nurses from developing countries does seem to raise human rights issues by harming the majority for the happiness of a few. So the issue of medical brain drain needs to be addressed in such a way that neither the aspiring migrants nor the source countries suffer. Measures that can be taken up by source countries include better salaries, better working conditions, increased security, higher education opportunities, and incentives to stimulate return migration. Receiving countries could help tackle this issue through self-sufficiency, financial compensation to the source countries in exchange for the skilled workforce from developing countries, and making and sticking to the agreements that forbid or restrict the recruitment of health professionals from countries that are facing severe shortages. Similarly, following the standard codes on recruitment of the foreign health workers like The WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO, 2010) and Commonwealth Code of Practice for the International Recruitment of Health Workers (Commonwealth Secretariat, 2002) could be yet another way to handle this issue though these codes would not have any legal binding.

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