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What should be done to address losses associated with “medical brain drain”?

The lack of human resources available to address enormous contemporary healthcare needs is “one of the most pressing global health issues of our time”.\textsuperscript{1} The World Health Organization has estimated the shortfall at approximately 4.3 million health care professionals.\textsuperscript{2} The shortages are most acutely felt in developing countries, where the scale of the problem sometimes threatens the very viability of even rudimentary healthcare systems. The shortages are exacerbated by the phenomenon known as “brain drain” where, in its most worrisome forms, skilled and educated citizens from developing countries depart for developed ones at very high rates.

The data on the empirical results of brain drain are complex and there are many types of effects to consider. In Debating Brain Drain: May Governments Restrict Emigration? (Oxford University Press, 2015) we consider some of this complexity, including positive and negative effects associated with impacts on health services, health outcomes, knowledge transfer, remittances, income, economic growth, human capital formation, institution building, fiscal contributions, and diaspora effects. On several particular dimensions, developing countries are huge net losers from migration of health professionals. Consider, for instance, that African countries are estimated to lose about 70\% of their healthcare workforce to high-income countries.\textsuperscript{3} These effects have been noted as particularly acute for the countries of sub-Saharan Africa.\textsuperscript{4} Not only do they lose those most able to deliver health services to vulnerable populations; they also lose the considerable financial investment made in the education of health personnel. For instance, Mills et al found that in their study involving nine sub-Saharan countries, $2.17
billion of the investment in training was lost.\textsuperscript{5} Kenya alone loses approximately $500 000 for each doctor that migrates and $300 000 for each nurse.\textsuperscript{6} It is also estimated that the United Kingdom saves about $2.7 billion by recruiting doctors from abroad, with the U.S. saving $846 million.\textsuperscript{7} In many cases, low-income countries are providing heavy subsidies to high-income ones, making some of the worst-off countries, worse-off still. For some countries, high skill migration can result in net benefits for countries of origin. There is a vigorous debate about the facts here, some of which is covered in \textit{Debating Brain Drain}. But there are enough real world cases of net losses that a key normative question is highly relevant: When they exist, how should we address the problems associated with the brain drain?

One measure that has the advantages of international scope and at least lip-service commitment is the World Health Organisation’s Code of Practice on International Recruitment of Health Personnel.\textsuperscript{8} This document offers a policy framework for the ethical recruitment of healthcare professionals. Bilateral agreements between home and host countries attempt to address net losses created by such recruitment, such as through offering financial reimbursement for each recruited healthcare professional or providing enhanced training opportunities or technology transfer. Of course, the code is entirely voluntary and relies substantially on the goodwill of individual members of high-income countries. When developed countries fail to play their part, what may developing countries do to solve their severe health workforce crises \textit{themselves}? Might governments of poor developing countries defensibly introduce compulsory service programs? Would they be justified in requiring high skilled migrants who have left the
country to pay taxes back to countries of origin for a short period (e.g. 3 years) after emigrating? These are central questions that we consider in *Debating Brain Drain*.

Gillian Brock argues that we can marshal a compelling case for carefully crafted programs requiring short periods of compulsory service (such as one year) or taxation (for three years) under certain specified conditions. She argues that a conjunction of considerations support her view, including the dire needs of compatriots, the investment of public resources in training highly skilled citizens who leave, governments’ responsibilities to provide services that would meet needs, the benefits the migrant has received while living in her country of origin, her duties to reciprocate, and signed contractual agreements. Important further conditions must be in place before a government is permitted to use such measures, such as that states are exercising power legitimately in making good faith (and somewhat successful) efforts to protect human rights, and the particular programs may not impose unreasonable costs on the health professional.

Michael Blake argues that these sorts of compulsory service and taxation proposals -- which could be used to restrict exit from developing countries -- are both unfair and illiberal. They are unfair because they place a disproportionate share of the burden of implementing justice on talented and educated residents of developing societies. And they are illiberal, because they rest upon an illegitimate vision of what it is that the state is entitled to do. The liberal state cannot condition or delay the emigration of a skilled person, any more than it could condition or delay that person’s exit from a religious community. Developing states might, under some circumstances, rely upon contracts to ensure the continuing supply of medical personnel – but even this is subject
to significant moral limitations. The net result of these considerations is that, for Blake, the state faces substantial limitations in how able it is to directly ensure that its highly-trained doctors and nurses remain where they were trained.

In this symposium these arguments are further developed in response to important comments by Philip Cole, Javier Hidalgo and Eszter Kollar. It is our hope that this symposium will be a stimulating contribution to the larger dialogue about brain drain, development, and ethics; such a dialogue, we believe, would stand some chance of at least clarifying what a less unjust global regime of medical migration might look like.


