

## **HEALTH-WORKER MIGRATION AND MIGRANT HEALTH-CARE: SEEKING COSMOPOLITANISM IN THE NHS**

### **ABSTRACT**

The UK's National Health Service (NHS) is critically reliant on staff from overseas, which means that a sizeable number of UK healthcare professionals receive their training at the cost of other states which are themselves urgently in need of healthcare professionals. At the same time, while healthcare is widely seen as a primary good, many migrants are unable to access the NHS without charge, and anti-immigration political trends are likely to further reduce that access. Both of these topics have received close attention in the global health ethics literature. In this paper I make the novel move of suggesting that these two seemingly disparate issues should be folded into the same moral narrative. The "brain drain" upon which the NHS and its users depend derives from the same gradient of wealth, security, and opportunity that produces migrants who require the NHS. I endorse cosmopolitanism as an ethical lens for supporting access to healthcare for migrants, and argue that the NHS in its current formulation effectively enacts a partial cosmopolitanism in its reliance on medical workers from abroad, but could more meaningfully instantiate that cosmopolitanism were it to offer the same healthcare to migrants as it does to citizens.

**Keywords:** NHS, migration, cosmopolitanism, global health

**Total word count: 6915**

“The Immigration Bill will stop migrants abusing public services to which they are not entitled, reduce the pull factors which draw illegal immigrants to the UK and make it easier to remove people who should not be here [...] We will continue to welcome the brightest and best migrants who want to contribute to our economy and society and play by the rules.” (Mark Harper MP, Immigration Minister) <sup>1</sup>

## INTRODUCTION

The National Health Service (NHS) is unfortunately named. In debates around the applicability of its services to migrants, some interlocutors are moved by the rhetorical suggestion that the NHS is national in the sense of being *nationalist*, rather than in the sense of being *nationalised*.<sup>2</sup> Anti-immigration campaigners underscore their nationalism with variation on the oft-repeated claim (largely within the tabloid press<sup>3</sup>) that the NHS is the “national health service, not the international health service.”

But the NHS is more international than most of us realise. Trivially, it is international because we live in a globalised world in which the emphasis on national citizenship is becoming increasingly symbolic,<sup>4</sup> and in which

---

1 UK Home Office. 2013. Immigration Bill. Factsheet: Overview of the Bill. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/249251/Overview\\_Immigration\\_Bill\\_Factsheet.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249251/Overview_Immigration_Bill_Factsheet.pdf) [Accessed 14 October 2016].

<sup>2</sup> Which emphasises its (ever-receding) distance from the global norm for health systems to be privatised and instead funded through health-insurance.

<sup>3</sup> <http://www.express.co.uk/news/politics/668321/Migrants-pay-more-NHS-New-charges-AE-prescriptions-health-tourism> [Accessed 14 October 2016].

<sup>4</sup> Cooper, T.L. and Yoder, D.E., 1999. The meaning and significance of citizenship in a transnational world: Implications for public administration. *Administrative Theory & Praxis*, 21(2), pp.195-204.

unprecedented numbers of people migrate, while diseases, and the knowledge and pharmaceuticals required to treat them, recognise no borders.

More specifically, the NHS, despite being celebrated as a quintessentially British service,<sup>5</sup> is staffed by large proportions of migrant health-care workers. Twenty-six per cent of UK registered doctors were trained outside of the UK, the vast majority of them in India and Pakistan, while eleven per cent of total workers within the NHS were born outside of the UK.<sup>6</sup>

In this paper I describe two issues of ethical concern: (a) the increasingly limited access that migrants have to NHS healthcare, and (b) the “brain drain” of healthcare professionals from Global South states to the NHS (and other Global North contexts). I argue that the “brain drain” upon which the NHS and its users depend derives from the same gradient of wealth, security, and opportunity that produces migrants who require the NHS. I rehearse the various proposed solutions to the healthcare brain drain, and conclude that all are either practically infeasible, or produce moral problems of their own. I conclude that since there is no morally legitimate way of limiting medical worker migration, granting all migrants

---

<sup>5</sup> The question of how to reconcile the cultural place of the NHS to and its deeply international reality is rarely addressed in the public discourse. As Raghuram notes “although the NHS has drawn upon international labour, this international nature of the NHS is usually denied. Instead the NHS is often used to write a story of the greatness of Britain, to reinforce the boundaries of nationhood.” p. 29 in Raghuram, P., 2009. Caring about ‘brain drain’ migration in a postcolonial world. *Geoforum*, 40(1), pp.25-33.

<sup>6</sup> Siddique, H. 2014. Figures show extent of NHS reliance on foreign nationals. *The Guardian*. Available at: [http://static.guim.co.uk/ni/1390829680973/NHS\\_staff\\_graphic.pdf](http://static.guim.co.uk/ni/1390829680973/NHS_staff_graphic.pdf) [Accessed 14 October 2016].

free access to the NHS is one way of beginning to enact the cosmopolitanism which the UK seems to be enacting in its reliance on migrant medical workers.

The paper is structured as follows. In section one I describe the moral concerns posed by the increasingly limited access migrants have to NHS services. In section two I introduce the idea of a global “brain drain” of medical workers, and rehearse some of the moral issues posed by this migration trend. Section three adjudicates some of the suggestions that have been made to address the issues posed by the migration of medical workers, concluding that none of the proposed or implemented measures are likely to substantively address the underlying issues. In section four I endorse moral cosmopolitanism and argue that the NHS in its current formulation might be seen to enact a partial cosmopolitanism in its reliance on medical workers from abroad, and could more fully instantiate that cosmopolitanism were to offer the same healthcare to non-citizens as it does to citizens. Section five concludes.

Whilst this article remarks on the situation in the UK, its arguments may be applied to other states in which a universal basic health care serves all citizens and depends upon the employment of substantial numbers of medical workers from Global South settings.<sup>7</sup>

## **I MIGRANTS' ACCESS TO THE NHS: A MORAL PROBLEM**

---

<sup>7</sup> Germany and Canada, for example, meet these criteria.

At the end of 2015, over 65 million people worldwide were forcibly displaced, mainly originating in the conflict-torn states of Syria, Afghanistan, and Somalia, and largely hosted by states in the Middle East and North Africa region.<sup>8</sup> Around a million migrants and refugees arrived in Europe<sup>9</sup> in that period, and the UK received 38,878 asylum applications, around half of which were granted.<sup>10</sup> Asylum-seekers and refugees have the same legal rights to free healthcare as British citizens.

A 2009 report carried out by researchers at the London School of Economics estimated that there were at that time between 417,000 and 863,000<sup>11</sup> undocumented<sup>12</sup> people living in the UK.<sup>13</sup> Even at its lowest estimate, undocumented people constitute around 1% of the UK population. Undocumented migrants are not entitled to any government welfare, are forbidden from working or renting property, and may be subject to detention, followed by “administrative removal” (i.e.

---

<sup>8</sup> UNHCR, 2014. Global Trends: Forced Displacement in 2014. <https://s3.amazonaws.com/unhcrsharedmedia/2016/2016-06-20-global-trends/2016-06-14-Global-Trends-2015.pdf> [Accessed 14 October 2016].

<sup>9</sup> Miles, T. 2015. EU gets one million migrants in 2015, smugglers seen making \$1 billion. Reuters. Available at: <http://www.reuters.com/article/us-europe-migrants-idUSKBN0U50WI20151222> [Accessed 23 October 2016].

<sup>10</sup> UK Home Office. 2016. National Statistics: Asylum. Available at: <https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2015/asylum> [Accessed 23 October 2016]

<sup>11</sup> <http://www.lse.ac.uk/geographyAndEnvironment/research/london/pdf/irregular%20migrants%20full%20report.pdf> [Accessed 14 October 2016].

<sup>12</sup> I use the term “undocumented” rather than the more common designator “illegal.” I do so because it seems value-laden and inhumane to use the latter term to categorise a human being who lack the “right” documentation, and more importantly it is not consistent with how we label other people who have broken laws, where it is the action, not the person, that is described as illegal.

<sup>13</sup> Think-tank Migration Watch estimates that there are as many as 1.1 million undocumented people living in the UK, though their special interests may lead to the inflation of estimates.

deportation) should their immigration status be discovered. Despite these draconian restrictions on their daily existence, undocumented people are in principle entitled to primary care, emergency care, family planning services,<sup>14</sup> sexual health services, and certain infectious diseases treatments, since these services are free to all. The Department of Health is currently attempting to identify ways of extending migrant charges to limit free access to primary and emergency care, with the guiding aim of rendering the NHS “one of the most restrictive healthcare systems in Europe for undocumented migrants.”<sup>15</sup>

The 2014 Immigration Act,<sup>16</sup> whose changes to NHS care came into effect in April 2015, introduced the “immigration health charge” according to which all migrants who do not have indefinite leave to remain in the UK must pay £200 each year in order to access NHS services. This is part of the ongoing “Migrant and Visitor NHS Cost Recovery Programme” which is set to continue to identify ways of charging migrants for their care.

Asylum-seekers and refugees, undocumented people, and regular migrants have different entitlements to NHS services. In order for these differential levels of access and charging to be practicable, NHS service providers must request the immigration status of current and prospective patients. This necessarily brings considerations regarding nationality into a health-care

---

<sup>14</sup> Undocumented people are not able to access maternity services without charge.

<sup>15</sup> Doctors of the World. 2016. Department of Health consultation on further NHS charging—“making a fair contribution.” Available at: [www.doctorsoftheworld.org.uk/files/DOTW\\_briefing\\_DH\\_consultation\\_on\\_further\\_NHS\\_Charging\\_Feb\\_2016\\_FINAL.pdf](http://www.doctorsoftheworld.org.uk/files/DOTW_briefing_DH_consultation_on_further_NHS_Charging_Feb_2016_FINAL.pdf). [Accessed 24 October 2016].

<sup>16</sup> Available at: <http://www.legislation.gov.uk/ukpga/2014/22/contents> [Accessed 20 October 2016].

setting that has prided itself on providing treatment without discrimination and regardless of a person's ability to pay.<sup>17</sup> Requesting that medical workers scrutinise the immigration status of patients makes medical encounters more prone to racism (whether intentional or not), and may introduce clinically indefensible delays into the treatment process. Further, it places new biopolitical gatekeeping obligations on medical staff, who become part of the broader mechanisms of border control, a role which places undue moral burdens<sup>18</sup> on workers whose remit should extend no further than responding to medical need.

Unsurprisingly, the increased surveillance of nationality and-or immigration status in the provision of health-care deters many migrants from using NHS services, regardless of their immigration status or their entitlements. A 2015 Doctors of the World (DOTW) report<sup>19</sup> documents the troubling effects of this increased scrutiny. 83% of patients seen in DOTW clinics in London reported being unable to register for primary care, which is ostensibly available to all. 11% of patients reported “fear of being arrested” as a barrier to accessing healthcare. On average, patients had spent 6.5 years in the UK before they approached DOTW for medical care, and half of the patients seen were by that point in need of urgent care.

---

<sup>17</sup> Choices, N.H.S., 2008. About the NHS. *NHS Choices*.

<sup>18</sup> Farrington, R., Saleh, S., Campbell, S., Jundi, A. and Worthington, E., 2016. Impact of proposal to extend charging for NHS in England. *The Lancet*, 388(10043), p.459.

<sup>19</sup> Chauvin P, Simonnot N, Vanbiervliet F, Vicart M, Vuillermoz C. 2015. Access to healthcare for people facing multiple vulnerabilities in health. Paris : Doctors of the World - Médecins du monde International Network.

Whilst the leading argument for excluding migrants from NHS care is economic, it is difficult to estimate the cost to the UK of migrants using the NHS, largely due to the complexities about entitlements, as well as confounders such as reciprocal arrangements with the health systems of other states. On the basis of the data that is available, it is estimated that a meagre 0.05% of the NHS budget is “lost” to “health tourism.”<sup>20</sup>

What we do know is that migrants in the UK tend to under-use the health services to which they are entitled.<sup>21</sup> Reported reasons include language difficulties, lack of information about available services, confusion about entitlements with respect to immigration status, previous or expected experiences of cultural insensitivity amongst medical workers, and the very many barriers to attending medical services caused by poverty (i.e. lack of: transport, child-care, employment leave).<sup>22</sup> At first sight, this might be interpreted as an instance of the “health migrant effect” but studies seem to suggest that migrants to Europe countries have worse physical and mental health outcomes than Europeans.<sup>23</sup> A better suggestion is that the

---

<sup>20</sup> Prederi. 2013. Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/254200/Quantitative\\_Assessment\\_of\\_Visitor\\_and\\_Migrant\\_Use\\_of\\_the\\_NHS\\_in\\_England\\_-\\_Exploring\\_the\\_Data\\_-\\_SUMMARY\\_2\\_\\_pdf.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254200/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_SUMMARY_2__pdf.pdf) [Accessed 23 October 2016].

<sup>21</sup> Steventon, A. and Bardsley, M., 2011. Use of secondary care in England by international immigrants. *Journal of health services research & policy*, 16(2), pp.90-94.

<sup>22</sup> Jayaweera, H. 2014. Health of Migrants in the UK: What Do We Know? *The Migration Observatory*. Available at: <http://www.migrationobservatory.ox.ac.uk/resources/briefings/health-of-migrants-in-the-uk-what-do-we-know/> [Accessed 20 October 2016].

<sup>23</sup> See e.g.: op. cit. note 22; Raphaely, N. and O'Moore, E., 2010. Understanding the health needs of migrants in the South East region. A report by the South East Migrant Health Study Group on behalf of the Department of Health; Mladovsky, P., 2007. Migrant health in the EU. *EUROHEALTH-LONDON-*, 13(1), p.9; into Maternal, C.E., 2007. Child Health (CEMACH). Saving Mothers Lives: Reviewing Maternal Deaths to make

aforementioned anxiety about detention and deportation plays a determinative role.

Clearly, the UK is failing to provide adequate healthcare to all those within its jurisdiction. Some migrants are *de re* prevented from accessing the full range of NHS services without charge due to their immigration status, others are drastically underusing the health services they are entitled due to the *de facto* barrier posed by fear and mistrust.

Across Europe, states are engaging in a disquieting “race to the bottom” to repel migrants by constructing living conditions which are as unappealing as possible.<sup>24</sup> Incremental savings and populist political gains are being prioritised over the most basic wellbeing of large numbers of vulnerable people. Treating the health of migrants as means to political and economic ends is deeply unethical from a deontological perspective. Moreover, making distinctions based a feature of people—their nationality or immigration status—that ought to be irrelevant to their right to have their health needs met is unethical from the perspective of moral cosmopolitanism. I will explore these issues in further detail in section four.

## **II THE GLOBAL “BRAIN DRAIN” OF MEDICAL WORKERS: ANOTHER MORAL PROBLEM**

---

motherhood safer–2003–2005. The seventh report on confidential enquiries into maternal deaths in the United Kingdom. London: CEMACH.

<sup>24</sup> This trend was strongly condemned by a spokesperson for UNHCR: <http://europe.newsweek.com/un-slams-race-bottom-refugee-cash-denmark-germany-switzerland-418278?rm=eu> [Accessed 22 October 2016].

While the continent of Africa bears a staggering 25% of the world's disease burden, its countries employ just 3% of the world's medical workers.<sup>25</sup> By contrast, the UK may well have the lowest disease burden<sup>26</sup> of any country in the world, yet is alone home to around 3% of the world's doctors,<sup>27</sup> and around 1% of the world's<sup>28</sup> total number of health workers.<sup>29</sup>

*Prima facie*, one might attribute this disparity to differences in development between Global South and Global North countries, and the subsequent higher density of institutions in which one may train, and clinics in which one may practice. Were that the major determinant, it ought still to provoke moral concern, since disease burden should surely coincide with health worker density if it is to ever be reduced. Yet the real levers of this phenomenon are even more worrying. The disparity between densities of medical workers in the Global South and Global North derives largely from the migration of Global South workers to Global North posts in order to benefit from higher salaries, improved levels of safety and security, and a higher standard of living. Most Global South countries *are*

---

25 Misau, Y.A., Al-Sadat, N. and Gerei, A.B., 2010. Brain-drain and health care delivery in developing countries. *Journal of Public Health in Africa*, 1(1).

26 Newton, J.N., Briggs, A.D., Murray, C.J., Dicker, D., Foreman, K.J., Wang, H., Naghavi, M., Forouzanfar, M.H., Ohno, S.L., Barber, R.M. and Vos, T., 2015. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 386(10010), pp.2257-2274.

27 [http://www.gmc-uk.org/doctors/register/search\\_stats.asp](http://www.gmc-uk.org/doctors/register/search_stats.asp) [Accessed 22 October 2016].

28 World Health Organization, 2006. Health workers: a global profile. *WHO. World Health Report*.

29 Choices, N.H.S., 2013. The NHS in England. *NHS choices website. Available at: www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx* [Accessed 22 October 2016].

training sufficient numbers of medical workers to meet their health needs, but large proportions of each cohort are migrating to Global North settings upon qualifying. To give a brief sense of the scale of the problem, consider that 34% of Zimbabwe's nurses, 29% of Ghana's doctors, and 65% of Bangladesh's doctors migrate each year.<sup>30</sup>

This "brain drain" poses two major moral issues:

1. Medical workers are lost by regions of major medical need to areas of minor medical need, exacerbating a severe international care deficit.
2. The educational costs of training medical workers are lost by low-income countries, while high-income countries benefit economically by drawing on the expertise of workers whose training they did not fund or subsidise.<sup>31</sup>

The second point may be illustrated with an example. A study documenting the decade 1986 to 1996<sup>32</sup> notes that an estimated six million US dollars in costs of tuition was lost through emigration of graduates of a single Ghanaian medical school.<sup>33</sup>

At the recruitment end, the UK is one of the main offenders, with more doctors trained overseas than any other EU country. The NHS deliberately

---

<sup>30</sup> p. 684 in Hooper, C.R., 2008. Adding insult to injury: the healthcare brain drain. *Journal of Medical Ethics*, 34(9), pp.684-687.

<sup>31</sup> Patel, V., 2003. Recruiting doctors from poor countries: the great brain robbery?. *British Medical Journal*, 327(7420), p.926.

<sup>32</sup> Which remains representative of subsequent decades.

<sup>33</sup> p. 5 in Dovlo, D., 2003, September. The brain drain and retention of health professionals in Africa. In *A case study prepared for a regional training conference on Improving Tertiary education in Sub-Saharan Africa: Things That Work* (pp. 23-25).

trains too few medical professionals<sup>34</sup> in the interest of frugality, relying on the attractiveness of the NHS as an employer, and the UK as a destination, to feel confident that it can meet its shortfall by poaching from the workforces of Global South countries. This means that UK taxpayers benefit from the knowledge and expertise of medical practitioners whose training did not cost UK taxpayers, constituting a considerable transfer of wealth (in the form of intellectual property) from the Global South to the North.

As Hooper puts it: “To continue to save money by training too few professionals and then topping up the deficit by raiding poor countries for their educated elite is deeply immoral. Ghana, India and Iraq, for example, cannot afford to lose these people and we have no right to take them.”<sup>35</sup>

In turn, many Global South countries (including the Philippines and Cuba) account for these high levels of migration by training surplus healthcare professionals. Whilst training greater number of medical workers increases the probability of meeting domestic health needs, it also produces greater numbers of potential migrants, at considerable cost to the state. For example, despite quadrupling enrolment on nursing courses in South Africa from one year to the next, there were still 32000 nursing vacancies to fill.<sup>36</sup> And whilst these measures seems to indicate that governments of these countries interpret the income recouped from migrants’ remittances as

---

<sup>34</sup> p. 44 in Ahmad, O. B. 2005. Managing medical migration from poor countries. *British Medical Journal-International Edition*, 331(7507), 43-45; p. 6 in Royal College of Physicians. 2016. Underfunded. Underdoctored. Overstretched. The NHS in 2016.

<sup>35</sup> P. 686 in op. cit. note 30.

<sup>36</sup> p.685 in op.cit. note 30.

exceeding the cost of training those migrants, this is a myopic trade-off. In most cases, healthcare shortages persist, and the funds that are recovered are not specifically reinvested in the state healthcare budget. Moreover, as Hooper<sup>37</sup> points out, the economies of exporting countries have become dependent on the remittances reclaimed from migrant medical workers in much the same way that some Global South economies are dependent on cash crops like coffee and rubber, with comparable concerns about narrow economies being critically reliant on the whims of Global North markets.

### **III ADDRESSING THE “BRAIN DRAIN”: INADEQUATE SOLUTIONS TO A COMPLEX REALITY**

In response to what was widely recognised to be a growing crisis, in 2010 the WHO implemented the WHO Global Code of Practice on the International Recruitment of Health Personnel, a set of voluntary principles which set out to ensure that ethical considerations influence international medical worker recruitment in sending states. It has so far had limited success. Whilst organisations in African countries encouraged and influenced the development of the Code, there has been limited commitment to implementing its recommendations within those countries who stand in most urgent need of the changes it promises, which may be

---

<sup>37</sup> p.685 in op.cit. note 30.

due to the belief that the Code prioritises the interests of receiving nations<sup>38</sup> as well as its failure to engage adequately with the more structural push factors which motivate the migration of medical workers.<sup>39</sup>

“Brain drain” is best understood through the “push” and “pull” factors which motivate decisions to migrate. Push/pull factors include: low/high salaries, poor/good working conditions, limited/extensive professional opportunities, and geopolitical insecurity/security. These factors map onto global systemic polarities of wealth, security, and opportunity, and are therefore resistant to resolution via minor changes to e.g. salaries and working conditions, which are in any case difficult to finance in resource-poor settings.

Some countries have attempted to tackle the problem more shrewdly, by reducing the attractiveness of their medical workers to foreign employers. In Thailand, switching the language of tuition in medical schools to Thai<sup>40</sup> resulted in a significant decline in the number of medical workers emigrating.<sup>41</sup> Despite its efficacy, this has the disadvantage of leaving medical workers ill-equipped to engage with international knowledge

---

38 Dambisya, Y.M., Kadama, P., Matinhure, S., Malema, N. and Dulo, C., 2013. Literature review on codes of practice on international recruitment of health professionals in global health diplomacy. *Harare, EQUINET*.

39 Bourgeault, I.L., Labonté, R., Packer, C., Runnels, V. and Murphy, G.T., 2016. Knowledge and potential impact of the WHO Global code of practice on the international recruitment of health personnel: Does it matter for source and destination country stakeholders?. *Human Resources for Health, 14*(1), p.25.

<sup>40</sup> Instead of English, which is seen as the international medical language.

<sup>41</sup> p. 7 in Groenhout, R., 2012. The “brain drain” problem: Migrating medical professionals and global health care. *IJFAB: International Journal of Feminist Approaches to Bioethics, 5*(1), pp.1-24.

exchange within their specialties, which invariably requires fluency in professional English.<sup>42</sup>

Others require a period of “national service” after qualification, which is sometimes enforced via financial penalties for those leaving early, as a way of recovering the costs of the educational investment made. Such measures seem ethically defensible, but tend to merely delay the inevitable exodus of workers, resulting in a lower-quality workforce that is perpetually junior and inexperienced.

Both of these measures seem unfair to the extent that they exclusively target medical workers, leaving them more geographically-constrained than graduates into other professions. This objection may be countered by the observation that medical work *is* morally distinct from other professions in that it endows the trainee with the ability, and therefore the responsibility, to meet a basic human need. To emigrate from a location of greater need to one of lesser need, especially when one is also equipped with the linguistic and cultural knowledge to be of particular service to one’s own community, may be seen as a violation of a moral duty. This argument might be configured as a form of triage. Just as it would violate professional standards for a surgeon to perform lucrative cosmetic surgery on one patient while another was in urgent need of emergency surgery, so too should medical workers be chastised for leaving contexts of great need to earn better salaries in contexts of lesser need.

---

<sup>42</sup> A fact which presents serious moral issues of its own!

Other interventions operate at the side of the receiving country, on the basis that the “brain drain” could be reduced or even eliminated if Global North countries refused to recruit Global South medical workers. The UK acknowledges its role in the growing crisis in 2004 with its “Code of Practice for the international recruitment of healthcare professionals,”<sup>43</sup> whose purpose was to encourage recruitment agencies to limit their employment from states and sectors with urgent shortages of medical workers. Complying to the Code remains voluntary for private recruitment agencies, and because of the strong economic incentive for employing from abroad, the commitment of the NHS to the UK’s own Code is unconvincing.

As Raghuram<sup>44</sup> notes, many of these current strategies for tackling the problems caused by this brain drain focus on the decisions of individual migrant medical workers, in attempts to encourage them to remain in, or return to, their home countries. Whether intentionally or not, this shifts the moral responsibility for brain drain on to individual medical workers, and implies that the overall moral problem might be solved additively if only they were each to exercise their duties towards their fellow citizens in the home country. This assumes that medical workers do, or should, feel geographically-specific responsibilities, and that these ought to trump both their commitment to serving all people equally, and their interest and

---

43 UK Department of Health. 2004. Code of Practice for the international recruitment of healthcare professionals.

44 p. 29 in op. cit. note 5.

responsibility in being members of an international “socio-cognitive”<sup>45</sup> community, within which (migrating and) working across different medical settings may be seen as a valuable and appropriate way of gathering a wealth of knowledge and experience.

This argument has force only in cases in which migrants foot the entire bill for their lengthy education. In reality, taxpayers subsidise the training of medical workers, so that the people of Global South nations invest in their own medical workers, just as UK taxpayers invest in those trained within the NHS. If those medical workers migrate in order to pursue their own best interests, those taxpayers do not see a return on their investment. And unlike other training courses, the cost of losing medical workers is steep. Hooper<sup>46</sup> describes this “free riding” as deeply immoral for Kantian reasons—it treats taxpayers as means, rather than ends in themselves.

The success of the NHS as a care provider depends on its long-term economic viability, which in turn relies on the global care gap, since it permits the UK to subsidise the education of insufficient numbers of medical staff in the confidence that trained staff from other countries will migrate. Such is the scale of this obvious injustice that there has been talk of reparations in order to compensate those exporting nations for the way in which a public good has been poached from a system within which the skills in question are much scarcer. Again, given that the UK’s motivation

---

45 Ibid.

46 p. 686 in op. cit. note 30.

for employing migrant medical workers is economic, fair reparations are unlikely to be offered, as they would presumably outweigh the cost of training sufficient number of medical workers domestically.

Finally, there are moral arguments in *favour* of the recruitment of migrant medical workers into the NHS which confound the case for limiting this trend. Diversity and multiculturalism, though much-contested terms, are valuable to communities in a globalised world. Further, migrant medical workers, in their knowledge and understanding of other languages, cultures, and medical contexts, offer skill-sets which UK-born medical workers necessarily lack, from which their colleagues and patients profit. One must remember that even if the migration of medical workers was limited, migration of other groups would continue. Having a diverse staff within the NHS permits the service to better meet the needs of a diverse body of patients.

An important consideration in favour of leaving the medical “brain drain” unregulated is that Global South economies are bolstered by the remittances received as migrant workers make regular financial contributions to their relatives in the home country, which are subject to taxation and introduce additional capital into the consumer economy. This boost to the national economy is often substantial,<sup>47</sup> and may therefore be

---

47 The 2014 global remittance economy in 2014 amounted to \$435 billion. (See <http://www.worldbank.org/en/news/press-release/2014/10/06/remittances-developing-countries-five-percent-conflict-related-migration-all-time-high-wb-report> [Accessed 23 October 2016].) Nepal generates almost a third of its gross domestic product via remittances, (see <http://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS>

seen as a healthy return on the educational investments made, which has even been characterised as “brain gain.”<sup>48</sup> Groenhout<sup>49</sup> quite rightly describes these arguments as libertarian, as they place trust in the “invisible hand” of trickle-down economics. Unfortunately, without regulation, remittances into an economy do nothing to guarantee the kind of specific long-term spending on public health which would help to close the care gap caused by migrating medical workers, which is one of the major moral issues at stake here.

Further, as Groenhout<sup>50</sup> emphasises, treating medical brain drain as a monolithic phenomenon within which all migrant medical workers are supposed to be similarly situated merely produces ineffectual generalities. The only generality that can and must be deployed is to note that brain drain is an unsurprising result of globalisation and free market capitalism, which indicates that as long as there are economic incentives, they will be permitted to prevail over attempts to regulate the economy of healthcare workers.

The moral issues involved in employing migrant health-workers from resource-poor countries derive from broader moral issues with globalisation, and will not be solved in any morally substantive sense by

---

[Accessed 23 October 2016].) a figure which stands at ten per cent for the Phillipines, which has the greatest number of nurses migrating annually (see p. 45 of WHO. 2014. Migration of health workers: the WHO code of practice and the global economic crisis).

48 Stark, O., 2004. Rethinking the brain drain. *World Development*, 32(1), pp.15-22.

49 pp. 9-10 in op. cit. note 41.

50 pp. 11-17 in op. cit. note 41.

merely altering the direct conditions under which the migration occurs, but must instead be tackled as part of a broader campaign against global polarities of wealth, opportunity, and security. In other words, an ideal healthcare system *would* employ health professionals from diverse backgrounds, and freedom of movement should in principle be celebrated and defended as a condition for human flourishing. As such, one should not expect, or perhaps even pursue, any measures which reduce the migration of healthcare professionals from the Global South but do not at the same time substantively modify the push and pull factors which motivate such migration trends.

#### **IV DOMESTIC COSMOPOLITANISM IN THE NHS? A PARTIAL SOLUTION**

The Universal Declaration of Human Rights espouses moral cosmopolitanism in that it declares a person's rights to be contingent only on her personhood, irrespective of her nationality, or any other contingent property. In practice, citizenship is central to discerning the entitlements of those who share the same geographical spaces, and is the basis for the exclusion of migrants from the automatic access to the NHS which UK nationals enjoy.

Gillian Brock defines cosmopolitanism as the contention that “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 happen to be.”<sup>51</sup> One can generate a moral position regarding migrant access to healthcare that is similarly insensitive to citizenship starting from the perspective of luck egalitarianism.<sup>52</sup> Shlomi Segal argues that healthcare is non-excludable (that is, cannot be denied to a person) when the person in question is within the geographical locality in which that healthcare is provided as a way of meeting essential needs. That is, “it is the space and not the identity of the individual that tracks our obligations here.”<sup>53</sup>

These considerations are brought together by Wild,<sup>54</sup> who argues that since access to healthcare is broadly deemed to be a primary good, it should be made available to all people within a given jurisdiction regardless of morally arbitrary features such as immigration status. Ideally, each state would meet the healthcare needs of all those under its jurisdiction. In such a world, migration trends would likely look very different, but it would seem fair that those who did migrate should receive healthcare in the new jurisdiction, as would a person undertaking the reverse-migration.

In our non-ideal world, only some countries are able to provide adequate healthcare to those under their jurisdiction. According to moral

---

51 p. 3 in Brock, G., 2015. Global Justice, Cosmopolitan Duties and Duties to Compatriots: The Case of Healthcare. *Public Health Ethics*, p.phu039.

52 See e.g. Tan, K.C., 2008. A defense of luck egalitarianism. *The journal of philosophy*, 105(11), pp.665-690.

53 p. 80 in Segal, S., 2009. *Health, luck, and justice*. Princeton University Press.

54 Wild, V., 2015. Universal access to health care for migrants: Applying cosmopolitanism to the domestic realm. *Public Health Ethics*, p.phv014.

cosmopolitanism, such states must then bear two additional responsibilities. They: (a) must extend that healthcare to all those who enter their jurisdictions, and (b) must contribute to the effort to provide healthcare to those within jurisdictions without adequate healthcare. The former responsibility is more easily achieved than the latter, since the relevant infrastructure is already in place, and the number of beneficiaries is very much smaller. Let us call the first responsibility (a) a commitment to weak cosmopolitanism, and the second responsibility (b) a commitment to strong cosmopolitanism.

I endorse cosmopolitanism as a general foundation for promoting fairer healthcare access for migrants, and suggest that the NHS already benefits from a variety of cosmopolitanism which ought to commit it to a weak cosmopolitanism.

So far, I have discussed two disparate issues in global health: the *de re* and *de facto* exclusion of some migrants from accessing health services, and the migration of medical professionals away from Global South countries with dire health provision, into resource-rich Global North countries. On closer inspection, these issues are closely related.

Both concern migration, though of very different social groups under different circumstances, and both contribute to the widening of existing inequalities. Undocumented people are arguably the most vulnerable people

in the UK.<sup>55</sup> On top of this, they are denied the standard medical care that others are entitled to, and that is necessary to the maintenance of good health. Documented migrants may face barriers due to charges, or barriers due to the climate of anxiety produced by government-sanctioned anti-immigration rhetoric and policies.

As for the migration of medical professionals: to the extent that they can be seen as a commodity, their movement from Global South regions to Global North regions is no different from the flow of resources that is noted more generally between these two world regions within the globalised economy. As such, this too goes along the grain of an existing gradient, which is to say an existing inequality.

Those practices that are currently underway to control or limit brain drain are largely ineffective, and produce new moral issues of their own. These difficulties arise in part because the migration of healthcare workers, as other kinds of migration, is in other senses morally defensible and beneficial, so the overall picture is complex.

Momentarily setting aside the cynical economics which under-writes medical recruitment, one can adopt a charitable reading of the reliance of the NHS on migrant workers. Consider that the UK government might be

---

<sup>55</sup> Consider that: fear of deportation means they cannot report crimes committed against them; they suffer tremendous poverty because they are unable to work; where they do find work, they are invariably exploited because they have no recourse to labour laws; they cannot access welfare payments or do not because of fear or misunderstanding, and are restricted in the informal support and social networks they can form in order to guard against these vulnerabilities, because their status requires them to keep a low profile socially.

interpreted as performing a variety of cosmopolitanism when it employs medical workers without regard for their nationality. Indeed, this is a cosmopolitanism whose extent is not seen in other employment sectors. In a sense, the NHS sees doctors and nurses as just that: people who have undertaken lengthy, rigorous courses at accredited institutions, and now possess the valuable intrinsic property of being able to care for human beings in specific ways. Nationality may pose some minor barrier in the form of acquiring the requisite documentation, but it does not usually represent a barrier to employment. Medical workers are seen as global citizens, who may move around in much the same way as other useful resources are permitted to.

Turning instead to *patients* within the NHS, the picture looks very different. Immigration status presents barriers to free access to NHS care. While migrant medical workers are seen as being fungible in relation to British medical workers, migrant patients are not. Their status is key in determining whether they can access the full range of NHS care without question, or whether they will be compelled to avoid all medical services for fear of being detained and deported.

On this view, the NHS upholds a one-sided cosmopolitanism with respect to NHS healthcare. My suggestion it commits to greater consistency in how it deploys this cosmopolitanism, by operating the same degree of indifference to nationality in how it grants patients access to healthcare as it does in its employment of personnel. To continue to operate as it does is to

flagrantly accept some of the most valuable assets of other countries, while refusing to share its own assets (including the care of those same migrant workers) with other migrants.

To fully instantiate moral cosmopolitanism would of course require much more onerous changes than this. In this paper I am suggesting that the NHS initially step up to its responsibility to meet the demand of weak, rather than strong, cosmopolitanism. To neglect to meet duties which can be easily met is a particularly serious dereliction of duty. Extending NHS services to all those under the jurisdiction of the UK is an easy first step which would allow the UK to partially atone for its poaching of medical workers. Making moves towards moral consistency is especially important for a service whose moral reputation is internationally renowned.

## **V CONCLUSION**

Of course, the UK government's policy on welfare for migrants is more likely to be influenced by a pragmatic concern about being seen to be prioritising the needs of British-born people. The outcome of the recent EU referendum was undoubtedly motivated by fear of immigration, even if this fear was largely a misdirection of concern about the scarcity of resources under austerity. Against this backdrop, the government will be keener than ever before to demonstrate to current British voters that it is committed to nationalism, not cosmopolitanism.

Yet the government must do more to make the public more cognisant of their own reliance on a workforce of migrants without whom the NHS would not be able to maintain its current standards of care. So too must the public be urged to remember that Britain's colonial past played a strongly determinative role in its current practices of utilising Global South medical workers as a stopgap workforce. Indeed, the establishment of medical colleges in India served as a way of undermining traditional medicine practices in order to further concretise British authority.<sup>56</sup> Indian independence roughly coincided with the founding of the NHS, which was initially critically under-staffed and relied upon Indian migrant doctors to make up the shortfall.

It is this legacy of imperialism to which the UK owes the wealth that makes the NHS possible. Consider that the British Empire spanned the countries now known as India, Pakistan, Bangladesh, Nigeria, Zimbabwe, Ghana, South Africa, Iraq, and Egypt, and extracted natural resources and labour<sup>57</sup> from these states, for which reparations have not yet been made. These states are now the UK's main sources of migrant doctors, so that one might see the global brain drain as a postcolonial continuation of the colonial extraction of resources.

Historically, the NHS has enjoyed a unique and robust moral status within British life, where across the political spectrum it is treasured as a proud

---

<sup>56</sup> Prakash, G., 1999. *Another Reason: Science and the Imagination of Modern India*. Princeton University Press, New Jersey.

<sup>57</sup> In some cases, slave labour.

instantiation of fairness and equality.<sup>58</sup> Despite being funded largely through general taxation, and being defensible primarily in economic<sup>59</sup> terms<sup>60</sup> it is widely regarded as an act of governmental beneficence.

The NHS ought to honour this proud tradition by giving back to the migrants under its jurisdiction what it has, throughout its seventy years, readily taken from other migrants and *ipso facto* from the communities they leave behind. Migrants are of course as diverse a group as any other, but the moral commitments that sit backstage to their circulation ought to be reconcilable.

As Minister of Health during the foundation of the NHS, Aneurin Bevan declared in 1948 that: “What should be the glory of the profession is that a doctor should be able to meet his patients with no financial anxiety. [...] [W]e ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world – put the welfare of the sick in front of every other consideration.”<sup>61</sup> The anxieties of some reach far further than finances, and in the name of civilisation and consistency, our domestic economic anxieties should be set aside to care for them too.

---

<sup>58</sup> See e.g. p.1287 in Whitehead, M., 1994. Who cares about equity in the NHS?. *British Medical Journal*, 308(6939).

<sup>59</sup> And therefore (on a cynical reading) being funded via the labour of the populace in order to guarantee their own future productivity,

<sup>60</sup> See e.g. Dowie, J., 1985. The political economy of the NHS: individualist justifications of collective action. *Social Science & Medicine*, 20(10), pp.1041-1048.

<sup>61</sup> House of Commons Debates, vol. 447, cols. 35/50, 9 February 1948. Available at: <http://www.sochealth.co.uk/national-health-service/the-sma-and-the-foundation-of-the-national-health-service-dr-leslie-hilliard-1980/aneurin-bevan-and-the-foundation-of-the-nhs/bevans-speech-to-the-house-of-commons-on-the-appointed-day-9-february-1948/> [Accessed 23 October 2016].