

## Responding to the Challenge of Migration of Health Workers: Rights, Obligations, and Equity in North/South Relations

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consensus is that we are off-piste. Reaching MDGs 4, 5 and 6 (the ‘health-related MDGs’) will require action from all countries. The health workforce crisis is perhaps the biggest challenge to these MDGs, and migration is certainly the biggest challenge within the crisis.

It is not too late to act. Left unchecked, migration will make the weakest health systems collapse while barely making a dent in the developed countries’ needs. A managed migration, through an international framework such as the Code of Practice, will help the world to reach the goals it set for itself in fighting misery, poverty, disease and premature death. GHWA and its partners are hopeful for the future, but any and all help in raising global awareness of the health worker crisis, to compel countries to act, will be most welcomed and deeply appreciated.

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### *Responding to the Challenge of Migration of Health Workers: Rights, Obligations, and Equity in North/South Relations*

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The migration of people has been going on for ages, as evidenced by multicultural societies in practically all countries around the globe. It was undocumented and perhaps did not attract too much attention so long as the immigrants lived peacefully with their new neighbours. In recent times, however, migration has become a thorny issue surrounded by much international debate, especially when it involves skilled people – the so-called ‘brain drain’. Though health worker migration is only a small fraction of skilled migration, the impact on their countries of origin is usually out of proportion to the numbers involved. The motives leading to migration have remained virtually the same over the years – with the dominant motive being economic – but there are other non-economic motives.

In principle, economic migration is associated with the movement of people from countries (or within countries between different localities) where there is a labour surplus to countries where there is a labour shortage. Other than the abhorrent slave trade, and some illegal human trafficking, movement of labour has been a voluntary response to advertisements and other forms of soliciting labour, or people deciding to search for jobs to improve their lot.

This discussion will focus on the response to migration of health workers as it affects rights, obligations and equity in North/South relations.

#### RIGHTS AND OBLIGATIONS

The question of the rights and obligations of migrant health workers is a double-edged sword. The Universal Declaration of Human Rights adopted in 1948 and other international treaties recognize 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. Health workers from many poor countries find themselves unable to obtain the very minimum standards of living, education, adequate working equipment, safe working environment, etc., hence there is often agitation and frequent industrial action to demand better conditions as enshrined in the Human Rights agreements. When health workers strike for their demands, they infringe on the rights of their clients to adequate health because the two rights conflict. Governments in poor countries are unable, in most cases, to meet the demands and the spiral goes on year after year. The end result is that some health workers decide to migrate to countries where they believe conditions are much better.

Once they are in the host country many migrants have to subject themselves to dirty and humiliating work. Some have to change their profession, e.g. doctors must work as nurses or move away from the health sector altogether to find menial work. In Zimbabwe, for example, such people are referred to as having 'joined the BBC or British Bottom Cleaners' (McGregor, 2007). Many of these health worker migrants possess much higher qualifications but feel trapped because they are made to do work much below their skills. These health workers are therefore in a fix; in their attempt to move away from bad conditions in their own home countries, they move into equally dehumanizing conditions abroad.

#### RESPONSE TO MIGRATION

Because of the devastating effects of health worker migration on the health of the populations in their home countries, the governments of these countries have responded with many measures to stem the rate of migration. These measures have been implemented partly through the use of incentives and partly through coercion. Incentives have occurred in various forms including increased salaries, introduction of allowances, provision of personal vehicles, personal houses, and scholarships for further qualifications, among others. Coercive measures have included withholding of certificates, seizure of passports, the introduction of exorbitant charges for transcripts and other documents needed for registering abroad, etc. These infringe on the basic human rights of the health workers.

In response to much international debate on the effects of migration of health workers, the host countries, usually rich western countries, introduced measures to officially reduce or stop migration from certain countries considered more vulnerable to the loss of health workers. However, this is also an infringement on the rights of health workers from these specified countries to migrate and improve their lot. In source and destination countries, these measures are either not rigidly enforced or some health workers are able to find loopholes in the system because the migration has not stopped, even from these specified countries.

#### THE WAY FORWARD

The fact that the health workers' right to migrate conflicts with the right of the population to adequate health care makes the solution of the problem of migration complex. All stakeholders must be involved in negotiations to reach a compromise.

Source countries must meet with their health workers to determine a compromise that is practical and satisfactory. The current practice of introducing incentives or coercive measures by the governments without the involvement of the health workers is unlikely to solve the problem. Indeed, coercion might even backfire as people might evade the measure or migrate as soon as a predetermined period (e.g. bonding) has expired. Host countries, for their part, must be fair to these health workers as well as their countries of origin.

For the health workers, host countries must see them as a vulnerable group and actively ensure their protection from exploitation by various recruiters. With respect to the poor countries it is absurd that rich countries are riding on the backs of poor countries to train health workers for them to absorb freely into their own health services – this is a perverse subsidy. At the very least, rich countries must compensate poor countries for the loss of health workers trained at public expense. The current excuse that it is too difficult to administer such restitution is untenable as the world has been able to design and implement systems far more complex than restitution.

#### REFERENCES

- McGregor, J. (2007) "Joining the BBC (British Bottom Cleaners)": Zimbabwean Migrants and the UK Care Industry', *Journal of Ethnic and Migration Studies* 33(5): 801–24.

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