developing world bioethics

Developing World Bioethics ISSN 1471-8731 (print); 1471-8847 (online)
Volume 11 Number 1 2011 pp 30–39

doi:10.1111/j.1471-8847.2010.00284.x

A QUESTION OF JUSTICE: ASSESSING NURSE MIGRATION FROM A PHILOSOPHICAL PERSPECTIVE

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Keywords
bioethics,
justice,
nurse migration,
philosophy

ABSTRACT
The intensified nurse migration leads to severe problems for the health care systems in many developing countries. Using the Philippines as an example, this paper will address the question of global nurse migration from a philosophical perspective. John Rawls' liberal and Michael Walzer's communitarian theory of justice will be examined in view of the ethical problem of nurse migration. In line with Rawls' A Theory of Justice*, nurse migration undermines the ability of the people in developing countries to make use of their basic rights and liberties. Walzer's communitarian assessment of nurse migration, on the other hand, will stress the shared 'thin' morality, as well as the shared history between the 'donating' and receiving countries. This paper argues that the commonality of a shared history and common values implies the moral obligation to ensure a fairer distribution of nurses.*

Health care workers are among the professionals most affected by global migration movements. Through various channels, health professionals – especially nurses – move in droves from developing countries to developed countries: from the Philippines to Saudi Arabia, from India to Ireland, and from Zimbabwe to the United Kingdom, and so on. These migration streams further the imbalance between the human health resources of the North and South. While Northern, developed countries have already a much higher nurse per population ratio, Southern, developing countries suffer chronically from a shortage of nurses. This situation is aggravated by the nurse exodus from developing countries. Such an uneven distribution of nurses over the globe cannot be just. It deprives large parts of the world's population access to professional health care services. While policy suggestions have been made to alleviate this problem, these suggestions however worked on an intuitive notion of justice, that is, it approaches the problem from the disciplines of nursing and public health. This article attempts to address this question in a systematic way by elaborating on the notion of justice as it is found in the philosophical discourse of the 20th century. Such a foundation hopefully will provide justification for the policy claims proposed elsewhere and make them more convincing.

THE EXTENT AND PROBLEM OF GLOBAL NURSE MIGRATION

Health care professionals are among the career persons drawn most strongly into migration in the age of globalization. Nurses move from predominantly developing countries to developed ones. Previously, migration ran mainly along previous colonial ties, from the Philippines to the United States (US), from South Africa and Australia to the United Kingdom and so on. However, today's circuits of international nurse migration are more complex: Cuban nurses migrate to South Africa, which in turn supplies nurses to Canada. Australia and New Zealand recruit nurses from the Pacific Island and 'send' nurses to the United Kingdom.[1] These migration flows tend to increase due to the lack of health-care professionals in developed countries and the future needs for nurses due to an aging population in the global North.[2] This

[1] B.L. Brush & J. Sochalski. International Nurse Migration: Lessons from the Philippines. *Policy Polit Nurs Pract* 2007; 8: 37–46.
[2] J. Galvez Tan. 2005. The National Nursing Crisis: 7 Strategic Solutions. Quezon City, Philippines: Philippines Center for Investigative Journalism. Available at: www.pcij.org/stories/2005/nursing-crisis-galvez-tan.pdf [Accessed 11 Jan 2010]; M. Kingma. 2006. *Nurses on the Move. Migration and the Global Health Care Economy*. Ithaca, NY: Cornell University Press: 29 ff.

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global nurse migration causes problems for health care in developing countries. The global maldistribution of nurses is already now heavily skewed towards developed countries. The nurse population ratio in Europe is ten times higher than in Africa or South-East Asia; it is likewise ten times higher in North America than in South America.[3] Migration further aggravates this inequality by withdrawing nurses from poor countries for the supply of the rich ones. Catherine Ceniza Choy describes this cluster of nurses in affluent countries as 'Empire of Care'.[4]

There is a variety of factors which allow nurse migration to take place. In general, these are categorized into 'push' and 'pull' factors. Pull factors are the one's bringing nurses into another country because of the opportunities offered there; push factors explain why nurses leave their country of origin in the first place. Commonly, migration is explained among economists and policy makers as a mix of these two intertwining forces.[5] Among the push factors most often mentioned are the meagre salaries nurses earn in developing countries, the lack of funded nursing positions, the inadequate resources for health care systems and the lack of social acceptance of the profession. These factors lead nurses to look for work in another sector or migrate abroad. They thereby set in place a vicious circle, making working conditions even harder for the remaining workforce.[6] Looking at the different nurse donor countries – the Caribbean, the Philippines, South Africa – one finds similar reasons that make nurses decide to look for employment elsewhere: Lack of adequate salaries, heavy workload and lack of career opportunities are among the dominant reasons why nurses migrate. On the other hand, the incentives from developed countries motivate them to migrate rather than find other work opportunities. A better salary is by far the most dominant pull factor. But as secondary reasons, better staffed health system, career opportunities, political stability and further education also play a role. In the US, the lack of nursing faculty in nursing colleges forces them to turn away students.[7] This also adds to the increasing demand of overseas nurses. Some of the push or pull factors might also be unique to a certain country or region. In Sub-Saharan Africa, for example, the high prevalence of HIV adds to the push factors. The idealization of life in the United States, in conjunction with a high social value attributed to it, adds to the pull factors of nurse migration from the Philippines.

It would be misleading to look at these migration flows only as decisions of single rational individuals weighing their options about which country it is best to work and live in, and finally settling for the economically more attractive option. These individual decisions are embedded in a historical, social as well as policy context. Moreover, the present nursing shortage in many developed countries is the result of concrete policies, making nursing a less attractive option by imposing budget cuts on health facilities in the 1980s and especially in the 1990s. Thus, in the United States alone half a million registered nurses – almost 20% of its overall workforce – are employed in a different field or are out of a job.[8] On the other side, in developing countries, the policy prescribed by the International Monetary Fund (IMF) and the World Bank in the last two decades was one of monetary austerity accompanied by the reform of the public sector. This reform consisted of a cut in public expenditure and the privatization of public enterprises. This policy ultimately led to cuts in the health care sector and thus to cuts in the salaries of health care workers.[9] Given this policy framework in nurse donor and recipient countries in the past decades, the current intensified flow of nurses cannot come as a surprise.

The historical perspective of nurse migration should not be disregarded, too. The enabling condition for nurse migration in the historical context was the introduction of Western type health care systems in developing countries during the colonial period; and not to forget the export of the language of the colonizers, which facilitates today's migration. The colonizers employed different measures seeking to improve the indigenous sanitary and health conditions. This 'benevolent' colonialism had to fight previous indigenous, animistic, holistic understanding of disease and health and replace it with the 'materialistic' understanding of the causes of disease of the West. Institutions like hospitals and professions like nursing were imported from the West. There were strong resistances, for example in the Philippines, against women working as nurses in hospitals.[10] Without this imposition of roughly Western structures – nursing training, English language proficiency, Western nursing work culture and 'gendered notions of nursing as women's work'[11] – today's migration would not be possible.

[3] J. Buchan & L. Calman. 2005. *Summary. The Global Shortage of Registered Nurses*. Geneva: International Council of Nurses: 2. Available at: http://www.icn.ch/global/summary.pdf [Accessed 11 Jan 2010].
[4] C.C. Choy. 2003. *Empire of Care. Nursing and Migration in Filipino American History*. Durham & London: Duke University Press: 3.
[5] Kingma, *op. cit.* note 2, p. 19; D.S. Kline. Push and Pull Factors in International Nurse Migration. *J Nurs Scholarsh* 2003; 35: 107–111.
[6] World Health Organization (WHO). 2003. *International Nurse Mobility. Trends and Policy Implications*. Geneva: WHO: 37. Hirschfeld notes that American nursing school have to turn away annually 150,000 qualified applicants due to understaffing. M.J. Hirschfeld. 2008. Globalisation: Good or Bad, for Whom? In *The Globalisation of Nursing*. V. Tschudin & C. Hancock, eds. Oxford/New York, NY: Radcliffe Publishing: 12–24.
[7] WHO, *op. cit.* note 6, p. 42.
[8] Kingma, *op. cit.* note 2, p. 31.
[9] Ibid: 25.
[10] Choy, *op. cit.* note 4, p. 25.
[11] Ibid: 41.

These wide-ranging international migration movements are supplemented with *intra*national migration flows which similarly pose a severe problem for the maintenance of health care. In the West-African countries of Ghana, Guinea and Senegal, the majority of nurses are employed in hospitals of the capital cities, even though their population comprise only 20% of the nations' overall population.[12] Special allowances are put in place in South Africa, for example, for health care workers committing themselves to work in rural areas. However, the 12% salary increase for nurses (compared to 22% for physicians) is hardly sufficient to make up for the disadvantages accompanying life in a rural setting.[13] Such financial incentive is not strong enough to balance major disadvantages like the lack of suitable equipment and understaffed rural health care facilities. Working in a rural hospital would also imply leaving the family network behind. This problem of unequal health care *intra*national recurs in many countries, as will be seen in the case study of the Philippines.

Although nurse migration is not new and has happened at least since the economic boom in the 1960s, 'its grand scale and directional shifts have never been seen before'.[14] In recent years – to cite just a few examples – the number of graduating nurses in Zimbabwe was smaller than the number of Zimbabwean nurses registering in the United Kingdom. Any hope for a recovery of the nurse workforce in Zimbabwe is thus unfounded; worse, the further depletion of nurses sets off a vicious circle making work less bearable for the nurses left behind. These nurses are put under more stress as they need to assume the work of the migrated nurses.[15] In other countries the picture is similar. Over the last twenty years, two third of the graduating nurses in Jamaica have emigrated.[16] In the Philippines, the number of deployed nurses has been significantly higher than the graduating nurses between 2000 and 2004.[17] Correspondingly, the recipient countries continue with their nurse recruitment: More Bangladeshi nurses work in the Middle East than in Bangladesh; 84% of all nurses employed in Saudi Arabia are migrants, and Ireland – traditionally an exporter of nurses – is recruiting nurses from China, the Philippines and other countries.[18] The demand of developed countries, from Japan to the United States, from Saudi Arabia to Norway, is expected to further increase due to nurse shortages and an increased demand due to an aging population.[19]

[12] Kingma, *op. cit.* note 2, p. 27.
[13] Ibid: 27; Hirschfeld, *op. cit.* note 6, p. 17.
[14] Kingma, *op. cit.* note 2, p. 173.
[15] Ibid.
[16] Ibid.
[17] Brush & Sochalski, *op. cit.* note 1, p. 41.
[18] Kingma, *op. cit.* note 2, p. 173 f.
[19] Galvez Tan, *op. cit.* note 2.

This nurse migration causes severe problems for the health systems in donor countries and is further aggravated by its increasing flow. The loss of nursing staff severely threatens the operation of health care facilities in developing countries. A centre for spinal injuries in South Africa had to be closed the very day its two anesthetists were recruited to Canada as the centre was unable to find replacements for them.[20] Zambia has almost doubled the salaries of their nurses but can barely manage to keep them from leaving the country in order to work as maids in the United Kingdom.[21] Two hundred hospitals have been closed in the Philippines due to a shortage of health care professionals.[22] This nurse exodus leads to an increased inequality of access to health services. Especially affected are rural areas in developing countries. To date, nothing indicates that the disparity of the ratio of nurses between Europe and Africa would alter towards a more equal distribution. Similarly nurse to patient ratio in hospitals of developing countries reaches crisis levels. All these data point to a problematic distribution of nurses that begs the question of justice. Before the issue of justice is addressed, a detailed look at the world's main provider of nurses, the Philippines, will help to better understand the dynamics of nurse migration.

NURSE MIGRATION: THE EXAMPLE OF THE PHILIPPINES

The biggest provider of nurses worldwide by far is the Philippines. It is also the only country which actively promotes exportation of nurses through its policies. It thus serves, to some extent, as a model for today's escalating migration of nurses, as other countries increasingly attempt to copy the Philippine model. It is worthwhile then to take a look at the dynamic unfolding in the Philippines to gain a proper account of the extent and the problems of nurse migration. The migration of nurses cannot simply be reduced to the aggregate decisions of individuals searching for an improvement of their lives. Rather, the ongoing nurse migration from the Philippines is a complex social phenomenon best understood in its historical dimension as well as in the context of the wider orientation of the Philippines as a migration society.

From a historical perspective, as illustrated by Choy,[23] the continuous interaction of the Philippines with its colonizers shaped the ambiguous relation of the archipelago with the so-called Western world. The Philippines was under the rule of the Spanish colonizers for over

[20] Kingma, *op. cit.* note 2, p. 179.
[21] Ibid: 182.
[22] F.M.E. Lorenzo et al. Nurse Migration from a Source Country Perspective: Philippine Country Case Study. *Health Serv Res* 2007; 42: 1406–1418: 1414.
[23] Choy, *op. cit.* note 4.

three hundred years and under United States rule for almost fifty years. It is the American rule that deeply shaped the health system in the Philippines. It introduced Western style health care and thus changed the indigenous ways of dealing with health and disease as well as the very notion of health and disease itself. Already in the early years of colonialism, American doctors and nurses came to the Philippines and on a much smaller scale Filipinos went to America to study medicine. The adoption of a Western style health system together with the English language brought about a necessary precondition for nurse migration. The *Exchange Visitor Program*, put in place after World War II facilitated the early stages of nurse migration, as it allowed nurses from the Philippines to work in America for up to two years. This opportunity was used both by Filipino nurses to immigrate permanently to the US and conversely by the American hospitals to overcome nurse shortages in the US mainland. When in the late 1960s the United States legislation allowed the influx of professional labour into its market, the medical professionals in the Philippines were in a good position to fill these gaps. Colonialism, an American style health system, English language and the Exchange Visitor Program have prepared the ground too well. Although the opening in the American job market only lasted for a short time, the next demand was soon to follow, in the oil exporting countries of the Middle East. First, the demand was mainly for construction workers but soon the demand for more female labourers as domestic helpers and nurses caught up. The global demand was matched by the willingness of the Philippine government in the 1970s under Ferdinand Marcos to export human labour to ease the pressure on the Philippine labour market and to strengthen the domestic economy through remittances. In this export policy, the feminization of migration was explicitly promoted. Nurses were one of the primary target groups for export. Marcos was quick to identify the market for nurses and implemented policies to serve it: '[T]his is a market that we should take advantage of. Instead of stopping the nurses from going abroad why don't we produce more nurses? If they want one thousand nurses we produce a thousand more'.[24]

Subsequent governments stuck to this policy and the export of labour became the Philippines most profitable export. Today, over 8 Million Filipinos, which is ten percent of the overall Philippine population, live and work all over the globe. Almost US$15 billion is sent home annually through official channels and this number increases further once the informal payments are taken into account.[25] Nowadays the global market for nurses not only demands 'one thousand nurses' as Marcos offered but tens of thousands. Recent official statistics show that around 10,000 nurses on average leave the Philippines each year.[26] However, this number takes into account the official channels only and there are good reasons to assume a great number of nurses leave the country through other channels.[27] A variety of indicators on the global nurse market suggest that the demand in the future will increase. Aging, care-needy populations and the chronic nurse shortage in many developed countries point to this direction. Moreover, the Philippines government also shows a persistent inclination to promote the labour export as shown recently in the deployment of Filipino nurses in the previously hermetically sealed Japanese labour market.[28]

The tradition of nurse migration paired with the opportunities for social and economic ascent attached to the practice of nursing overseas strongly affects the dynamics of nursing and nursing education in the Philippines. First of all, the volatility of the nursing market worldwide has strong repercussions on the country. Shifts in global demands have led alternately in the past decades to severe nurse shortages and oversupply in the Philippines as it takes some time for nursing schools to adapt to the rapid changes in the labour market.[29] Second, nursing is not so much seen as a profession to help others but merely as a ticket abroad. The main motivation is the opportunity of finding well-paying work in a foreign country. When this project fails however, nurses

[24] Quoted in, ibid: 115 f.

[25] M.M.B. Asis & F. Baggio. 2008. Introduction: Will Turning Transnational Foster Development in the Philippines? In: *Moving Out, Back and Up: International Migration and Development Prospects in the Philippines*, M.M.B. Asis & F. Baggio, eds. Quezon City, Philippines: Scalabrini Migration Center: 1–16.

[26] Philippine Overseas Employment Administration (POEA). 2006. *OFW Global Presence. A Compendium of Overseas Employment Statistics 2006*. Mandaluyong City, Philippines: POEA. Available at: http://www.poea.gov.ph/stats/2006Stats.pdf [Accessed 11 Jan 2010]; Philippine Overseas Employment Administration (POEA). 2007. *2007 Overseas Employment Statistics.* Mandaluyong City, Philippines: POEA. Available at: http://www.poea.gov.ph/stats/stats2007.pdf [Accessed 11 Jan 2010].

[27] Former Secretary of Health, Jaime Z. Galvez Tan points out that for example in 2001 the Philippine Overseas Employment Administration (POEA) reported only 304 nurses moving to the United States. And, he continues: 'This is definitely gross underreporting since the International Union of Nurses reported that close to 10,000 Filipino nurses were directly hired by US based hospitals in 2001 through their nursing job fairs held in various parts of the Philippines.' (Galvez Tan, *op. cit.* note 2)

[28] Manila Times. 2007. Editorial: Our Nurses in Japan. *The Manila Times Internet Edition* 9 January. Available at: http://www.manilatimes.net/national/2007/jan/09/yehey/opinion/20070109opi1.html [Accessed 10 Jan 2009]; R. Tulfo. 2007. What's Wrong with Sending Nurses to Japan? *Philippine Daily Inquirer* 16 October. Available at: http://newsinfo.inquirer.net/inquirerheadlines/metro/view/20071016-94663/What%92s_wrong_with_sending_nurses_to_Japan%3F [Accessed 27 Apr 2010].

[29] R.E. Ball. Divergent Development, Racialised Rights: Globalised Labour Markets and the Trade of Nurses – The Case of the Philippines. *Womens Stud Int Forum* 2004; 27: 119–133.

are not automatically absorbed by the domestic market. In such situations, trained nurses look for other options like working as call centre agents or as flight attendants. Thus, the number of nurses available for the Philippine health care system cannot simply be calculated by subtracting the migrating nurses from the freshly graduated ones. For some years in the 21st century, the quantity of migrant nurses surpassed the number of nursing graduates. This brings us to the third and most important point, the 'brain hemorrhage' which Galvez Tan describes as ailing the Philippine health system.[30] Many hospitals find it hard to find nurses with one or more years of work experience.[31] And most dramatically, many doctors train to be nurses in order to migrate because they can earn more as nurses abroad than as doctors in the Philippines. As of 2007, according to Galvez Tan, an estimated of 9,000 doctors trained or were training as nurses. Half of them already left the country.[32] This development stirred a national debate when the country's top medical graduate announced his intention to leave the country to train as a nurse in the United States.[33] It is this exodus together with a geographical maldistribution of nurses within the Philippines that led to the closure of 200 hospitals and the partial closure of another 800.[34] The closure of predominantly rural hospitals increases the disparity of health coverage between the capital region and the provinces within the country. Access to healthcare for less privileged segments of society becomes even more difficult than before. In addition to the closure of hospitals, the nurse-patient ratio, especially in provincial hospitals, has substantially deteriorated. Whereas in the 1990s, the ratio was still 1:15 to 1:20; now the ratio has increased to 1:40 or even 1:60.[35] That the overall coverage of health care in the Philippines has deteriorated can also be seen at the numbers of attended deaths. This number indicating the coverage of health care has recently gone back to the levels of the 1970s.[36]

Whether the situation, of the nursing profession in the Philippines, will improve in the coming years due to the increased numbers of newly graduated nurses remains to be seen. The crossing over of doctors to the nursing profession remains a worrying sign and whether hospitals might recover in time remains uncertain. Although there might be enough fresh graduates, there is still a lack of experienced nurses. Furthermore, there is no assurance that the new graduates will practice nursing in the Philippines.

The problem of the nursing profession in the Philippines thus mirrors the problem of global nurse migration. The question then is how can this problem be adequately addressed and how can policies bring about a fairer nurse distribution, without limiting the individual's right to freedom of movement. Such questions need to be addressed in the larger context of a theory of justice, which is required as a social philosophical basis for further reflections on policy recommendations. With regards to this question, the dominant liberal conception of justice and its communitarian critique are presented before applying the developed concept to the ethical question of global nurse migration.

THE CONCEPT OF JUSTICE ACCORDING TO JOHN RAWLS

Discussing the notion of justice in nurse migration requires an account of the concept of justice as discussed in philosophy. The benchmark theory of justice has been put forward by the American philosopher John Rawls in his study, *A Theory of Justice* (published first in 1971). The basic notions of his theory, as well as some points of critique will need to be made before returning to the topic of nurse migration.

Rawls' basic question is simple: How can society be organized in a just manner? The guiding question thus is not about how to be a just person but really what justice is as an attribute of a social organization: 'Justice is the first virtue of social institutions, as truth is of systems of thought.'[37] Justice thus, is an attribute of institutional structures, of a social organism. Rawls puts himself in the tradition of the social contract theory which works on the hypothesis of people joining together and deciding to bring about a social and political community. The human being is by nature a creature in the political community (ζῷον πολιτικόν) and needs others to live his life. In this

[30] Galvez Tan, *op. cit.* note 2.

[31] M.E. Perrin et al. Nurse Migration and its Implications for Philippine Hospitals. *Int Nurs Rev* 2007; 54: 219–226.

[32] A. Geller. 2007. Filipino Doc Picks Life as Nurse in U.S. *The Washington Post* 7 January. Available at: http://www.washingtonpost.com/wp-dyn/content/article/2007/01/07/AR2007010700163.html [Accessed 27 Apr 2010].

[33] A lot of the public discussion being waged around this emigration took place in the context of nationalism. On the one hand it was considered a sell-out if the most skilled leave the country, mainly by the country's leading newspaper. On the other hand, it was pointed out that given the wretched condition of the country, to leave it is the only possibility to secure one's family a better life (P.N. Abinales & D.J. Amoroso. 2005. *State and Society in the Philippines*. New York, NY/Oxford, UK: Rowman and Littlefield Publishers: 299 f.). It was later noted by the *Philippine Daily Inquirer*, not without a sort of delayed satisfaction, that abroad there is 'no greener pasture' as the country's 'top notcher' resigned his job due to unsatisfactory living conditions, but was quick to find a new one (G. Lirio. 2006. No Greener Pasture for Top notcher. *Philippine Daily Inquirer* 4 September. Available at: http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20060904-18821/No_greener_pasture_for_topnotcher [Accessed 27 Apr 2010]).

[34] Lorenzo, *op. cit.* note 22, p. 1414.

[35] Ibid.

[36] Ibid.

[37] J. Rawls. 1999. *A Theory of Justice, (Revised Edition)*. Cambridge, MA: Belknap Press: 3.

framework of mutual dependence – which is a necessary condition for human flourishing, much in contrast to Hobbes' misanthropic view – 'everyone's well-being depends upon a scheme of cooperation without which no one could have a satisfactory life.'[38] The social contract theory normally gains its legitimacy from an initial pre-social moment. This state of nature might be pictured as a state of war as Hobbes suggests, one of more or less peaceful coexistence without, however, the security of property as found in Locke or even superior to the socially stratified society as in Rousseau's *Discourse*. However, the state of nature has always been pictured as the initial stage, which is subsequently translated into a man-made civil order – a civil order that might be more or less just. Rawls gives this basis of a state-of-nature a new twist by his introduction of the original position.[39] Rawls raises the question: what sort of society would people in the state of nature conceptualize? But the imagined people are envisaged in a particular way, namely as rational beings, ignorant of their particular identity in the society to be organized. They do not know their gender, their social class, their race, their sexual orientation and in general, their concrete situation of life. It is Rawls' declared aim to address the problem of the inequality of birth which determines much of one's chances in life. A theory of justice needs to address these inequalities first.[40] His original position, where people agree upon the organization of the society, accounts for this.

Behind this 'veil of ignorance', people would come up with two principles of justice. The first principle puts an emphasis on a maximum of individual liberty applicable to everyone. Thus my liberties should in no way limit the liberties of someone else. These encompass the classical liberal ideals such as:

> political liberty (the right to vote and to hold public office) and freedom of speech and assembly; liberty of conscience and freedom of thought; freedom of the person, which includes freedom from psychological oppression and physical assault and dismemberment (integrity of the person); the right to hold personal property and freedom from arbitrary arrest.[41]

The second principle – the so-called difference principle – applies 'to the distribution of income and wealth and to the design of organizations that make use of differences in authority and responsibility.'[42] Inequalities in income and wealth are allowed as long as even the least-advantaged can profit from them. As complete economic equality leaves everyone worse off, inequalities can be justified on the basis that everyone can profit from the wealth generated. The second principle further states that, positions of authority and responsibility must be open to everyone.

The standard of justice in Rawls' theory is rather high. A just society only allows for inequality if, and only if, it is to everyone's advantage. Accordingly: 'Injustice, then, is simply inequalities that are not to the benefit of all.'[43] The background assumption is that in the original position, people ignorant of their position in society would indeed opt for this type of social organization. It is the choice that guarantees them a decent life whatever their position in society might be. Accordingly in Rawls' theory, much of what we achieve in life is a consequence of the natural talents we were given and the social strata we are born into. Neither of which we can claim credit for.[44] Of course we have every right to use these talents and make the best out of our situation but we are still inevitably tied to the overall social cooperation to which we owe our position. Thus, economic and social inequality has to be minimized. However, Rawls is opposed to a complete egalitarian society because it would leave the poor worse off. A minimum of social and economic inequality will allow for better development and even enable the ones worse off in society to improve their situation in absolute terms.[45] For the cases where the two principles get in conflict – basic rights versus economic equality – Rawls gives a preference to the first principle. We are not allowed to limit our rights and liberties for a greater economic equality. However, a certain economic equality, guaranteeing a social minimum relative to a given society, is necessary for people to be free and equal members of society and make use of their basic rights. How these two principles are concretely translated into a political commonwealth has to be decided on the level of legislation and is not part of the original position.

In view of the topic at stake, the global migration of nurses, it is worthwhile to look into some details of Rawls' theory. In *Justice as Fairness*,[46] Rawls assesses the importance of health care for the participation

[38] Ibid: 13.
[39] Ibid: 102 ff.
[40] Ibid: 7.
[41] Ibid: 53.
[42] Ibid.
[43] Ibid: 54.
[44] Ibid: 89.
[45] The assumption Rawls works on is that people understand and define themselves in absolute terms rather than relative to the rest of society. In reality one might as well prefer being slightly worse off, if the rich neighbour is on the same level as oneself. However, Rawls works on the assumption that people in the original position, behind the veil of ignorance, are mutually disinterested. In defence of Rawls, one also has to point out that behind the veil of ignorance we can reasonably expect people to choose to live in a society where, absolutely speaking, all people are better off even though there is some amount of inequality, which however still allows everyone to successfully aspire for a socially and economically higher position.
[46] J. Rawls. 2001. *Justice as Fairness. A restatement*. Cambridge, MA: Belknap Press: 171 ff.

of members in the society. Impairment of health always hinders us from cooperating as free and equal individuals. Thus, the people in the original position have an interest to set up a social organization to ensure their continuous ability to participate in social cooperation. Health, thus, is a primary good and something that should be guaranteed to everyone within society. In the original position, we would have an interest to organize society in a way that the least-advantaged ones do not fall under a certain minimum. This social minimum includes the coverage of medical care needed to remain an active member of society. Health is mainly seen by Rawls as a requirement for active participation in society:

> [P]rovision for medical care [. . .] is to meet the needs and requirements of citizens as free and equal. Such care falls under the general means necessary to underwrite fair equality of opportunity and our capacity to take advantage of our basic rights and liberties, and thus to be normal and fully cooperating members of society over a complete life.[47]

Health (much like a good education) is a precondition for equality in society. Without it, we can not make adequate use of the rights and liberties attributed to us by means of the first principle of justice. A surprising consequence of Rawls' liberalism is that a government which does not secure basic liberties and one which does not provide adequate health care fall equally short of enabling a fair society. In both types of societies, the first principle of justice is not given the respect it deserves.[48]

The framework of Rawls is universal in its outlook as it assumes that every rational person would opt for the suggested organization of society which might be realized in a property owning society or 'by a liberal socialist regime.'[49] With *A Theory of Justice,* Rawls presents the dominant liberal political theory of the 20th century. He lays the theoretical foundation for the social democratic state by bringing together the appreciation for basic liberties with the redistribution of economic goods, while guaranteeing a social minimum and universal access to health care and education. At the same time, Rawls' theory abstains from ethical judgments about the good life. It does not give preference to a particular way of life and thus provides the basis for Western pluralism.[50]

THE COMMUNITARIAN CRITIQUE (MICHAEL WALZER)

Many criticisms have been raised against Rawls' concept of justice. From the libertarian perspective of Robert Nozick, who advocates a minimal state, Rawls' distributive element embedded in the second principle is too far reaching as it limits basic liberties, especially the liberty to own property.[51] The communitarian perspective of Michael Walzer challenges the universal outlook of Rawls and argues that social goods have different values in different communities.[52] A utilitarian would criticise the value given to individual liberty over the benefits for everyone. According to this position, the overall sum of utility, mostly understood in terms of happiness, has to be maximized. Utilitarianism would give preference to maximizing benefits over individual (political) rights.[53] Deconstructivism criticises the pretence of the liberal outlook to actually provide principles of justice and would emphasize, in contrast, the aporias inherent in the very concept.[54] It would be beyond the scope of this article to give a comprehensive account of these criticisms. I will limit myself to the communitarian criticism, which I deem relevant to the issue at stake, namely health care in general and specifically the global migration of nurses.

The communitarian criticism of Rawls points out that norms of justice are found in a concrete cultural context rather than abstractly posited behind a 'veil of ignorance'. Justice is rooted in a particular lifestyle and different cultures give rise to different concepts of justice. According to Walzer, it is exactly the ignorance of this plurality which injustice consists of. Different cultures have different lifestyles and thus value different (social) goods differently. What a particular good is worth is not society-independent but rather is socially constructed. Walzer

[47] Ibid: 174.

[48] On a personal note, people in objectively wretched conditions, such as city slum-dwellers in Manila, who can access neither health care nor basic education for their children, would easily trade some of their basic liberties for the benefits of social and economic equality. Their economic and social position does not allow them to be equal members of society and so they end up being deprived not only of social participation but ultimately also of their basic rights. For a concrete account of this deprivation, this inability to articulate their demands, see: A.M.G. Rodriguez. The Mass Raises Its Ugly Head: When the Margins Speak with Their Own Voices. *The Loyola Schools Review: School of Humanities* 2008; VII: 77–99.

[49] Rawls, *op. cit.* note 37, p. xv.

[50] To what extent the theoretical, postulated pluralism of Western society is indeed actualized is another question. The rhetorical commitment is not necessarily followed by a pluralistic practice, as discussions about minarets in Switzerland, about non-Christian religious instruction in Austria and gay-marriages in the United States show, to name just a few examples.

[51] R. Nozick. 1974. *Anarchy, State, and Utopia.* Oxford, UK: Basic Books.

[52] M. Walzer.1983. *Spheres of Justice. A Defense of Pluralism and Equality*. New York, NY: Basic Books.

[53] J.S. Mill & J. Bentham. 1987. *Utilitarianism and Other Essays*, Alan Ryan, ed. London, UK: Penguin Books.

[54] J. Derrida. Deconstruction and the Possibility of Justice. *Cardozo Law Rev* 1990; 11: No. 5–6. For a discussion of Derrida's take on justice see: L. Kaelin. 2008. The Intrinsic Violence of Rights: Derrida and Hegel. Available at: http://www.unesconatcom.ph/docs/SHS/papers/Kaelin.pdf [Accessed 11 Jan 2010].

considers the Western focus on money as the dominant good, as a deplorable reduction of the plurality of goods. The weight of the different goods – friendship, family and relatives, love, hard work, material wealth, living in harmony with others and/or nature – needs to be taken seriously. The liberal attempt to formulate one standard of justice and thus give the different goods a particular value, fails to see the social construction of value. It is within a particular culture only that justice can be judged. Already the emphasis on the individual is a Western presupposition and cannot easily be applied to other cultures.

What is required, according to the communitarian view of justice, is knowledge of a particular culture and how goods are socially constructed, to evaluate its notion of justice. Clifford Geertz' influence can be seen when Walzer distinguishes between 'thick' and 'thin' morality. Geertz showed in his benchmark essay, *Thick Description,* that societies carry their own interpretations with them, and through them their norms can be understood.[55] Walzer requires us to gain knowledge of cultures and their 'thick' morality consisting of shared cultural norms and a common lifestyle. The 'thick' morality is particular to a moral community. However, there is a universal 'thin' morality which takes its normative potential from the thick morality of particular communities. This 'thin' morality is formed at the interaction between the particular communities and is thus forming universal moral minimal standards.[56] In this communitarian perspective, Rawls' theory is doing injustice to the cultural diversity and the variety of lifestyles by suggesting too far reaching universal standards of justice.

What does that all mean for the topic at hand? First of all, we have to acknowledge the cultural relativity of the concept of health. To what extent health is a good and how health is defined and understood varies among different cultures. Health and disease are not simply natural descriptions but socio-cultural phenomena. Although health is valued universally, it can be understood in many different ways. Depending on the philosophical interpretation of the person – physically, spiritually and emotionally – what health consists of will differ among nations and cultures. While in Europe health is predominantly determined by the functioning of the physical body, in other cultural communities, more subtle concepts like the spiritual or astral body play a role in a person's health. Health then might be understood as a hybrid of the different layers (or bodies) of the human person. Second, along with the different understanding of health comes a different character to healthcare in developing countries. Professionalization in health often has not completely penetrated society and in many areas family care is either a substitute for professional care, or at least an important supplement to professional care. This impacts the function of nurses in the different cultural contexts. While nurses are the primary care-givers in Western hospitals, the family retains its function as primary care-giver in the hospital setting of many countries in the developing world. Third, nurse migration primarily takes place between developing and industrialized countries with different value systems, lifestyles and notions of justice. This interaction between different cultures urges us to take the communitarian critique seriously and not to apply quickly a universal standard. But ironically, it was exactly the interaction between these different spheres of justice that brought about the nurse migration in the first place. The ties produced through the colonial history and the first wave of late 20th century globalization caused the increased global flow of nurses. The forthcoming evaluation of nurse migration needs to take into consideration this unique historical interaction of previously separated spheres of justice.

JUSTICE AND NURSE MIGRATION

In his wake-up call on the drastic consequences of the massive nurse outflow from the Philippines, Galvez Tan suggests a number of accompanying measures to ease the burden imposed on the Philippine health system. Among the policy suggestions put forward is first of all a hospital to hospital partnership from a nurse donor hospital in the Philippines to a recipient hospital abroad. The recipient hospital would commit itself to contribute to the education of a replacement for each nurse hired from this hospital. On the national level, Galvez Tan suggests bilateral treaties between nurse donor and nurse recipient countries. The recipient countries would receive financial assistance for educating nurses to fill the gaps left by the migrating ones. Further suggested measures attempt to reach a better understanding of the available nursing resources in the country and to be able to better foresee the future demand for nurses abroad.[57] The task of this last paragraph is to provide a philosophical underpinning for the ethical discussion on the migration of nurses.

When we analyze nurse migration against the background of a theory of justice, we first need to clarify our perspective. A global view, from a universal ethical vantage point, has to be distinguished from a genuinely national perspective; either from a receiving or a donating country. From a global perspective, the question is how the unequal nurse distribution turns out to be a moral problem. On the basis of Rawls' theory of justice applied on the global scale, the present lack of health care

[55] C. Geertz. 1973. Thick Description: Toward an Interpretive Theory of Culture. In: *The Interpretation of Cultures. Selected Essays.* C Geertz. New York, NY: Basic Books: 3–30.

[56] M. Walzer. 1994. *Thick and Thin. Moral Argument at Home and Abroad.* South Bend, IN: University of Notre Dame Press.

[57] Galvez Tan, *op. cit.* note 2.

in large parts of the world deprives people of their ability to make use of their political liberties. Health care, as Rawls points out, is a prerequisite for people to be free and equal. It enables them to recover from sickness and accident and thus make use of their rights and liberties. The current nurse migration amplifies this global health care imbalance by depriving the poor even more of the care needed. Deprived of health care in situations of sickness and accident, their political rights and liberties are of no use at all. Thus, along the lines of Rawls' theory, the migration of nurses makes an unfair world even less fair.

One might point out, against this position, that the main problem is a global shortage of nurses and in this situation; there will be a loser – either at home or abroad. If the nurses remain in developing countries as the argument above demands, then health care suffers in the North. If the nurses continue to migrate, then developing countries will keep on suffering due to nurse shortage. A libertarian position might simply invoke the freedom of movement of all nurses and demand that the state abstains from regulating the free movement of labour. Such a position fails to take into account, first, the differences in the gravity of the nurse shortage in developing and industrialized countries; second, it does not reflect on potential measures for increasing the global supply of nurses. The depletion of nurse stocks especially in sub-Saharan Africa and also the Philippines leads to a break-down of even the basic health services. In a rural setting in a poor country, the local hospital might be the only hope in case of diseases. If it had to close due to a shortage of health personnel, then there is no alternative at hand. Such a precarious situation is not in view in developed countries. Moreover, the resources of Western countries are in place to deal with the nurse shortage in the medium term by attracting more nursing students. Rawls puts emphasis on the need to restore 'our capabilities when by illness and accident we fall below the minimum and are unable to play our part in society'.[58] Thus, on a global level, the first priority is availability of health care resources to cover the minimum required by citizens to participate in society.

If we change perspectives and ask from the viewpoint of the respective countries, whether something morally wrong (unjust) is committed here, the answer would be the same. The sending country – the Philippines for example, the only country which has a state-sponsored migration program – is neglecting its moral duty towards its own citizens. Rawls is very clear about the importance of a minimum, needed for the active participation in the life of society. This minimum includes health care. Basic health care, thus, is non-negotiable and a government deliberately undermining it is violating the first principle of justice. Slightly trickier is the question from the perspective of the receiving country. Does it have a moral responsibility to care about the problems in health care, in donor countries, caused by its recruiting patterns? Following Rawls, the moral responsibility does not stop at the border of a political community. Rawls' aim is to provide a universal theory of what is just, and what the basic rights are. To undermine the basic rights of others through an insensitive recruitment policy runs counter to the main thrust of Rawls' political philosophy. Even though we have to acknowledge the reality of the boundaries of political communities, Rawls's argument of the original position and the two principles of justice aspire to cover every rational being. Thus, receiving countries cannot simply deny the moral implications of that practice and they have to admit the injustice inherent in nurse migration.

When we shift our attention to the level of the migrating nurse herself, we have to acknowledge with Rawls, her basic freedom of movement. This basic liberty constrains the ability of the state to keep nurses, by force, in a given country. Therefore the nurse's freedom of movement stands against the patient's right to care. Following Rawls, we cannot demand of the individual nurse supererogatory actions to renounce her basic rights for the well-being of the patient. But as Rawls' *Theory of Justice* is about justice in a social setting, we can formulate certain demands in order to render the global health care system more just. Along the lines of this theory, global society should impose a framework which can mitigate the impact of nurse migration on developing health care systems. Such a framework could contain policies along the lines of the ones suggested by Galvez Tan, like a hospital-to-hospital partnership between nurse donor and recipient countries; bilateral agreements between countries; or from the side of the developing countries, a requirement for each graduate to serve a number of years in the country of education before working abroad.

A communitarian perspective on nurse migration might challenge the tacit assumption of a global (moral) society's duty to ensure the minimum coverage of health care services for all. A communitarian objection might be put as follows: Within a community with a 'thick' morality, where people argue about the rules regulating the possession and distribution of goods, such regulations might be justified. However, the demand of global regulation fails to take into account the plurality of value systems. These systems vary between donating and receiving countries involved in nurse migration. Not only that, but our duties to people abroad – non-members of our political community – are somehow limited. Moreover, different political communities deem different goods to be relevant, and consequently subject to fair and equal distribution. Global regulation would ignore these crucial differences by presuming one global standard, imposed on everyone regardless of the cultural peculiarities. Only an analysis of the cultural patterns and values

[58] Rawls, *op. cit.* note 46, p. 75.

of countries suffering from nurse migration might enable one to come up with a standard of justice. Application of an arguably universal principle of justice to this situation will fail to grasp the peculiarity of these cultures.

One *might* suggest such a communitarian reading. However, such an interpretation – if at all seriously put forward by anyone – fails to recognize the relevance of the global 'thin' morality, as well as the main thrust of Walzer's philosophy. After all, he attempts not only to defend pluralism but also equality, as can be seen already from the subtitle of his main work. The suggested moral minimalism, the 'thin' morality, hinges on the 'thick' moralities of particular communities. In Walzer's view, the 'thin' morality encompasses the opposition to 'political tyranny or the oppression of the poor',[59] as well as 'rules against murder, deceit, torture, oppression, and tyranny.'[60] This 'thin' morality does not yet justify the global regulation of nurse migration for the benefit of the donating countries. However, Walzer is willing to argue for a right of military intervention in order to maintain the minimal standard of life and liberty. Certainly, nurse migration is no *direct* threat to life; but it is an indirect one. On this basis I would assume that Walzer's communitarianism would allow, and even recommend, global rules to mitigate the impact of nurse migration on donating countries.

This preliminary conclusion of the communitarian reasoning can further be supported by two factual particularities of nurse migration. First, most of the 'sending' countries have come by this status involuntary. They try to keep their nurses within their country but are powerless given the economic power of industrialized countries. The Philippines is as of now the only country with an official nurse export policy, and even there, migration is highly debated. Nurse migration happens against the explicit desire of the wider society of these countries. It would thus be wrong to presume a set of shared values in developing countries favourable to nurse migration. Second, nurse migration is facilitated by a shared morality, and ties that have been established in the colonial past. The similarity of the health systems also makes the nurses attractive to Western countries. This shared morality – not yet a truly 'thick' morality, but certainly one that cannot be exhaustibly described in minimal terms – brings with it responsibilities. Although, these different countries are not bound together by the same laws, they are tied together by a shared history and – to a certain extent – shared morality. The morality is shared because of the similarities of the health systems (making nurse migration possible) and thus the similar importance of health care for these peoples. This shared past and morality is reason enough to implement rules that will bring about a fairer distribution of the precarious health care services.

[59] Walzer, *op. cit.* note 56, p. 5.
[60] Ibid: 10.

CONCLUSION

This paper assessed the global phenomenon of nurse migration by means of a theory of justice. It has shown the extent of nurse migration and how it puts health care systems in developing countries under serious stress. People's access to health care has significantly deteriorated in some of the donor countries, due to the exodus of nurses. This deplorable phenomenon is problematic from the perspective of a theory of justice, whether justice is conceptualized universally, or whether we use a communitarian framework. On the most general level, unequal distribution of health care throughout the world is unfair; an unfairness that is increased by the actual nurse migration. From the perspective of Rawls, health care is necessary for people to be equal members of a (global) society. There is also a strong moral obligation on the national level of the receiving and donating country to work towards a fairer distribution of health care services. The moral framework of communitarianism, which emphasizes the moral autonomy of communities, comes through different deliberations to the same conclusion. Only the shared history and some shared values made nurse migration possible in the first place. These commonalities create a moral cluster where the fate of the other community cannot be ignored. On the basis of this injustice of the actual nurse migration, regulations are needed to ensure a more equal distribution of health care workers globally. As indicated by the theories of Rawls and Walzer, the receiving countries (and institutions) have a moral obligation to make up for the imbalance inflicted on the health care systems of donor countries. Given the asymmetrical relationship – hospitals recruiting individuals from developing countries – regulations need to be put in place at both the institutional (hospital) and the national levels. Partnerships on the hospital level require support at the level of national legislation to be sustainable. Public awareness of the global imbalance and the related health problems in developing countries is needed to stimulate policy changes in the West. Monitoring and regulating migration can however only be part of the solution of the health care problems in developing countries. Failure to address globally the health care crisis in many developing countries would perpetuate an injustice and further damage the fragile health systems of these countries.

Acknowledgements

The author wishes to thank the Austrian Research Society (Österreichische Forschungsgemeinschaft, ÖFG) for their funding which made research for this article in the Philippines possible.

BIOGRAPHY

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