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Push, Pull, and Reverse: Self-Interest, Responsibility, and the Global Health Care Worker Shortage

Katherine E. Kirby · Patricia Siplon

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Abstract The world is suffering from a dearth of health care workers, and sub-Saharan Africa, an area of great need, is experiencing the worst shortage. Developed countries are making the problem worse by luring health care workers away from the countries that need them most, while developing countries do not have the resources to stem the flow or even replace those lost. Postmodern philosopher Emmanuel Levinas offers a unique ethical framework that is helpful in assessing both the irresponsibility inherent in the current global health care situation and the responsibility and obligation held by the stakeholders involved in this global crisis. Drawing on Levinas' exploration of individual freedom and self-pursuit, infinite responsibility for the Other, and the potential emergence of a just community, we demonstrate its effectiveness in explaining the health care worker crisis, and we argue in favor of a variety of policy and development assistance measures that are grounded in an orientation of non-indifference toward Others.

Keywords Africa · Development · Ethics · Global justice · Health care equity · HIV/AIDS · Levinas · Philosophy and policy · Brain drain

K. E. Kirby (✉)
Department of Philosophy & Global Studies Program, St. Michael's College,
One Winooski Park, Box 368, Colchester, VT 05439, USA
e-mail: kkirby@smcvt.edu

P. Siplon
Department of Political Science, Saint Michael's College,
One Winooski Park, Box 372, Colchester, VT 05439, USA
e-mail: psiplon@smcvt.edu

The Health Care Worker Shortage: Globally Distributed, Unequally Experienced

The world is in the throes of a global health care shortage, with rich and poor countries alike struggling for health care workers to meet their national needs for health care. The shortages are much worse in developing countries, however, and not surprisingly given the region's low level of resources and high burden of disease, sub-Saharan Africa suffers from the greatest shortages. Wealthy country demand worsens the problem as African health care workers answer the siren call of higher wages and better working conditions offered by North American and European nations looking for more workers, especially nurses, to deal with their unmet health care demands.

In July, 2008 the wealthiest nations of the world used the 2008 Hokkaido Tokyo G8 Summit to offer assurances that "the G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 workers per 1,000 people, initially in partnership with the African countries where they are currently engaged and that are experiencing a critical shortage of health workers."[1] Yet, as the international network known as the Health Workforce Advocacy Initiative (HWAI) pointed out, these assurances are inadequate. The threshold adopted in the statement is hypocritical since all G8 countries, many of which claim to have health worker shortages, have health care worker-to-population ratios over four times this threshold. More importantly, the HWAI points out that the G8 failed to commit any actual specific level of financial support to achieve this "commitment".[2]

While the developed world drags its feet on reversing the tide of talent flowing away from the patients most in need, the negative impacts of the shortages created are widely known. Even major advances in bilateral and multilateral health assistance will not be able to overcome these shortages, and on the contrary, are being bottlenecked by them. In its July 2006 report to the Senate, the Office of the United States Global AIDS Coordinator, the agent responsible for the President's Emergency Plan for AIDS Relief (PEPFAR), cautioned that "it is widely acknowledged that the lack of trained health workers is a major barrier to scaling up AIDS services, particularly ART [antiretroviral therapy]".[3] Similarly, the World Health Organization has announced that achievement of the Millennium Development Goals is severely imperiled by the health worker shortage. Of the eight goals agreed upon in September 2000 at the United Nations Millennium Summit, three are most explicitly health-focused: goal 4 to reduce under-five mortality by two-thirds; goal 5 to reduce maternal mortality by three-fourths; and goal 6 to halt and reverse the spread of HIV/AIDS, malaria, and other diseases. All three of these goals, as well as others in the document, will not be reached without major changes beginning with a reversal of the health care worker shortage.[4]

[1] G8 Health Experts Group [8, p. 4].

[2] Health Workforce Advocacy Initiative [12, pp. 1–4].

[3] Office of the United States Global AIDS Coordinator [32, p. 6].

[4] World Health Organization [42].

Global health advocates and their governments have acknowledged the stunning differences in health status levels between developed and developing countries since at least the International Conference on Primary Health held in Alma Ata within the former USSR in 1978. The Conference was attended by almost all member countries of UNICEF and the WHO, and the Declaration produced by these attendees notes that "the existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable, and therefore, of common concern to all countries."[5] Yet, instead of lessening, this "gross inequality" has gotten steadily worse, and one of the most extreme facets has been the deterioration of the health care systems, including the human resources, needed to deliver care to the world's poorest people. Ever-increasing advances in medical technology and sanitation brought infectious diseases under control in developed countries, and health preoccupations in these countries came to focus on rising life expectancies (necessitating more nursing, and nursing home, care) and the "lifestyle diseases". These lifestyle diseases are connected to high fat, high sugar diets, diminished daily physical activity and consumption of tobacco, alcohol and other recreational substances. The cumulative impact of these changes is shown in a report from the National Center for Health Statistics, finding that, in 2006, Americans had achieved a record high life expectancy of 78.1 years, and suffered from heart disease, malignant neoplasm (cancer), and cerebrovascular disease as the three leading causes of death respectively.[6]

By contrast, such changes were not experienced by most developing countries, particularly in sub-Saharan Africa in the late 1970s, 1980s and 1990s. Instead, these countries were forced to confront their growing external debts (up from $80 billion in 1982 to $350 billion in 1998) by committing ever-increasing amounts of export earnings to debt servicing.[7] They also submitted their economies to structural adjustment programs that required decreased social (including health) spending, and increased cost-sharing and user fees, including among the poorest of their citizens. This translated into neglect of health care infrastructure, lack of spending on training health care professionals, and stagnation in salaries and cutting of positions in the health care and educational sectors.[8] In a study surveying historical trends of payment for African public sector health workers over the last four decades, researchers found that, of 32 countries for which data was available, between 1986 and 1996, real wages fell in 26 countries, and nine also lowered non-wage benefits, while least 21 were forced to fire some workers.[9]

The Joint Learning Initiative (JLI), a group of more than 100 health leaders, estimates that there is a shortage of more than four million workers. Further, the JLI suggests that nearly all countries suffer from "worker shortage, skill mix imbalance,

[5] International Conference on Primary Health Care [14].

[6] Heron et al. [13, pp. 1, 4].

[7] Chatora et al. [4, pp. 296–306].

[8] See Schoepf et al. [39] for a particularly salient discussion of these issues and their impact on the health outcomes of African nations.

[9] McCoy et al. [28, p. 676].

maldistribution, negative work environment, and weak knowledge base".[10] Developed countries view their own shortages as real, and important. In June 2006 the Association of American Medical Colleges (AAMC) issued a statement recommending a 30% increase over 2002 enrollment levels (an increase of 4,946 additional matriculants per year) to be accomplished by establishing new medical schools and increasing enrollments in existing ones in the United States.[11] The perceived shortage is even fueling brain drain among developed countries. For instance, a 2007 study appearing in the *Canadian Medical Association Journal* found that the United States is using Canada as a source of physicians, particularly physicians covering rural areas, which are universally hardest to staff in all countries.

Concerns about shortages of nurses are even greater, and expected to continue to rise, as the aging of the general population simultaneously increases demands for services and deprives the patient base of nurses, who are aging as a workforce. In a study of nursing education, the Health Resources and Services Administration (HRSA) cited the Bureau of Labor Statistics as estimating a shortfall of a million nurses in the United States by 2020. It also lists a variety of impacts of nursing shortages including adverse health outcomes, increased risk of hospital deaths, and acceleration of nurse burnout because of increased patient loads.[12] A vicious cycle has been set into place in the United States, whereby the nursing shortage is making retention of remaining nurses ever more difficult.

Yet the perceived shortage of health care professionals in wealthy countries pales in comparison to that suffered by some of the poorest developing countries of the world, particularly those of sub-Saharan Africa. Although there has always been inequity in the distribution of health care workers around the world, this inequity has now reached such proportions that authors of a February, 2008 commentary in the British medical journal the *Lancet* concluded that the active recruitment of African health care workers "is a systematic and widespread problem throughout Africa and a cause of social alarm" and should be viewed as "an international crime".[13]

The starkness of the inequity is best illustrated in the most heavily impacted continent of the world, Africa. There, the World Health Organization estimates that there is a 1.5 million person shortfall of trained health care workers; 36 of the 57 countries the WHO have classified as having critical health care worker shortages are in Africa. The shortfall seems all the more cruel against figures that suggest that the region experiences 25% of the world's disease burden, but has only 3% of the world's human resources and 1% of its financial resources to cope with it.[14] The health implications of the shortfall are obvious and devastating. Summarizing the work of the JLI's report, *Human Resources for Health: Overcoming the Crisis*, Delanyo Dovlo points out that a 10% increase in health care workforce density is

[10] Chen et al. [5, p. 1984].

[11] Association of American Medical Colleges [2, p. 2].

[12] Health Resources and Services Administration [11].

[13] Mills et al. [31, p. 687].

[14] World Health Organization [43], cited in Lawrence Gostin [9, pp. 1827–1829].

correlated with a 5% decline in maternal mortality, leading to the conclusion that current policies "may be responsible for the deaths of thousands of African children and women."[15]

Within most developing countries with severe health worker shortages, two further dynamics—the migration from rural to urban areas and from public to private workplaces—means that impoverished subsistence farmers living in rural areas are usually the worse-served of all. For them, the quest for health care means walking (or being carried) many miles to a poorly equipped and even more poorly-staffed clinic where there may be a single doctor or nurse trying to deliver health care to a catchment area of tens of thousands, possibly even hundreds of thousands, of people.

The global AIDS treatment activist movement that began in the late 1990s and accelerated in the first years of the new millennium helped to raise the issue with renewed urgency in two ways. First, it shed a light on the devastating impact that HIV/AIDS was having on the health of under-resourced countries, and on the ways in which HIV/AIDS was increasing demand for health care workers at the same time as it was decimating their ranks. Second, the activist movement was successful in demanding access to life-saving antiretroviral therapies for millions, and for mobilizing the resources, most notably through the UN-initiated Global Fund to Fight AIDS, Tuberculosis and Malaria and the 5 year $15 billion President's Emergency Plan for AIDS Relief (PEPFAR) passed in 2003 and reauthorized in 2008. As the resources of these two programs, as well as major increases in other bilateral programs, became available, the bottleneck created by the dearth of health care workers has become increasingly apparent.

In the following section, the dynamics of "push" and "pull" factors which exacerbate the problem of health care shortage and brain drain, or block solutions, are examined. Factors which are helping to push health care workers from the areas where they are most needed include difficult working conditions in developing countries and institutional blocks to sustainable incentives for health care workers to stay in these countries, as well as the additional strains and disincentives created by the HIV/AIDS pandemic. Active recruitment by the health sector in wealthy countries also acts as a mechanism to pull trained health care workers from developing to developed countries. Following this explanation, Emmanuel Levinas' conception of the ethical relation is introduced, through which it is possible to understand a radical irresponsibility that is the source of the injustice inherent in the crisis. We then explore the responsibility each participant in this struggle holds which must motivate and shape our efforts to seek justice and equity. Levinas' unique emphasis on a foundational kind of responsibility is necessary as a grounding for the assessment and justification of any practical policy solutions.

The Dynamics of "Push and Pull" Factors

Many analysts describing the flow of health care workers across the international wealth gradients speak of the "push" and "pull" factors that simultaneously work

[15] Dovlo [7, p. 0378].

within the developing countries by giving health care workers strong motivations to leave, and from outside them by furnishing these same workers with additional strong incentives to draw the workers into richer nations.

The "Push" Factors

The first of these "push" factors flows logically from the discussion above. As the situation becomes more desperate in the rural areas, and as positions remain unfilled for ever-longer periods of time, the position of the intrepid few who stay becomes ever more untenable. With every loss or unfilled position, the workload and responsibility increases on those who stay. Emily Makha, a 70-year-old nurse/midwife in Lesotho describes the burden as follows:

> As the only nurse here, I have to do the work of at least four nurses. I take blood samples, sputum, do both ante-natal and post-natal cases, and do curative cares for general patients, baby deliveries, etc. If I have to go somewhere, the clinic remains closed. Most nurses have left for the UK or South Africa. As a matter of fact, if I were younger, I would also have gone by now![16]

A second "push" factor is created because the same countries experiencing the worst effects of the health worker shortage, are also sitting directly in the most devastating path of the global HIV/AIDS pandemic. Sub-Saharan Africa has only 15% of the world's population, but two-thirds of its AIDS cases. With respect to the health workers struggling to do their jobs in resource-strapped environments, the JLI points out that HIV/AIDS constitutes "a triple threat that is increasing workloads on health workers, exposing them to infection, and stressing their morale."[17] A study conducted among nurses in KwaZulu Natal, South Africa's most populous province, as well as the one with the highest HIV prevalence among pregnant women, at 37.5%, found that the stress brought by HIV/AIDS among the patients takes many forms. They further connected this stress as "an important factor in nurses' decisions to leave the profession, choose different professions or seek work abroad."[18]

Significantly, health care workers are not immune to the destructive forces of HIV in their own lives. In addition to the constant fear of occupational exposure, in the words of a Zambian nurse, "We are also dying like any other people, we are also people."[19] This statement formed the title of an article examining the negative impacts of HIV/AIDS on health workers in two Zambian districts. In addition to the expected increases in workload and emotional exhaustion, the authors reported the severe affects of HIV on workers who were positive. Those who were infected refused to talk about their illness and were wary of being tested. In fact, fear of stigma was so strong that, despite the fact that 48% of workers surveyed in one

[16] Medecins Sans Frontieres [29, p. 10].

[17] Chen et al. [5, p. 1984].

[18] Zelnick et al. [45, p. 177].

[19] Dieleman et al. [6, p. 144].

district and 25% in the other reported having had needle stick accidents in the last year, only four workers said they had accessed post-exposure prophylaxis. Managers in the study attributed this low uptake to a fear of HIV testing.[20]

In addition to the workplace push factors outlined above are the glaringly low salaries offered to health care workers in these conditions. Data about salaries is hard to find, and often even harder to compare, a point made by a 2008 study in the *Lancet* which had set out, with limited success, to do just that.[21] But a 2004 study by Vujicik and others on the role of wages in developing country migration of health care workers offers some useful illustrations. After converting wages into US dollars at purchasing power parity (to control for cost of living) for five "destination" countries and 11 "source" countries, they found that physician wages in the United States (where they are the highest of the destination countries studied) were about 25 times what they were in Zambia and about four times what they were in South Africa. Nursing wages in the USA (again the highest of the destination nations) were about 28 times those of Zambia and twice those of South Africa.[22]

The "push" factor of salaries in developing countries may appear to be an internal issue but the reality is very different. Two external factors, quite out of the control of developing countries, stand in the way of increasing these salaries and thereby decreasing the incentive of health care workers to escape their own impoverished circumstances. The first is a strong reluctance on the part of developed countries to fund "unsustainable" projects. In this case, "sustainability" refers not to the donor countries' ability to provide funding for the long term, but to the recipient country's ability to take over the financial obligation in a relatively short period of time. In other words, donor countries have balked at providing aid to raise the salaries of health care workers desperately needed in developing countries because the salary levels, once raised, will need to be maintained, and they do not wish to obligate themselves to such a long-term commitment. Yet, as Gorik Ooms points out, for many African country governments to be able to provide the $35 per person annual expenditure that the Commission on Macroeconomics and Health has estimated to be the minimum expenditure necessary to achieve adequate health levels, they would need to spend *more than their entire government budgets on only health.* In the face of this obvious impossibility, he concludes that "sustainability"—defined as independence from foreign aid—"is an illusion."[23]

The reluctance of the donor countries to provide assistance in raising salaries to maintain health care workers in the areas of the world where they are most needed is further abetted by an additional outside force, the International Monetary Fund (IMF). For even if money were made available to be used to "top up" salaries, in many of the countries where it is most desperately needed, it cannot be applied. Civil society organizations have pointed out this problem for some time, and the IMF's own internal study confirmed it in 2007, when its Independent Evaluation

[20] Dieleman et al. [6, pp. 143–144].

[21] McCoy et al. [28, p. 680].

[22] Vujicik et al. [42].

[23] Ooms et al. [33, p. 1204].

Office found that the IMF often recommended public sector wage ceilings.[24] Wealthy countries can continue to provide money for health care: the IMF simply prohibits it being spent in this sector, with the result that, in 29 sub-Saharan countries between 1999 and 2005, on average, only 27 cents of each dollar in foreign assistance went to program expenditures; the rest went instead to paying down domestic debt and buying foreign exchange reserves, two activities favored by the IMF.[25]

The "Pull" Factors

The health systems of developed nations do not play an agnostic role in the flow of health care from poor to wealthy countries. Rather, they operate proactively as "pull" agents in their active recruitment of health care workers. Despite pleas from developing countries, including a 1996 speech from South African then-Deputy President Thabo Mbaki to the World Health Assembly, agents of developed countries, and sometimes the governments themselves (usually via specialized immigration policies) have aggressively pursued health care workers trained in developing countries, including African nations.[26] In their *Lancet* editorial contending recruitment practices are actually criminal, Mills and his co-authors detail these practices: "advertising in national newspapers and journals, text-messaging to health workers, personal emails and internet sites, and recruitment workshops," as well as offers of "legal assistance with immigration, guaranteed earnings, and moving expenses."[27]

In addition to refusing to offer necessary aid, wealthy countries are actively encouraging workers to *leave*. But even this is not the whole extent of the problem. The developed countries have actually forced the developing countries, including some of the poorest and most disease-burdened on the planet, into a position of subsidizing the wealthy countries' health care systems. This is because almost all of the doctors, nurses, pharmacists and other health care workers leaving African and other developing regions of the world were educated in state-sponsored universities and colleges in these developing countries. Thus, when a doctor or a nurse leaves her African homeland for the more lucrative and well-equipped wards of North America and Europe, her home nation loses not only her skills and services, but also its investment in time and money that was made in putting her through medical or nursing school in the first place. Worse, the developing country must now make a further significant time and financial investment in training another health worker simply to replace the one who has left. Noting the magnitude of the problem, *New York Times* reporter Tina Rosenberg writes the following:

> Malawian nurses have moved to Britain and other English-speaking countries en masse, and now two-thirds of nursing posts in Malawi's public health

[24] International Monetary Fund, Independent Evaluation Office [15].

[25] For fuller discussions of how the IMF blocks sub-Saharan African countries from spending donor aid on health development, see Rowden [38, pp. 19–24], and Ooms et al. [34].

[26] Hagopian et al. [10].

[27] Mills et al. [31].

> system are vacant. Zambia has lost three-quarters of its new physicians in recent years. Even in South Africa, 21 percent of graduating doctors migrate. The financial consequences for the poorer nations can be severe. A doctor who moves from Johannesburg to North Dakota costs the South African government as much as $100,000, the price of training him there.[28]

Despite the best attempts of western nations to ignore both the extreme disparities in health care between wealthy and African nations and the dynamics that are continuing to increase those disparities, the global AIDS pandemic, and the resources mobilized to fight it, have forced the issue. Reversing the flow of workers, and the damage caused by their absence will require a variety of actions by multiple sets of actors.

Ethics and the Health Care Worker Shortage

The actions of the developed world in this case have been called "criminal" because they perpetuate a radical inequality the result of which is an unjust distribution of life-saving resources. This crisis goes beyond merely practical considerations in that it reveals a prioritization of some human lives over others. The first step in solving the ethical crisis must be the development of a clear explanation of the human dynamics which underlie it. We must first understand *why* the crisis exists and continues unabated. With that explanation, we can conceptualize a restructuring of our interpersonal, inter-community, and inter-national engagements to render them not only economically, politically, and practically reasonable, but also ethically responsible.

A Foundation for Theories of Ethical Engagement

There are numerous ethical or moral philosophers to whom we might turn for guidance in this project. We might consider applying a utilitarian theory, wherein we would consider the quality and quantity of goods and harms at stake for both the developed world and the developing world. Or we might refer to Kant's second formulation of the categorical imperative, which makes clear that we must recognize every person as a rational, free being—an end in herself—and we must never treat any person as merely a means to our own ends. We might also turn to Aristotle for assistance, recognizing that the cultivation of virtuous character is indispensable for ethical engagement. Indeed, there is no need to argue that these theories of ethical engagement fail to offer potentially useful suggestions for solving the dilemma at hand, and we will return, in due course, to consideration of how such theories may contribute valuable insights. However, the solutions they offer rest upon the suspension of self-interest, or *at least* the *balancing* of self-interest with interest in the well-being of others, as do social contract theory and various models of distributive justice. Such theories seem to rest upon something *prior* to the

[28] Rosenberg [37, p. 16].

creation and application of rules, laws, formulae, or guidelines for action. They require that the individual adopt an orientation of non-indifference to the exploitation, violation, or neglect of others. They give us ways of rationally determining what counts as good or right or virtuous or just, but do they explain the *responsibility* that *obligates* the individual to choose the good of others over self-interest?

Emmanuel Levinas' phenomenological description of human subjectivity *as responsibility* for others provides a key insight into the human dynamics at work in this present health care crisis because it explores precisely the prioritization of self-interest that foils our enactment of *any model* for ethical behavior. Our endeavor in what follows will not be the assessment of models of justice, as it was not Levinas' project to do so. He says, "My task does not consist in constructing ethics; I only try to find its meaning…. One can without doubt construct an ethics in function of what I have…said, but this is not my own theme."[29] For Levinas, responsibility for others inevitably "leads to the liberal state, to political justice, through the plurality of individuals belonging to the 'extension' of the human genus."[30] Taking up the question of just policy and equity in the later sections of this essay, we will examine his theory's applicability and offer suggestions as to characteristics necessary for *any policy determinations* that might be made, but our primary task will be an exploration of the kind of human responsibility for others that must be the *grounding motivation* of any model for ethics or justice.

Application of Levinas' work allows us to discern ethical failure on two related levels. First is the failure to embrace responsibility for the Other[31] on the part of individuals and collective bodies and institutions in the developed world in seeking our own self-preservation and benefit at the expense of the developing world. This failure then, secondly, places an impossible decision upon the shoulders of individual health care workers who are torn between serving their own communities and leaving to make a better living for themselves and their families. In a sense, these individuals are cornered into either (1) abandoning the communities of which they are a part and to which they provide essential care and assistance or (2) accepting a life of dedicated service to their own communities, which more often than not results in *extraordinary* sacrifice for their own families.

A Levinasian Explanation: Individual Power, Responsibility, and Otherness

The Power of the Independent Self

For Levinas, the ethical relation depends upon the orientation of the individual, and the relation of justice within or between communities or nations (or any larger

[29] Levinas [22, p. 90].

[30] Levinas [25, p. 195].

[31] The differentiated use of the lowercase "o" and capital "O" in discussing the "other"/"Other" is very important. Only the transcendent, irreplaceable human being, capable of commanding me ethically, is "Other." While Levinas is inconsistent in the use of the capital "O," it has been used consistently in this paper with the intent of highlighting this distinction.

collectivity of individuals) must be founded upon the orientation of those individuals' concerns and endeavors. Within each individual there exists a fierce drive to survive and flourish—to preserve oneself and one's lineage, and also to fulfill one's own desires and interests. A life oriented toward such goals is that of the autonomous, independently-rational I, celebrated by modern liberalism. Levinas explains, saying the following:

> [t]he way of the I against the 'other' of the world consists in *sojourning*, in *identifying oneself* by existing here *at home with oneself*…. It finds in the world a site…and a home…. Dwelling is the very mode of *maintaining oneself*…a site where *I can*, where, dependent on a reality that is other, I am, despite this dependence or thanks to it, free…. [E]verything belongs to me.[32]

I absorb others into the world I create for myself, wherein I constitute their meaning and purpose. It is freedom which characterizes the existence of the self living for-itself, as there is really nothing restraining me from moving through the world as I so choose, taking what I want, leaving what I don't want, and interacting with the world around me in whatever way I decide. The endeavors of the I in this mode center around self-interest, and the freedom about which Levinas speaks here is a spontaneous freedom. As he says in *Totality and Infinity*, the actions of the I in the mode of interiority are "the exercise of a freedom sure of itself in its naïve spontaneity" whose primary task is "the determination of the other by the same…the very movement of representation…."[33] This mode is not purely animalistic, for Levinas, but rather supremely rational. I engage with the world with rational intention, and I strategize and invent and create defenses to protect the world I create for myself. The key is that everything I do is for the purpose of caring for the self.

There is nothing wrong with these activities of the self, until I engage with another human being, enacting my freedom for the purpose of self-preservation, *without regard for her*. There is a "positivity" to my freedom, which Levinas describes in "Uniqueness" as "a perseverance in being which is life; the human individual lives in the will to live…."[34] This does not mean mere survival, but rather the creation and shaping of one's life, in all its fullness. But there is also a "negativity in…freedom, in excluding the freedom of others which limits" the self's freedom.[35] The expression of my free will has the power to exclude or constrain the freedom of Others. For Levinas, my pursuit of my own being and interests can easily result in a life in which the individual becomes just like "a tree that grows without regard for everything it suppresses and breaks, grabbing all the nourishment, air and sun."[36] This is a usurpation of the Other that occurs when the self-interested I is indifferent to the well-being of the Other. For Levinas, "…freedom situates me effrontedly before the non-me in myself and outside of myself…it

[32] Levinas [20, p. 37].

[33] Levinas [20, pp. 86 and 85, respectively].

[34] Levinas [25, p. 189].

[35] Levinas [25, pp. 190–1].

[36] Levinas [24, p. 100].

consists in negating or possessing the non-me….”[37] In this mode of existing, the Other is reduced to a resource for my own self-pursuit or she[38] is excluded from the world I create for myself altogether. The self, oriented toward the self, is “entirely deaf to the Other, outside of all communication and all refusal to communicate—without ears, like a hungry stomach.”[39] Rationality seeks the *good of the I*, and in that mode I am deaf to the good of Others.

The developed world has the freedom and, more importantly, the *power* that comes with greater resources to ensure our own well-being. “Money,” Levinas tells us, means “the possibility or ability to take possession”—to acquire the things that are needed for prosperity.[40] Like the I seeking self-fulfillment, we in the developed world seek our own good or benefit. The phenomenon of brain drain epitomizes the irresponsible use of our freedom and power at the expense of others, enacted at the broader collective level, on our behalf, through the decisions and policies made by governments, international and non-governmental organizations, and private sector entities. We need health care workers, so we poach them from other nations, without any compensation to the system that educated them or the community that is left without essential health care in their absence. We remain bound up within the self-seeking endeavor of the I for-itself. As Levinas would explain, we refuse to rein in our own freedom for the sake of Others. Though we may endeavor to calculate maximum happiness, treat others as deserving ends, cultivate generosity, and create just policies for distribution of resources, our endeavors fail because we maintain the priority of the freedom of self-pursuit.

Individual health care workers in the developing world are not uniquely immune to the temptation of self-interestedness, and the alternative is an exceptionally difficult life with little financial reward, great personal risk, struggle to provide for their own families, and extremely limited resources to provide the services they seek to provide for others. Seeking self-fulfillment as we all do, and incentivized by the developed world’s promises, they are compelled to seek their own good at the expense of Others who are closest to them. Though certainly existentially free, in a strict sense, to remain, the context of their lives creates a lack of freedom in a more practical sense. This latter contextual unfreedom ought to be understood, as Amartya Sen has suggested, as a deprivation of the “freedom to live the kind of lives that people have reason to value.”[41] This very freedom, as capability, is promised by the developed world, so workers end up leaving their families, friends, community members, and countrymen, leaving behind the huge number of

[37] Levinas [20, p. 87].

[38] Feminine pronouns are being used for the sake of simplicity in writing, and in recognition of historical masculine gender exclusivity in language. There is debate over Levinas’ discussions of the feminine, but these debates are outside of the scope of this paper. See *Ethics and Infinity* in which Levinas answers an interview question on this matter, saying, “Perhaps…all these allusions to the ontological differences between the masculine and the feminine would appear less archaic if, instead of dividing humanity into two species (or into two genders), they would signify that the participation in the masculine and in the feminine were the attribute of every human being” See Levinas [22, p. 68].

[39] Levinas [20, p. 134].

[40] Levinas [27, p. 203].

[41] Sen [40, p. 295].

individuals who desperately need health care. The irresponsibility of the developed world that refuses to sacrifice for Others presents the individual health care worker with extraordinary responsibility and all the demand for sacrifice.

Ethical Responsibility and the Suspension of Self-Interest

Levinas tells us that there is, however, another dimension to subjectivity that transcends self-interest, in that the I is also *always already* in relation to Others, and thus always already *existing in the ethical relation*. Violence, for Levinas, means precisely the limiting of the Other's freedom, in whatever form it takes. The Other, he argues, issues forth the "revelation of a resistance to my powers that…calls [into] question the naïve right of my powers, my glorious spontaneity as a living being. Morality begins when freedom, instead of being justified by itself, feels itself to be arbitrary and violent."[42] The mere existence of the Other person, vulnerable to the potentially violent exercise of my freedom, demands that I halt my self-interested actions and engage in moral critique of those actions. I must stop what I'm doing for myself and consider that my actions may cause harm or deprivation to the Other. Certainly, such rational suspension of self-interest involves an act of will—a choice or a commitment. But this willful reorientation of the self recognizes that I *am responsible* for enacting my freedom *ethically* whether I embrace that responsibility or reject it. As Levinas tells us in *Ethics and Infinity*, responsibility is "the essential, primary and fundamental structure of subjectivity," and thus "Ethics…does not supplement a preceding existential base; the very node of the subjective is knotted in ethics understood as responsibility."[43] The vulnerability of the Other requires that I acknowledge that I *am responsible* for her well-being in the use of my freedom and power.

In embracing the responsibility I have to rein in my freedom and ensure that its expression in no way impinges on the freedom of Others, I act ethically. My concerns, interests, and activities are reoriented away from the self and toward the good of the Other person. I become "one-for-the-other." As Levinas explains, "In the exposure to wounds and outrages, in the feeling proper to responsibility, the oneself is provoked as irreplaceable, as devoted to others, without being able to resign, and thus as incarnated in order to offer itself, to suffer, and to give."[44] This is a radical shift, according to Levinas, and he insists that this new orientation is one in which the well-being of the Other person is allowed to override my own. Such a way of being can be rightly characterized as sacrifice, even if only in the minimal sense of setting aside my own interests to consider those of an Other.

[42] Levinas [20, p. 84].

[43] Levinas [22, p. 95]. E. Jeffrey Popke discusses this notion of subjectivity as responsibility, in "The Face of the Other: Zapatismo, Responsibility, and the Ethics of Deconstruction," contrasting it with modern philosophy. He explains that, for Levinas, "our subjectivity appears first and foremost as a relationship of responsibility to and for the other…. This responsibility is not in any sense a moral or philosophical commitment that can be made by an autonomous subject. It is, rather, the very nature of subjectivity itself…." (Popke [36, p. 303]).

[44] Levinas [21, p. 105].

What explains the present lack of institutional incentives that would enable individuals to remain in their communities to provide care without facing a demand for *extraordinary* self-sacrifice? The Levinasian answer is that such incentives would require that we, in the developed world, sacrifice. We, in the developed world, would have to suffer a little. Our culture of individuality, and the "self-made" man or woman, does not explain suffering for the Other as *necessary*, or morally obligatory. Our culture emphasizes the individual over the collective – individual independence and the drive to succeed *over* interdependence and the desire to care for Others. The individual is not understood as *always already* responsible for Others, so she is not recognized as responsible for anything she has not freely chosen. Consequently, the collective bodies representing and seeking to fulfill our individual interests also fail to take themselves to be responsible for Others in this way. The actions and policies created by such collective bodies, insofar as they respond merely to self-interest, must be halted and critiqued, in recognition that those actions and policies hold the potential to cause harm or deprivation.

Otherness, Revelation, and Relativity

For Levinas, this sacrifice of self-interest is morally necessary because of the uniqueness and irreplaceability of the Other with whom I am always already engaged. He describes the Other, in the following passage:

> [The Other] is not only an *alter-ego*. He is what I am not: he is the weak one whereas I am the strong one; he is the poor one, 'the widow and the orphan'…. Or else the other is the stranger, the enemy and the powerful one. What is essential is that he has these qualities by virtue of his very alterity.[45]

There certainly are practical differences between self and Other, but this, for Levinas, is not the alterity that makes the acknowledgement of responsibility urgent. The individual Other is unique in a way that goes beyond such thematizable differences. Her singularity is "a different alterity" wherein she "turn[s] out to be the one who concern[s] me par excellence."[46] As Levinas continues in "Uniqueness," "the difference of the other person," in this sense, "is not a formal, reciprocal, and insufficient otherness within the multiplicity of individuals of a genus, but an otherness of the unique…transcending all genus."[47] The Other person is not merely one individual among others of the same human essence, even if the human genus is characterized by practical diversity. As unique, she is irreplaceable and her suffering stands out as demanding my ethical attention. She cannot be conceptualized according to an understanding of human essence, and neither can she be objectified according to rational categories of difference. She is

[45] Levinas [26, p. 98]. It is true that, for Levinas, in the political realm, I am the Other to the Other, and this would certainly mean that the developing world is likewise obligated to express non-indifference to the developed world. But Levinas is concerned with the very practical suffering in the world, so it is appropriate to identify the developing world with the widow and the orphan.

[46] Levinas [25, p. 193].

[47] Levinas [25, p. 194].

"unassimilable, incomparable" and "irreducible."[48] She transcends such conceptual reductions, and thus the suspension of self-interest for her sake requires the suspension of my rational judgments of her, in order to allow her to reveal herself to me. Violence against her includes both the neglect of her suffering and the arrogant judgment of her prior to listening to what she reveals to me.

Compassion, for Levinas, means that I have passion with, and for, the Other as she struggles and suffers, rather than indifference or apathy. It is not the same as empathy, which presumes to take on the standpoint of the Other. Such rational conceptualization and presumed identification with the Other's plight "[remain] within…the world of the solitary ego which has no relationship with the other qua other, for whom the other is another me, an *alter-ego* known by sympathy, that is, by a return to oneself."[49] Struggle is not universal, but rather, is unique to the individual who struggles. I can never independently know the Other's experience. I must *listen* to what she reveals. Throughout *Otherwise than Being*, Levinas makes clear that the other person *teaches* me. He says, "Teaching is a way for truth to be produced such that it is not my work, such that I could not derive it from my own interiority."[50] I must be "taught" or instructed as to what the Other needs. This requires that space be created for her voice to be heard.

Certainly, I must take what the Other reveals to me and make rational sense of it, understand it, and judge and decide how to act. But when we first take the time necessary to *suspend* our own perspectives, conceptions, and judgments and truly listen to the Other, we are taught that suffering is relative, not objective or universal. I learn that every individual Other has her own unique story of struggle. And when I make the subsequent move to conceptualize and categorize, as I *must* in order to judge and decide upon actions, I am better equipped to understand that the struggle of an HIV-positive individual in the developed world, who has at least moderate access to ARV's and clinics, is different from the struggle of an HIV-positive individual in the developing world, who must travel long distances to see a health care worker, possibly leave with medication that is hard to refill or replace, and go home to face the stigma of disease. This differentiated understanding, in that it is categorization or thematization, does *not* capture the unique suffering of the singular Other. But the singularity of the Other, in her preciousness and irreducibility, makes such differentiated understanding important and *urgent* when it comes to practical, rational action and policy. *Presumptions* we make about the Other, prior to listening to her, can lead us far astray. Ethical engagement must be dialogic, not monological. When larger collectives create policy or decide upon actions, the temptation to generalize is rarely avoided, and the singular Other affected by that policy or decision is often never heard.

We can identify an example of just such an ethical transgression on the part of international governance structures, particularly the International Monetary Fund, which has applied its policy ultimatums with a broad brush, as if all individuals and

[48] Levinas [25, p. 194].

[49] Levinas [26, p. 86].

[50] Levinas [21, p. 295]. See also Levinas [21, p. 180] and Levinas [20, p.51] for more on Levinas' notion of "teaching".

nations in need are the same. The particular form that practical aid might take will depend upon the circumstances of individuals within the nation or community in need. Failing to listen to the voices of the unique individuals struggling to provide health care reveals a failure to take singularity seriously, and it will inevitably result in the subsequent failure to take into account the particular circumstances of the individuals it purports to aid. This has rendered the IMF's actions counterproductive, and in some cases, harmful. Such failure leaves these international governance structures with inadequate knowledge and results in the tendency to stereotype and reduce the suffering of people in need of health care, as well the struggle of those who seek to provide that care, to nothing more than a mere problem among many to be solved—a faceless competition for human resources.

Pointing Toward Levinasian Policy Commitments: Equality, Justice, and Sustainability

Comparison, Equality, and Justice

Ethically responsible action, arising out of non-indifference toward Others, will inevitably require the comparison of incomparable, unique Others—a very difficult task. I am obligated not only to one Other at a time, but rather my ethical attention is always pulled in multiple directions. I am obligated to all Others, and thus the concern for justice, equality, reciprocity, and fairness emerges out of ethical non-indifference. Just institutions, driven by the non-indifference of individuals they represent and serve, must be created in order to establish equitable consideration and distribution of goods and burdens for each and all. As Levinas explains in *Ethics and Infinity*, "[t]he interpersonal relation I establish with the Other, I must also establish with other men, there is thus a necessity to moderate this privilege of the Other; from whence comes justice."[51] I must weigh and compare my obligations, making compromises where necessary. It is a departure from the pure ethical encounter, which is "*modified* by the fact that there is justice, and that, with justice, there is a state, and as citizens we are equal."[52] Of course, living in an interconnected global world, we must include not only fellow citizens of one "state" but fellow *global* citizens. Given that our actions engage us with people across the world, it is not merely regional or national justice that we have a responsibility to seek, but rather *global justice*.

It is here where the ethical theories previously mentioned might be enacted, *arising out of the responsibility that requires the suspension of self-interest*. Recognizing that "society between human beings…can only exist on the understanding that the interests of all are to be regarded equally,"[53] a careful, thorough utilitarian calculus, for example, would seek a solution that maximizes happiness—including everything from basic human health and survival to the sense

[51] Levinas [22, p. 90].

[52] Levinas [23, p. 179].

[53] Mill [30, p. 32].

of dignity which, according to John Stuart Mill, "is so essential a part of happiness…that nothing which conflicts with it could be otherwise than momentarily an object of desire"[54]—while minimizing pain and sacrifice. When one doctor or nurse in the developing world stands between the life or death of hundreds of people, does this compare to the services she might provide to far fewer patients in the developed world—patients who already have at least minimal access to health care? Similarly, models of distributive justice must be grounded in this equality and fair consideration of the well-being of each and all, with the self identified as no more deserving than any other, if they are to attain the just allocation of resources and obligations that they purport to seek.

If we follow Kant's insistence that each individual be treated as an end-in-herself, we will never violate or betray the good of the other by using her as mere means to the attainment of personal gain. We will recognize that the individual health worker is not simply a piece of the solution to our own health care crisis or a mere resource to be used by the developed world. Levinas would insist, of course, that the Other is invaluable not merely because she is a rational and free human, like every other human, but precisely because she is *unlike* every other human. As we move from the interpersonal face-to-face relation with a singular Other to the justice of the community, what is universal is, paradoxically, the uniqueness and irreplaceability of each individual. Consequently, though they would both define the reverence that subverts self-interest as Kant does—as "an awareness of a value which demolishes my self-love"[55]—the "object" of reverence, for Levinas, is not the objective moral law, but rather the Other herself. Universal moral laws, however, will have to be established to protect each unique Other, and to provide the social context in which she can be free to live a life she values.

Finally, we certainly ought to seek to be generous, temperate, courageous, and so forth, as Aristotle suggests, but such striving, for Levinas, ought not be motivated by a concern for one's own character development. Rather, the cultivation of virtues ought to arise out of a radical non-indifference to the suffering of each and every Other. Practical wisdom, when *oriented around* the embrace of the responsibility that is an inextricable dimension of human subjectivity, will help us to discern what counts as just and generous, and must be utilized on the level of collective bodies for the benefit of both individuals and the community of others. This may tell us that it is a vice to seek the acquisition of a health care workforce that is disproportionate to our patient-load when compared to that of the developing world. Again, Levinas would protest the idea that ethics rests *primarily* on identification with another who is, *just like me*, a rational being seeking the same goods as the self. But in the *subsequent* move to justice, he would agree that the self and the other must be recognized as equal.

So what kinds of policies and commitments would Levinasian justice entail in response to the global shortage of health care workers? As a starting point in remediating the self-centeredness at the heart of the health care crisis, the collective entities which are actively recruiting from the developing countries must begin with

[54] Mill [30, p. 9].

[55] Kant [18, footnote to line 401.16].

some reflective self-assessment on the ethical merit of their actions and how they might be brought to a higher ethical standard of conduct. Who do they care about primarily? Themselves or Others? Ideally, policy encourages and makes possible those actions that benefit others and the community, and this can enlighten and educate, enabling individuals to recognize more clearly their ethical responsibilities. However, Levinas would tell us that an action is not ethical if done *merely* for the sake of following policy. Ethical enlightenment and the willing embrace of responsibility cannot be guaranteed by policy, though it ought to be recognized and sought in the creation of policy.

Practically speaking, developed countries, and the health care and training institutions within them, must work to increase the supply of health care workers both at home and abroad and to create a context in which those workers are valued and supported. To increase supply at home, developed countries must increase the incentives for their own citizens to go into nursing and, particularly in the United States, nursing education. These incentives, if properly designed and implemented, can have a doubly positive impact. First, they can resolve the immediate practical problem and second, they can demonstrate genuine concern for *both* the sick and vulnerable and those who devote their lives to their care. Currently, a major reason for the nursing shortage in the US is a lack of capacity for scale-up of nursing schools, where over 30,000 qualified applicants to nursing schools are believed to be turned away each year, primarily because of insufficient faculty.[56] These are individuals who choose to spend their professional lives caring for the vulnerable in their societies. They are already, to some degree, expressing a kind of ethical enlightenment that embraces the responsibility to respond to the suffering of Others. The work of creating incentives should aim to support and encourage them in this vocation—to make their lives better. We cannot just *use* people, offering them as little reward as possible to garner their labor. We must care about, and for, individual health care workers as unique Others and seek to make their burdens more bearable. Just institutions, Levinas would say, are those that always remember that their *primary* purpose is to seek the good of each individual within society.

A good start toward creating incentives that are Other-oriented in the United States is the Higher Education Opportunity Act which was signed into law on August 14, 2008. Among other provisions, the Act offers a $10,000 loan forgiveness program for registered nurses (RNs) working full-time in clinical settings or as nursing educators, provides an additional $3,000 per additional nursing student who colleges are able to admit above previous capacity, offers grants to schools to encourage post-graduate nursing education, and called upon the Institute of Medicine to conduct a study on the capacity constraints on schools of nursing.[57] The Institute of Medicine has now conducted its study, and has offered 10 recommendations, many of which are fully resonant with the challenges and remedies suggested by this paper, including efforts to increase the supply of both nurses with bachelor's degrees and doctorate, the institution of rewards and incentives for

[56] Yordy [44, p. 2], citing a 2005 study conducted by L. E. Berlin, S. J. Wilsey, and G. D. Bednash for the American Association of Colleges of Nursing.

[57] American Nurses Association [1, p. 1].

serving in rural and underserved areas, and increasing nursing opportunities and leadership roles to increase career satisfaction.[58]

In the case of developing countries, the governments of these nations have the same responsibility to do whatever is in their power (and if actors in the developed world change their behavior, that power will increase) to encourage health care workers to stay in their countries. Like in the developed world, this will mean supporting and encouraging those workers by addressing their needs and seeking to make their lives better. This includes not only commitments to allocate greater expenditures to the health care sector, but also greater openness to civil society, including professional, patient and other non-governmental organizations advocating for better working conditions, facilities, and procedures for the health care sector. In addition, from a Levinasian perspective, the developed world has a responsibility to support these same individuals in their struggle to care for their community members. The developed world enjoys the freedom and power inherent in possessing a greater abundance of resources, and it should use this freedom to choose to serve Others rather than its own agenda alone. Where international aid is predicated upon a developing nation's adoption of policies that lessen governmental expenditure on health and education, we must recognize that the self-interests of the developed world are overriding concern for the struggles of individuals. Such a restriction on aid neither encourages the positive action we are discussing nor enlightens people regarding their ethical responsibility to care for the ill and vulnerable.

Finally, and perhaps most controversially, health professionals themselves in developing countries also carry important ethical responsibility. Although it is true that health care workers, like every other human being, have a right to freedom of movement, it is also true that, in the global context we have created, the exercise of that freedom is literally costing the lives of the patients they are leaving behind. In the current situation, where they are being paid unlivable wages and forced to work in untenable work situations, it is reasonable for them to argue that their well-being, and the well-being of the families and dependents they support, have been pitted against the lives of their patients. Their freedom—in the sense of the capability to choose the life one values—is dramatically restricted. But if the "push" factors, such as wages and working conditions can be addressed, so that health care workers are not being asked to forgo their own and their family's well-being in such a *radical* way for that of their patients', then health workers, with greater freedom to choose, can also be expected to make sacrifices for the sake of the poorest people bearing the worst disease burden in developing countries.

At present, there is a radical imbalance and inequity of burden and sacrifice. Justice means that responsible action would be shared and balanced, so that the burden does not fall on one struggling segment of the world community alone. In this regard, just institutions and policies enable people to enact responsibility, and both developed and developing countries must play a role. For instance, there can be strong mutual benefits from temporary migration by health workers, allowing skills transfers and the development of personal relationships, while ensuring that these

[58] Institute of Medicine [16].

new skills would ultimately also benefit patients in home countries. Making such temporary migrations—including multiple entry and re-entry—easier would be an example of such a policy that would encourage health care workers to enjoy their own personal freedoms without neglecting their ethical responsibility to home-country patients.

There is reason for some optimism. For instance, in May, 2008 a group of international non-governmental organizations launched an NGO Code of Conduct for Health Systems Strengthening that was intended to create a good practice framework and discourage international NGOs from luring health workers for their own programs from the public sector in developing countries.[59] And on September 17, 2008 the South African paper the *Mail and Guardian* published a story entitled "UK to Stop Poaching Doctors" announcing that the British Home Office would be changing its policies to make it harder for non-EU health professionals to get work permits.[60] Of course, this should be done not simply to constrain the work of these professionals. It should be done to encourage their service to their home countries, out of a real *concern* for those communities on the part of the developed world. Thus, such policy must be matched with programs that manifest equivalent concern for those professionals who sacrifice for their community members.

Un-doing the harm already done will require a quantification of the scope of the problem. Amy Hagopian and her colleagues cite a figure from the United Nations Commission for Trade and Development estimating that each professional leaving Africa costs the continent $184,000 resulting in a total loss of $4 billion per year, or about a third of official development funds to Africa.[61] The developed world must not be indifferent to this loss/cost. It is significant, and it demands our concernful attention. Developed countries should be reversing the flow of these resources, and should be focusing on, among other initiatives, the development of more medical, nursing, and allied health schools (sub-Saharan Africa currently has a total of 87 medical schools and 11 countries in the region have none at all), and the training of community health workers to help fill the gaps (who, coincidentally, tend to be more easily trained and retained in rural and underserved communities).

Revisability, Sustainability, and Remembering Responsibility

The essential Levinasian point is that such a concern for justice and equality is necessary *because* of my ethical responsibility for *individuals*.[62] Levinas tells us, in *Ethics and Infinity*, that "[j]ustice, exercised through institutions, which are inevitable, must always be held in check by the initial interpersonal relation."[63]

[59] Bristol [3, p. 2162]. The text of the code of conduct, as well as background information and an opportunity to sign on are available at http://www.ngocodeofconduct.org/.

[60] Zvomuya [46].

[61] Hagopian et al. [10].

[62] Justice and ethics are conflated in *Totality and Infinity*, and Levinas later acknowledges this and draws the distinction between them that is being described here.

[63] Levinas [22, p. 90].

Levinas scholar Adriaan Peperzak explains this notion of justice quite eloquently in "Freedom," suggesting the following:

> Certainly, the planning of society by large and general structures is a condition of justice. But so too is the realization of the attitude…that gives every other man the chance to be a man, by showing him hospitality and service…. [H]ospitality transcends the work of macro-structures…. Therefore, the solution of the world problem…cannot be found in corrections and reorganizations of macro-structures alone. However necessary this great work may be and will remain, the micro-ethics of *goodness* remains indispensable for mankind to become human and not change into a technically perfect, but inhuman system, in which no individual will feel at home.[64]

Reorganization of policies and institutions, *by itself*, is insufficient for solving global justice failures. Justice must arise out of, and *in service to*, the ethical relation of *non-indifference* toward each individual. When this ethical orientation is lost or forgotten, either by individuals or the collectives that act on their behalf—when self-interest overrides sincere concern for the Other's well-being—the possibility of creating and maintaining just institutions, laws, policies, and programs disappears.

Rational judgments and comparisons are always a reduction of the Other's suffering to concepts that I can grasp. The ethical orientation that underlies justice demands, and in fact *necessitates*, a need to constantly pay attention and revise our ideas, judgments, and decisions regarding what counts as appropriate action on the basis of what is voiced by Others in the developing world. This need for revision, and the willingness to admit mistakes and embrace instruction and advice from the communities we hope to serve, is never-ending.

This may seem discouraging if we take it to suggest that the problem will never be solved. However, such a conclusion does not follow from the insight that ethical responsibility is never-ending. Levinas' point is not that any particular crisis, or the actions needed to resolve that crisis, would be without end. The point is that our ethical *responsibility* to attend to Others is infinite and persists even once a *particular* crisis is resolved. Thus, our commitment to Others must be infinite in the sense that we will consistently be concerned about their well-being and strive to work for their benefit, not only our own. Practically, this would mean the *long-term commitment* of aid on the part of collective institutions, education resources, medication, personnel, and so forth, without the constraint of "time-frames" or deadlines, after which aid expires.

Taking real responsibility for those who suffer in the developing world means caring about what happens to them and acting on their behalf, no matter how long it takes, even if we are never finished. As individuals, we must demand this from the institutions we entrust with the creation of policy. Levinas says the following, in an interview:

> I have described ethical responsibility as insomnia or wakefulness precisely because it is a perpetual duty of vigilance and effort which can never

[64] Peperzak [35, p. 360].

> slumber…. [L]ove cannot sleep, can never be peaceful or permanent. Love is the incessant watching over of the other; it can never be satisfied or contented….[65]

The ethical relation demands that I embrace my responsibility for the Other, and this requires the acceptance of my *infinite* responsibility to listen to her, protect her, and seek her well-being. As Gorik Ooms and others have suggested, we must re-conceptualize the concept of "sustainability". Responsibility, yielding justice, takes the form of concern for sustainability, where that refers to the capacity and commitment of developed countries to support the health care needs of their less wealthy neighbors, *not* the capacity of these neighbors to rapidly assume these financial burdens.

Conclusion: Non-Indifference and Sacrifice

Non-indifference towards the Other requires sacrifice in the suspension of self-interest. Sometimes, when the situation is dire, the sacrifice that will be required to secure or protect the well-being of the Other will be extreme. The global HIV/AIDS epidemic is the tragic circumstance that heightens and intensifies the necessity of ethical non-indifference, because the devastation brought by this disease is extreme, widespread, and long-term. The sacrifice Levinas discusses is *not*, fundamentally, a matter of giving to the Other out of my abundance—as something that I can easily spare. Levinas explains sacrifice as follows, in *Otherwise than Being*:

> Pain penetrates into the very heart of the for-oneself that beats in enjoyment, in the life that is complacent in itself…. To give, to-be-for-another, despite oneself, but in interrupting the for-oneself, is to take the bread out of one's own mouth, to nourish the hunger of another with one's own fasting.[66]

It is a matter of giving to the Other even out of the very meager resources I have, without concern for my own well-being overriding my concern for the Other. All practical efforts that are not grounded in this underlying responsibility will fail to place the well-being of unique and irreplaceable Others above self-interest.

The apathy and narrow self-interestedness of the developed world results in the failure to recognize the *unequal* burden borne by the developing world, especially in the face of the particular devastation wrought by HIV/AIDS, and thus the endeavor to create justice fails and the resultant policies perpetuate struggle and inequity. The HIV/AIDS epidemic is not the reason why we are responsible, but it certainly is the reason why acting responsibly, in this case, is extremely difficult rather than easy and straightforward. There is such extraordinary suffering in the world because of this epidemic, and thus our failure to accept responsibility for the well-being of those who suffer and those who work to alleviate such suffering should be

[65] Kearney [19, p. 66].

[66] Levinas [21, p. 56]. David Jopling, in "Levinas on Desire, Dialogue, and the Other," refers to this extreme generosity of "the person who takes the bread out of his or her own mouth to nourish the hunger of another…" (Jopling [17, p. 426]).

considered an ethical "crime" against humanity. Our apathy indicts us and shows us to be self-absorbed, indifferent bystanders, at best.

The health care worker shortage in sub-Saharan Africa and related brain drain of health care workers to developed countries are both logical outcomes of an unjust global system with a radically unequal distribution of sacrifice, grounded in an underlying disregard for Others. Such a system allocates health care not on the basis of greatest need, but on the basis of ability to purchase health services. The global AIDS pandemic, which accelerates the need for health workers at the same time as it infects and kills them, has heightened the urgency of this problem, and efforts to cope with HIV/AIDS are now being stymied by this same health worker shortage.

Levinas offers a phenomenological account of the responsibility that must drive and direct justice. The embrace of such responsibility and implementation of the just policies to which it points offer a means of addressing both the immediate crisis at hand and the ethical dilemma faced by developing world health care workers. By offering stronger incentives to our own health work forces, particularly nurses, to go into nursing education and stay in clinical care, we can better provide for the good of those health workers, while also meeting the health care needs of patients and beginning to staunch the incessant clamor for skilled health care from developing countries. Justice grounded in ethical responsibility demands that we recognize, and seek to rectify, the unequal burden of sacrifice faced by health workers in the developing world. This demands that we reverse the flow of resources spent on training developing country health care workers from the current system, where impoverished countries pay to train workers who are then siphoned off, to an *ethically responsible* one, where wealthy countries provide funds to ramp up the capacity of developing countries to train more workers and also top up the salaries of these workers to provide incentives for them to stay where they are. By doing this, we can increase the capacity of health care systems in areas of the world that need them most, for the purpose of saving and bettering the lives of individuals in need.

By recognizing that it is *our ethical responsibility to one another* that must be *continuously* acknowledged and embraced, we can envision genuinely sustainable solutions to the global health worker shortage. Levinas articulates the urgency of this responsibility for Others, offering the following insight:

> …the least intoxicated and the most lucid humanity of our time, at the moments most free from the concern 'that existence takes for its very existence' has in its clarity no other shadow, in its rest no other disquietude or insomnia than what comes from the destitution of the others. Its insomnia is but the absolute impossibility to slip away and distract oneself.[67]

Ethical responsibility, for Levinas, demands that we—individually and collectively—adopt an orientation toward Others that forbids the forgetfulness and the indifference that enable us to ignore the need and destitution of Other people in our world.

[67] Levinas [21, p. 93].

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