What's Wrong with the GLOBAL MIGRATION of Health Care Professionals?

Individual Rights and International Justice

by JAMES DWYER

When health care workers migrate from poor countries to rich countries, they are exercising an important human right and helping rich countries fulfill obligations of social justice. They are also, however, creating problems of social justice in the countries they leave. Solving these problems requires balancing social needs against individual rights and studying the relationship of social justice to international justice.

In New Zealand, the United Kingdom, Australia, the United States, and Canada, over 20 percent of practicing physicians are foreign medical graduates. Many of these physicians emigrated from low- and middle-income countries that struggle under relatively high burdens of disease. Jamaica, Haiti, Pakistan, India, Ghana, South Africa, and Uganda, for example, have lost more than 10 percent of their practicing physicians. For some countries, the loss has been much more dramatic. Since Zambia gained its independence, it has graduated about five hundred physicians. Only sixty still practice in the country.[1] The migration of nurses follows a roughly similar pattern. The United Kingdom, the United States, and Canada have imported large numbers of nurses from the Philippines, India, the Caribbean, and Africa. Some of the nurses were actively recruited by hospitals and health care systems. Others availed themselves of informal networks of migration.

Although this global migration benefits the destination countries, it seems terribly unfair. Some of the

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wealthiest and healthiest societies are pulling health care professionals from poorer and sicker countries, leaving them with substantially fewer health care workers to attend to enormous health needs. Canada, for example, where the average life expectancy is seventy-nine years, is attracting nurses from South Africa, where the average life expectancy is forty-nine years. In the usual flow of medical migration, the source countries lose a lot: highly needed and skilled personnel, public investments in education and training, and leadership and social capital. But they also gain. Workers who go abroad often send home remittances. Health care professionals who are working abroad sometimes help to develop transnational connections and partnerships. And if health care professionals return home to practice, they bring with them enhanced skills and new ideas. To understand the ethical aspects of this global migration, it's tempting to try to add up all the gains and losses in order to arrive at a net balance.

But I think that's the wrong way to proceed. Although the consequences are undoubtedly important, we should not assume at the outset that justice is to be understood on an accounting or business model. I want to begin with the question of whether health care workers have a right to emigrate. This discussion will lead to questions about social and, eventually, international justice and the complex relationship between them. I shall conclude by considering a few examples of fundamental changes that, while respecting individual rights, would move us closer to ideals of responsibility, social justice, and international justice.

The Migration of Health Care Workers

First, a few indicators and studies in order to provide a better description of the migration of health care workers. One measurement of medical migration is the percentage of physicians practicing in a particular country who are graduates of foreign medical schools. The five highest percentages are found in wealthy, English-speaking countries: in New Zealand, 35 percent of physicians graduated from foreign medical schools; in the United Kingdom, 28 percent; in Australia, 27 percent; in the United States, 25 percent; and in Canada, 23 percent.[2]

Of course, not all of these foreign medical graduates are from developing countries. There are physicians from Ireland practicing in the United Kingdom; physicians from the United Kingdom practicing in Australia; and physicians from Canada practicing in the United States. But a substantial number come from low- and middle-income countries with relatively high burdens of disease. In the United States, for example, over 60 percent of immigrant physicians come from low- or middle-income countries. Over forty thousand are from India, over seventeen thousand from the Philippines, and almost ten thousand from Pakistan.

As impressive as these numbers are, an even better indicator of the problem is the emigration factor—that is, the percentage of physicians who have left the country where they went to medical school.[3] Many countries in different global regions have lost well over 10 percent of their physicians. In the Indian subcontinent, Sri Lanka has lost 28 percent of its physicians, Pakistan 12 percent, and India 11 percent. In the Caribbean, Jamaica has lost 41 percent, Haiti 35 percent, and the Dominican Republic 17 percent. In Africa, Ghana has lost 30 percent, South Africa 19 percent, Ethiopia 15 percent, Uganda 14 percent, Nigeria 12 percent, and Sudan 11 percent. South Africa is a complex case. While many South African physicians have left to practice in more developed countries, many physicians from other African countries have been drawn to practice in South Africa.

In most wealthy countries, the percentage of nurses who are foreign-trained is not as high as it is for physicians. For example, about 10 percent of the nurses in the United Kingdom are foreign-trained, compared to 28 percent of the physicians.[4] But the situation is changing. In the last ten years, the proportion of foreign-trained nurses among newly registered nurses has risen dramatically. In 2001, more foreign-trained nurses than British-trained nurses registered in the United Kingdom.[5] Many of these newly registered nurses are from the Philippines, India, South Africa, and other African countries.

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For many hospitals and health care systems, the out-migration of nurses has become unmanageable. At one hospital in Malawi, 60 percent of the registered nurses emigrated during a three-year period.[6] In Ghana, 50 percent of the registered nurses have left during the last ten years.[7] In the Philippines, about 70 percent of nursing graduates move abroad, where they can earn 10 to 20 times more. Although nursing schools have expanded in the Philippines, and the country counts on remittances as part of its development plan, it now has

about thirty thousand vacant nursing positions.[8]

In most source countries, three or four migrations are taking place simultaneously, compounding the access problems. Health care workers are moving from rural areas to urban areas and from the public sector to the private sector (the latter due in part to structural adjustment policies that have forced countries to curtail public expenditures).[9] There are even reports, though no hard data, that well-funded NGOs are hiring health care workers away from the public system. Thus, the overall shortage of health care workers tends to be felt most acutely by the most disadvantaged groups—those in rural areas and those that depend on the public system. In South Africa, for example, the outflow of nurses has been particularly detrimental to the public sector.[10]

Many factors are pulling health care professionals to more developed countries: higher salaries, better working conditions, more training opportunities, relatively stable political conditions, beliefs about merit, and hopes for the future. These factors combine with the dominance of English in science, the standardization of health care, and the effects of colonialism. All these factors work within a labor market that is more global than ever. The resulting migration is not surprising, but it does raise deep ethical questions.

Rights and Responsibilities

The first ethical issue to address is whether people have a right to emigrate. I believe they do because of what it protects people against, what it allows people to do, and how it is related to other rights and concerns. Consider some widely accepted basic rights. People have a right to security against genocide, slavery, arbitrary arrest, torture, and persecution. They also have a right of conscience that allows freedom of religion, political opinion, and a range of beliefs. And they have a right to marry and practice an occupation. All of these are human rights, which puts them in a special subclass of rights. The right to emigrate serves to reinforce these rights and to protect people when these rights are violated or in danger. If people are allowed to leave, then they can seek asylum or residence elsewhere. Recognizing the right to emigrate would justifiably limit the power that governments have over people and allow people more freedom of movement to pursue their goals and help their families.

Article 13 of the Universal Declaration of Human Rights of 1948 tells us that the right to emigrate is itself a human right. I'm not sure that there is a principled, nonpragmatic way to delineate the subclass of human rights,[11] but whether the right to emigrate is a human right or not, it is certainly an important right. Still, like all rights, it needs to be specified, qualified, and balanced against other rights and concerns. Even the Universal Declaration of Human Rights, which includes an expansive list of rights, recognizes that people have duties to the community and that rights may be limited based on "the just requirements of morality, public order and general welfare" (Article 29).

The right to emigrate should be qualified by and balanced against the social responsibility of health care professionals. One basis of this responsibility is the public investment that society makes in the education and training of health care professionals. This investment takes many forms: state schools, state subsidies, tax regulations, loans, research grants, public hospitals and clinics, patients to learn on, cadavers to dissect, teachers who have been publicly educated, and so on. But establishing responsibility is not only about identifying and tracing public resources. It's also about delineating the legitimate structure of social institutions. In my view, it is right for a social system to encourage people to develop and exercise their abilities in ways that contribute to the social good.[12] Some degree of responsibility may be embedded in the structure of a legitimate social order.

The need for qualifying the right to emigrate arises when a sizeable number of people take advantage of the social order to develop abilities, but then use those abilities to benefit people in other societies that are wealthier and healthier. The issue here is not about forcing people to develop abilities and then to exercise them in a prescribed way. People are free not to study; they are free not to exercise their skills; they are even free to leave a society. But at least in many circumstances, *when* people choose to acquire professional skills and rely on public resources and institutions to achieve that goal, they also acquire some social responsibilities.

Putting social responsibility into practice requires balance and judgment. A society could justifiably require that health care professionals complete a substantial period of public service before they emigrate, or even before they graduate. It could also justifiably require a payment if health care professionals want to emigrate before practicing for a number of years. Moderate and reasonable schemes qualify, but do not violate, the right to emigrate.

We should also think about the destination countries. Does recognizing a right to emigrate entail a duty to accept immigrants? Some rights do entail correlative duties, but others do not. If I have a right not to be tortured, then other people have a duty not to torture me. But if I have a right to marry, it does not follow that anyone has a duty to marry me. I would put the right to emigrate in the second category. People have a right to leave their country, but no particular country has a duty to take them in. (The right to asylum seems to belong in the first category, however: people have a right to seek asylum, and if the claim is reasonable, the country where they have sought asylum has a duty to take them in.)

Overall, it makes ethical sense to recognize both that people have a

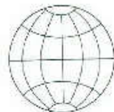
qualified right to emigrate and that states have a qualified right to regulate immigration. A country's right to regulate immigration does not depend on the appropriateness of current national boundaries, which may be quite contingent and arbitrary. It is based on the need for defined territories that allow peoples to form representative governments, maintain just political institutions, deal more effectively with social problems, and take more responsibility for the natural environment.[13] The problem of medical migration does not arise because the destination countries are trying to restrict immigration, but because they are restricting immigration in a highly selective way. They seem only too willing to accept highly qualified health care workers while trying to keep out less skilled workers. It is this approach to immigration that raises issues of justice.

Social Justice and Responsibility

Before taking up the issue of international justice, I want to consider the migration of health care workers from the perspective of *social* justice—the justice of arrangements and structures within a society. Lacking space for a detailed account of social justice, I will note just a few basic features of social justice that help illuminate the problem of medical migration. I believe a just society would (1) respect rights and foster responsibilities, (2) help people meet basic needs, and (3) give some priority to the least advantaged.

We have already discussed how the first feature is relevant to the problem of global migration, but the second and third features need a little further explanation. The intuition behind the second is that a society that could but does not work to help people meet basic needs (for nutrition and safety, for example) seems unjust, even cruel. "Basic needs" is a vague concept, of course. Sometimes we know whether something is a basic need, but sometimes we do not; and in my own view, there is no easy, context-free way to specify basic needs, especially those that concern health care. I may "need" a very expensive, rare, and technical treatment (extracorporeal oxygenation, for example) in order to live. From an individual point of view, this treatment may seem like a basic need because it is the only way to sustain life. But from a social point of view—taking into account population needs, cost-effectiveness, and opportunity costs—we may not want to count this need as basic.

The idea behind the third feature is that a society that favors and devotes more and more resources to groups that are already better off seems unjust. Such a society seems to be organized according to power relations, not norms of justice. Talk about priority is also vague, of course: sometimes we know who the disadvantaged groups are, how much priority they should be given, and what count as important social goods, and sometimes we do not.



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The vagueness in my description of social justice is a merit, given my purpose. I want to avoid a protracted argument about the exact features of justice, and I want to connect my conclusions with a range of views—for example, the view that we should maximize the benefit to the least advantaged, as well as views that balance this priority against the overall good. Hence, I tried to describe social justice only with that amount of precision that will help me illuminate some important aspects of medical migration.

Now, consider how the destination countries make use of medical migration. Often, they use immigrant health care workers to serve underserved populations: to work as general practitioners in rural areas, to staff hospitals in inner cities, to serve in the prison health system, and so on. The Canadian provinces of Alberta and Saskatchewan, for example, have recruited foreign physicians to practice in rural areas.[14] The United States accepts many foreign medical graduates to work as residents at teaching hospitals that serve inner cities. Many of these residency positions are in fields like pediatrics and internal medicine, not dermatology and orthopedic surgery, and many of the foreign graduates who accept these positions end up staying in the United States.

The destination countries are not to be faulted for trying to meet the health care needs of disadvantaged groups. Indeed, this effort is congruent with the goals of meeting people's basic needs and giving some priority to those who are disadvantaged, which I have just noted are features of social justice. The ethical problem concerns the origin of the medical staffing shortfall and the response to it. The shortfall stems, in part, from the fact that those in the health care profession in destination countries have relatively little sense of social responsibility. Physicians would rather practice dermatology in the suburbs than pediatrics in the inner city. And the profession does not take responsibility for the distribution of physicians within society (in terms of places and specialties).

Politicians and planners respond to the distribution problem by focusing on solutions that are quick, cheap, and market-based, such as importing foreign health care workers. But importing foreign workers to meet national health care needs takes measures that are international in

scope to solve a problem of social responsibility and social justice. It pits the interests of relatively disadvantaged groups in wealthier societies against the interests of people in low- and middle-income countries. This is not an inevitable tragedy, but a socially constructed problem.

The destination countries also use immigrant health care workers to address overall shortages. The United States, for example, is experiencing a shortage of nurses. The present shortfall is about one hundred thousand less than the demand. Because of the limited supply of American nurses, the relatively low rates of retention, and the aging population, the shortfall in 2020 could be as high as eight hundred thousand.[15] Some estimates also project shortages in the supply of physicians, at least in specialties like family practice and geriatrics.

Addressing overall shortages of health workers also meets a population's basic health care needs, which is congruent with social justice. But it is important to consider various ways of responding to the perceived shortages and to examine critically the assumptions behind the perception. Importing nurses is one possible measure. The destination countries could also expand their nursing schools, raise the salaries of nursing faculty, recruit more people into these schools, and try to retain more nurses who are already in the work force. These countries could even try to make the profession of nursing more attractive to their own citizens by increasing nurses' pay, improving their work conditions, increasing their autonomy, and according them more respect. This response would require a long-term view and a willingness to make fundamental changes.

Or the destination countries could take a more radical step and critically examine the very idea of a shortage. After all, compared to most countries, they have no shortage of health care professionals. The United Kingdom has one physician for about every three hundred people, whereas Ghana has one physician for about every fifteen thousand people.[16] But even in absolute terms, the idea of a shortage assumes too much. In an ethical analysis, making some distinction between real needs and market demands is important. The projected shortages are based on market demands, but the real needs are for conditions that sustain good health and responses that ameliorate or palliate ill health.

Within a wealthy country, health economists have noted a pretty clear correlation between the number of doctors and the expenditures for health care, but they have not seen a clear correlation between the number of doctors and measures of population health. More may not be better, especially if we consider the opportunity costs. If health and justice are important goals, and opportunity costs count, then a society might not need more physicians. It might need instead a different mix and distribution of physicians, or a different kind of health care system, or it might need to focus attention on the social determinants of health (rather than on simply responding to health needs after they arise).

The bottom line is that destination countries are using immigrant health care professionals to address real problems of social justice, but by relying on these skilled workers, and by not considering other options, they are making it more difficult for the source countries to address health needs and care for the disadvantaged in their own societies. This way of addressing social justice in wealthy countries is undermining social justice in poorer countries. It is this complex relationship that gives rise to the deepest problem of international justice.

International Justice and Responsibility

One approach to the issue of international justice takes a cosmopolitan view. It discounts the importance of national boundaries, emphasizes human need, and applies principles of social justice globally. The contrasting approach embodies a political view. It gives more weight to national boundaries, focuses less directly on individual need, and emphasizes background conditions that encourage just societies.[17]

The cosmopolitan approach undeniably has a certain intuitive appeal. It seems morally important to try to extend features of social justice to the world as a whole, and it seems morally salient to consider basic human needs in all countries and to give some priority to the least advantaged in the world. The cosmopolitan approach also illuminates some of the ethical concerns with global medical migration. People need social conditions that promote and sustain good health and social responses that ameliorate or palliate ill health. Clearly, basic health needs matter in a way that some goods do not. I am relatively unconcerned about the migration of basketball players to North America. Many of the best players in the world leave their countries to work in the National Basketball Association, drawn by the high salaries, the social prestige, and the opportunity to develop and test their skills. But physicians and nurses are different from basketball players in ethically significant ways.

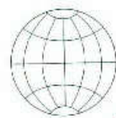
The focus on basic need may also help to explain why some medical migrations are more morally troubling than others. I am troubled by the emigration of 30 percent of Ghana's physicians because life expectancy in Ghana is about fifty-seven years. I am less troubled by medical migration out of Ireland. About 40 percent of Irish physicians have emigrated, yet in spite of this high rate, life expectancy in Ireland is about seventy-six years. Of course, the high rate of Irish medical emigration still raises questions about international fairness, postcolonial exploitation, and national policies, but the questions lack the moral salience and urgency that they have when we think about Ghana. Comparative need, even between people who live in different societies, seems to make a moral difference, at least to

some degree and in some contexts. Even the underserved groups in the destination countries are better off than many or most people in the source countries. The rural areas of Canada, for example, have better measures of population health than South Africa as a whole, and much better measures than the disadvantaged areas in South Africa. And that factors into my moral judgment.

The implications of the cosmopolitan approach for global medical migration are not difficult to sort out. A cosmopolitan approach that extends the features of social justice that I sketched demands that we take into account the interests and perspectives of the least advantaged groups. This concern with the least advantaged is missing from accounting models of international justice that simply tally up the average gains and losses in the respective countries. Balance sheets that try to calculate what a source country loses and what it gains in remittances and partnerships tend to ignore the distribution. The least advantaged in the source countries are often left behind because the remittances rarely benefit them, and the out-migrations undermine the public sector on which they depend. The private gains do not compensate fairly for the public losses.

Similarly, the political approach also has a certain intuitive moral appeal. It sometimes makes moral sense to give some weight to national boundaries while trying to create international frameworks and conditions that foster internally just societies. This approach can also help to articulate what's troubling about the current forms of medical migration. As I said before, I believe that each society should be ordered so as to attend to basic needs and give some priority to the least advantaged in society. But the international system of medical migration makes achieving these aspects of social justice harder and more expensive for poor countries, and easier and less expensive for rich countries. That's what seems so unfair, even morally perverse: the international system tends to undermine social justice in the neediest countries.

But now a complication. Consider the migration of manufacturing capital. Suppose a company decides to shift its manufacturing base from a relatively rich country (with high labor costs) to a relatively poor country (with low labor costs). This shift may benefit workers in the poor country and consumers in many countries, but it will probably hurt working class people in the rich country. In a way, the shift makes it harder or more expensive for the rich country to achieve features of social justice—especially if jobs are outsourced to countries that lack labor unions and ignore safety regulations and pollution standards. In this sense, then, this example is analogous to that of medical migration out of poor countries. But it may not be similarly problematic. What it really points to is the need to look more comprehensively, from the point of view of justice, at international transactions and conditions.



The destination countries are not to be faulted for trying to meet the health care needs of disadvantaged groups. The ethical problem concerns the origin of the medical staffing shortfall and the response to it.

In the international realm, we could work to create conditions that ensure a free market—in this case, a free labor market—and simply accept as fair whatever results. But it would be a mistake to emphasize markets, contracts, and procedural justice while ignoring the importance of background institutions and norms. This approach has not worked well in the domestic case, and there's no reason to think it would work any better in the international case.

In the domestic case, in order to achieve a just social order, society needs to attend to the background institutions and conditions in which markets operate. The features of justice that one desires help to specify what the social conditions should be. For example, John Rawls desires a social order that works to secure equal liberties, to ensure fair value of political liberty, to promote fair equality of opportunity, and to improve the situation of the least advantaged. But certain conditions are needed to approximate fair value of political liberty and fair equality of opportunity. He writes:

> A free market system must be set within a framework of political and legal institutions that adjust the long-run trend of economic forces so as to prevent excessive concentrations of property and wealth, especially those likely to lead to political domination. Society must also establish, among other things, equal opportunities of education for all regardless of family income.[18]

If market forces are not embedded in appropriate institutions and inequalities of goods are not kept within appropriate limits, they result in political domination and gross inequalities in opportunities.

I have a similar concern about international transactions.[19] International institutions and conditions should promote justice at two levels.

They should promote just relations between societies in matters like the use of force, the protection of the environment, and other areas. But they should also promote the development of internally just societies (with due regard for different reasonable ways of ordering society). I suggested before that just social orders strive to help people meet basic needs and give some priority to the disadvantaged. But the unregulated migration of health care workers tends to undermine those worthy aims. To try to micromanage every international transaction would be foolish, but to profess concern about social justice while ignoring international conditions that impede its realization is naïve, even hypocritical. Thus, both the cosmopolitan and the political approaches point toward similar conclusions about the problem of medical migration, in spite of their important differences.

The right to emigrate needs to be qualified by and balanced against the social responsibility of health care professionals.

Ways of Responding

The migration of health care workers from developing to developed countries, now in its fifth decade, has been as enduring as it has been significant. So what can be done about it? This is the question that people often ask when I give talks about medical migration. Different people ask it in different ways—some with great concern, and others with an air of cynicism or defiance. Sometimes the question is a challenge to formulate a solution that leaves everything else the same: an unlimited right to emigrate, low levels of social responsibility (in both source and destination countries), an emphasis on training first-world doctors, policies that restrict the public sector, skewed distributions of health care workers within countries and within specialties, unquestioned assumptions about shortages, a reliance on global labor markets, and international norms that make social justice harder to achieve. If those are the constraints, then my answer is, Not much. All we can do is tinker around the edges of the problem: for example, we can ask public agencies to follow codes of recruitment, which private agencies will probably ignore.

But if we are willing to consider more fundamental changes, then there are many ideas worth exploring. First, given the current international political climate, the source countries may want to consider some responses that they could undertake themselves. For example, they could require substantial social commitments from people who are educated as health care professionals. They could also focus more attention and resources on training community health workers.

This second idea, in particular, is worth exploring. In many source countries, a significant number of people suffer health problems because they lack adequate nutrition, safe water, good sanitation, and very basic medical care. Blindness, for example, is sometimes caused by biological conditions that cannot be prevented. In a few of these cases, the only treatment may be a cornea transplant, which requires highly trained ophthalmologists and a complex medical infrastructure. But almost 4 percent of all blindness is caused by (late stage) trachoma, an infection transmitted by flies found in communities with unsanitary living conditions.[20] Preventing blindness from trachoma does not require board-certified ophthalmologists and cornea banks. It requires political will, appropriate social organization, and community health workers.

Focusing attention on community health workers may allow source countries both to promote basic health *and* to reduce health disparities. Community health workers must understand something about science and causal mechanisms, but they must understand more about social conditions and interventions. To be effective, they need a command of the local language, a lot of local knowledge, a variety of skills, and the trust of the people they are working with. Because local languages, knowledge, and skills are not easily transferred, community health workers are less likely to emigrate. By contrast, many medical and nursing students learn knowledge and skills that are standardized, abstract, transferable, and refined for secondary and tertiary care. In his article on medical migration, Fitzhugh Mullan notes that "many medical schools in source nations are influenced by the 'Western aspirations' of their students, so that their training programs are not well aligned with local patterns of disease and levels of technology. The result is that graduates can be dissatisfied with opportunities in their own countries, inappropriately trained for local problems, and inclined to seek placement abroad."[21]

Of course, the destination countries have a greater responsibility to take action. They could address the maldistributions of health care professionals, in terms of locations and specialties, in their own countries. They could call into question assumptions about shortages and think about ways to promote conditions that foster health. They could even think about how to set fair limits and meaningful conditions on the expansion of medical consumption.

The destination countries could also work with other countries to address the problem of international justice. To begin, they could enter

into cooperative agreements with source countries. But the ultimate goal should be to create international norms and institutions that embed market forces in ways that promote, rather than undermine, efforts to achieve social justice.

The responses I have outlined here would aim to encourage social responsibility while upholding a right to emigrate, and would promote social justice in ways more compatible with international justice. All of them, however, would require fundamental changes in the way we think about the problems, organize social institutions, and regulate interactions between societies. They require that we take a long-term view of human resources, take ethical concerns more seriously, and develop political will.

Acknowledgments

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2. All these statistics are from F. Mullan, "The Metrics of the Physician Brain Drain," *New England Journal of Medicine* 353 (2005): 1810-18. I have rounded off his figures to the nearest whole number. The following statistics about physicians are also from this excellent study.

3. As Mullan notes, these figures understate the problem. They are based on physicians who are practicing in the United Kingdom, Australia, the United States, and Canada. They do not include physicians who left to practice in other countries and physicians who are not working as physicians. A physician from Sri Lanka who is practicing in New Zealand is not included, for example. A physician from Haiti working as a lab tech in the United States is also not included.

4. The estimates for nurses range from about 8 percent to 14 percent. See, for example, S. Glover et al., *Migration: An Economic and Social Analysis* (London: Home Office, 2001).

5. J. Buchan and J. Sochalski, "The Migration of Nurses: Trends and Policies," *Bulletin of the World Health Organization* 82, no. 8 (2004): 587-94.

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7. C. Nullis-Kapp, "Efforts Under Way to Stem the 'Brain Drain' of Doctors and Nurses," *Bulletin of the World Health Organization* 83, no. 2 (2005): 84-85.

8. S. Bach, "International Migration of Health Workers: Labour and Social Issues," working paper written for the International Labour Office, 4.

9. See N. Daniels, "Equity and Population Health: Toward a Broader Bioethics Agenda," *Hastings Center Report* 36, no. 4 (2006): 30-31.

10. See Bach, "International Migration of Health Workers," 14.

11. John Rawls thinks there is. See J. Rawls, *The Law of Peoples* (Cambridge, Mass.: Harvard University Press, 1999), 78-80.

12. This is one of the key ideas behind Rawls's difference principle. See *Justice as Fairness: A Restatement* (Cambridge, Mass.: Harvard University Press, 2001), 61-79.

13. For a more detailed discussion of the right to regulate immigration and the social responsibility for immigrants, see J. Dwyer, "Illegal Immigrants, Health Care, and Social Responsibility," *Hastings Center Report* 34, no. 1 (2004): 34-41.

14. Bach, "International Migration of Health Workers," 5; P. Bundred and C. Levitt, "Medical Migration: Who Are the Real Losers?" *The Lancet* 356 (2000): 245-46.

15. Bach, "International Migration of Health Workers," 6.

16. Nullis-Kapp, "Efforts Under Way," 85.

17. For a discussion of these two approaches, see J. Dwyer, "Global Health and Justice" *Bioethics* 19, nos. 5-6 (2005): 460-75.

18. Rawls, *Justice as Fairness*, 44. Other thinkers have also emphasized the need to embed economic forces within civil and political society. See M. Walzer, "The Civil Society Argument," in *Theorizing Citizenship*, ed. R. Beiner (Albany, N.Y.: State University of New York Press, 1995), 165. See also K. Polanyi, *The Great Transformation* (Boston, Mass.: Beacon Press, 1957), 57.

19. So does Rawls: "Unless fair background conditions exist and are maintained over time from one generation to the next, market transactions will not remain fair, and unjustified inequalities among peoples will gradually develop. These background conditions and all that they involve have a role analogous to that of the basic structure in domestic society." Rawls, *The Law of Peoples*, 42.

20. J. Ngondi et al., "The Epidemiology of Trachoma in Eastern Equatoria and Upper Nile States, Southern Sudan," *Bulletin of the World Health Organization* 83, no. 12 (2005): 904.

21. Mullan, "The Metrics of the Physician Brain Drain," 1816.

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