Why Restrictions on the Immigration of Health Workers are Unjust

1. Introduction

Many health workers, such as doctors, nurses, and midwives, emigrate from poor countries to rich countries. In 2000, approximately one fifth of African-born physicians and one tenth of African-born nurses lived in high-income countries. Seventy percent of Angolan health physicians have left the country. About sixty-three percent of Liberian doctors have emigrated.[1] A third of medical graduates from Nigerian state medical schools move to the United States, the United Kingdom, and Canada within ten years of graduating.[2] Health care workers in low-income countries seem to be immigrating to high-income countries at an increasing rate.[3]

Why do health workers emigrate? Health workers earn *much* higher pay abroad. Nurses earn on average about twenty-five times more in Australia and Canada than they do in Zambia. Doctors on average earn about twenty-two times more in the United States than they do in Ghana.[4] Health workers benefit in other, non-monetary ways too. They often enjoy more security and better access to professional training in rich countries.

But the emigration of health workers has costs too. Many low-income countries have few health workers. Africa has a population of 600 million people, but only about 600,000 doctors, nurses, and midwives live there. Africa has a high disease burden. Among other problems, Sub-Saharan Africa faces an AIDS pandemic. The World Health

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[1] M. Clemens & G. Pettersson. New Data on Health Care Professionals Abroad. *Hum Resour Health* 2008; 6.

[2] E. Mills, et al. Should Active Recruitment of Health Care Workers From sub-Sahara Africa be viewed as a Crime? *J Lancet* 2008; 371: 685-688: 685.

[3] Organization for Economic Cooperation and Development (OECD). 2010. The International Migration of Healthcare Workers: Policy Brief. Available at: www.oecd.org/dataoecd/8/1/44783473.pdf [Accessed 28 Feb 2012].

[4] M. Vujicic, et al. The Role of Wages in the Migration of Health Care Professionals. *Hum Resour Health* 2004; 2.

Organization (WHO) estimates that the Americas have 37 percent of the world's health workforce with 10 percent of the global disease burden, while Africa has 3 percent of the world's health workforce and 24 percent of the global disease burden.[5] According to some empirical studies, the emigration of physicians from Sub-Sahara Africa is associated with increased morality from disease.[6] The governments of low-income countries also invest heavily in the education and training of health workers. One estimate finds that the Kenyan government invests about $48,169 in the training of every physician (the average person earns less than two dollars per day in Kenya).[7] When health workers leave, poor countries may lose this investment.

Some ethicists and political philosophers argue that the skilled emigration of health workers harms the global poor and that this may be a good reason to restrict the immigration of these workers. These authors contend that rich states should restrict the immigration of health workers if the emigration of these workers damages people's access to decent healthcare and recipient states are unable to compensate poor countries for the loss of these workers. Gillian Brock argues that rich states should respond to the problems that medical emigration generates by "either refusing visas to potential recruits whose emigration would exacerbate those problems or demanding that in exchange for the issuing of the relevant visa adequate compensation to the source country is forthcoming."[8] She says: "I am not against movement across borders per se, but rather

[5] World Health Organization. 2006. *World Health Report 2006: Working Together for Health*. Geneva, CH: WHO: 8. Available at: http://www.who.int/entity/whr/2006/whr06_en.pdf [Accessed 12 Dec 2011].
[6] A. Bhargava & F. Docquier. HIV Pandemic, Medical Brain Drain, and Economic Development. *World Bank Econ Rev* 2008; 22: 345-366.
[7] J. Kirigia, et al. The Cost of Health Professionals' Brain Drain in Kenya. *BMC Health Serv Res* 2006; 6.
[8] G. Brock. 2009. *Global Justice: A Cosmopolitan Account*. New York: Oxford University Press: 287.

specifically against uncompensated movement across borders, where compensation is clearly warranted."[9] Other authors endorse similar conclusions.[10]

In this paper, I will assume that, if a critical number of health workers emigrate from poor countries to rich countries, then some people in these poor countries will lack adequate access to healthcare and will suffer more health-related harms as a consequence. I will argue that restrictions on the immigration of health workers are nonetheless unjust, even if recipient states otherwise fail to mitigate or compensate for the negative effects that may accompany the migration of these workers (by "restrictions on the immigration of health workers," I mean a policy of excluding foreign health workers in particular from a state's territory or limiting their permanent residency). While other authors have also suggested that it is unjust to restrict the free movement of health workers because this policy would infringe on the liberties of these workers, these authors have by and large neglected to explain why this infringement should count as a decisive objection to immigration restrictions. Moreover, other ethicists have generally failed to consider the question of non-ideal theory about whether immigration restrictions are permissible if recipient states are unable or unwilling to mitigate the problems that medical migration generates.[11] I will address these challenges in this essay.

2. Positive and Negative Duties

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[9] G. Brock. 2010. Migration and Global Justice: Realistic Options For Here and Now. *Open Democracy* 23 May. Available at: http://www.opendemocracy.net/gillian-brock/migration-and-global-justice-realistic-options-for-here-and-now. [Accessed 25 Jan 2012].

[10] See, for instance: C.R. Hooper. Adding Insult to Injury: the Healthcare Brain Drain. *J Med Ethics* 2008; 34: 684-687.

[11] See: R. Shah, ed. 2010. *The International Migration of Health Workers: Ethics, Rights and Justice*. New York: Palgrave Macmillan. Most of the contributors to this volume reject immigration restrictions, but most of them argue for this conclusion by claiming that rich states should address the problems this migration creates in other ways. They generally neglect to consider the question of whether immigration restrictions are justified if states reliably fail to mitigate the problems of medical migration in these ways.

In this section, I will argue that restrictions on the immigration of health workers are permissible only if that recipient states' positive duties to prevent health-related harms to people in sending countries outweigh their negative duties to respect the liberties of health workers. My major claim is that this condition is seldom, if ever, satisfied. So, immigration restrictions that aim to decrease medical migration are, in general, unjust.

We have moral reasons to help people in need. We also have moral reasons to avoid coercively interfering with people. Sometimes these reasons conflict. Consider the following case. Imagine that Bradley is walking along and notices a child drowning in a pond. Bradley only needs to take a few minutes to save the drowning child and there is little personal cost and risk of harm to Bradley. But Bradley decides to refrain from saving the child and he moves to keep walking on. Suppose that a third party, Robert, can persuade Bradley to save the drowning child by threatening Bradley with coercion. Imagine also that Robert is unable to save the child himself for some reason. Robert doesn't know how to swim, suppose. Furthermore, Robert has excellent reason to believe that, if he threatens Bradley with coercion, then Bradley will actually save the child. Call this scenario: *minor coercion*. In minor coercion, it seems that Robert acts permissibly by coercing Bradley. While there is a moral reason to refrain from interfering with Bradley, Robert's act of interference dose not imposes significant burdens on Bradley and Robert also has a weighty moral reason to help the child. It is plausible that the moral reasons to help the child outweigh the moral reasons to refrain from interfering with Bradley in this case.

Consider another case. In this new case, Robert uses coercive threats to force Bradley to work for him for a year. Robert gives Bradley some options. Bradley can either work on a farm, in a restaurant, or in a hospital. But Bradley has to work in one of these places, although Bradley would much rather work elsewhere as a teacher and there are plenty of people who want to hire Bradley. If Bradley tries to escape, Robert will use force to prevent Bradley from leaving. Robert takes half of the income that Bradley made during this year and donates it to famine relief. This donation saves the life of one child. Assume also that Robert is unable to save this child's life in some other way. Call this scenario: *major coercion*. Robert's interference in major coercion seems impermissible. Robert's moral reasons to avoid interfering with Bradley appear to defeat the moral reasons to help the child.

These examples suggest that, although the moral reasons to help a person can outweigh our reasons to avoid interfering with another person, it can also be wrong to coercively infringe on a person's liberties even if this is necessary to prevent greater harms to someone else. At first glance, this claim is hard to explain. In major coercion, it is surely the case that the child's interest in survival is more important from an impartial perspective than Bradley's interest in avoiding interference. So, why should we believe that Bradley's interest in occupational liberty should outweigh the child's interest in survival from a moral perspective?

The answer to this question appeals to a distinction between doing and allowing. The judgment that Robert's actions in major coercion are impermissible reflects a commitment to the view that a person's mode of agency affects the moral status of her actions. It is morally worse for an agent to actively interfere with someone in a harmful

way than to fail to benefit this person. It is worse to cause harm to someone or violate her rights than it is prevent harm or protect the rights of others. That is, we have stronger moral reasons to avoid actively causing harmful interference than we have to prevent something bad from happening. From an impartial perspective, the child's interest in survival is more urgent than Bradley's interest in avoiding interference. Nonetheless, Robert's moral reasons to refrain from interfering with Bradley are stronger than Robert's reasons to protect the child's interests. We can describe my point about the relative stringency of moral reasons to aid and moral reasons to avoid interference in terms of positive and negative duties. Positive duties are duties to provide aid or support to other people. Negative duties are duties to abstain from harmful intervention or interference (positive and negative duties correlate to positive and negative rights, respectively). Negative duties are stronger than positive duties when the interest at stake is of comparable significance from an impartial perspective. When Robert coerces Bradley, Robert violates a negative duty in order to satisfy a positive duty. This negative duty defeats the positive duty. For this reason, Robert's actions are impermissible.

Why do negative duties have greater weight than positive duties? Some philosophers argue that the priority of negative duties expresses the fact that people have a kind of inviolable moral status. Warren Quinn eloquently describes this view:

> The moral sense in which your mind or body is yours seem to be the same as that in which your life is yours. And if your life is yours then there must be decisions concerning it that are yours to make—decisions protected by negative rights. One such matter is the choice of work or vocation. We think there is something morally amiss when people are forced to be farmers or flute players because the

balance of social needs tip in that direction. Barring great emergencies, we think people's lives must be theirs to lead. Not because this makes things go best in some independent sense but because the alternative seems to obliterate them as individuals.[12]

Quinn's point here is that the negative duties to refrain from violating people's occupational liberties generally defeat our reasons to benefit other people and, furthermore, these negative duties are grounded in the recognition that individuals should have authority over their lives, bodies, and activities. According to Quinn, morality endows us with a kind of inviolability that explains the priority of negative duties over positive duties. But I will refrain from comprehensively defending this distinction between doing and allowing here. This distinction is an assumption of this essay.

Yet, while negative duties have priority over positive duties, positive duties may still sometimes outweigh negative duties when the interests that ground the relevant positive duties are *much more important* than the interests that ground the competing negative duties. Minor coercion illustrates this point. Here is another example. Consider major coercion again, but with a modification. Instead of saving one child, imagine that Robert could save thirty children by infringing on Bradley's occupational liberties. Perhaps, in this case, Robert's positive duties would outweigh his negative duties. There is some threshold where positive duties do seem to outweigh negative duties.

These reflections support the following claim:

The Harm Constraint. It is morally permissible for agent A to significantly interfere with person B's occupational liberty in order to satisfy a general positive

[12] W. Quinn. Actions, Intentions, and Consequences: The Doctrine of Doing and Allowing. *Philos Rev* 1989; 98: 287-312: 309-310.

duty only if this infringement is necessary to prevent much greater harms to other people in cases where B is not liable to this interference.

By "occupational liberty," I mean the liberty to employ your body and time in productive activity under arrangements that you have accepted. By "significantly interfere," I mean that an agent's interference usurps or damages a person's authority over central work-related activities. For instance, an agent significantly interferes with a person's occupational liberty if this agent coercively prevents this person from accessing a wide range of valuable employment options that would have otherwise been available to her. Before I continue, let me add a brief note about the liability qualifier in the harm constraint. Sometimes we can waive or forfeit the negative rights that we normally possess against other people when we perform actions that render us liable to this interference. For example, when we pose an unexcused and unjustified threat to another person, we may forfeit our negative rights against interference. I will explore the relevance of the liability condition later in section 3. I will bracket this condition in this section.[13]

Immigration restrictions coercively interfere with occupational liberty. When states restrict immigration, states credibly threaten people with physical force in order to deter people from using their body and labor in ways that they want to use them. States

[13]An objector might argue that the harm constraint rules out many desirable labor market regulations, such as occupational licensing and minimum wage laws, and this counterintuitive implication suggests that the harm constraint is false. I have two responses to this objection. First, it is unclear whether the harm constraint does actually rule out these regulations. It is plausible that some labor market regulations, such as occupational health and safety regulations and some occupational licensing laws, prevent serious harms and do not significantly interfere with the occupational liberties of workers. My second response is simply to concede that, if labor market regulations really do significantly infringe on people's occupational liberties without preventing serious harms, then that these regulations are indeed unjust. Yet this claim is not as counterintuitive as it may initially appear. In fact, many people seem to accept this claim. For instance, many people object to certain occupational licensing laws, such as occupational licensing laws that legally forbid people from becoming florists or hair braiders without expensive and lengthy training, because these laws constrain people's occupational liberties and fail to prevent serious harm. This common objection to occupational licensing seems to implicitly appeal to something like the harm constraint.

also often use physical force to remove people from their territories. While immigration restrictions are obviously not instances of forced labor, immigration restrictions nonetheless coercively constrain people's occupational choices. If rich countries prevented health workers in poor countries from immigrating, many of these workers would lose a vast array of valuable employment options. If the harm constraint is true, then it is difficult to justify immigration restrictions on the grounds that these restrictions will protect the health-related interests of people in poor countries. Suppose that, if rich countries restrict the immigration of health workers from poor countries, this will reliably save lives and avert other harms in these countries. It may nevertheless be wrong for states to restrict immigration even if these facts are true. More precisely, it is insufficient to justify immigration restrictions by pointing out that some harm will results from the emigration of health workers. To justify immigration restrictions, one must show that the harms are severe enough that our positive duties to prevent these harms can outweigh the negative duties to respect the liberties of health workers.

An objector might argue that the emigration of health workers does bring about severe harm to other people. This objector claims that, if these workers emigrate, then *many* people will die or suffer harms because they will lack access to adequate medical treatment. If positive duties can outweigh negative duties in extreme cases, then perhaps positive duties can outweigh negative duties to respect the liberties of health workers because the emigration of health workers does result in sufficiently bad outcomes. So, this objector might conclude that restrictions on the immigration of health workers satisfy the harm constraint. Although there may be cases where the emigration of health workers does not have bad effects, a policy that prohibits the immigration of health workers is

nonetheless justified on the grounds that this policy would, on the whole, prevent seriously harmful outcomes.

The problem with this objection is that there is little rigorous empirical evidence for the conclusion that the emigration of health workers typically causes severe harms to other people. The empirical evidence indicates that the emigration of health workers is often one contributing factor to poor health outcomes, but this emigration in itself fails to cause these harmful outcomes. One recent review of the empirical literature concludes that, while medical migration is potentially an aggravating factor, this migration "is not the main cause [of bad health outcomes] but rather a symptom of deeper underlying problems, which often extend beyond the health sector towards the broader economic and political environment."[14] To support these claims, I will now consider in more detail the empirical evidence on the effects of medical emigration on health outcomes, such as infant morality and life expectancy (I will consider the fiscal costs of medical emigration in section 3).

Most studies of medical migration only find suggestive correlations between the emigration of health workers and bad outcomes, such as higher mortality rates or lower life expectancy.[15] But this correlation fails to establish a causal relationship between emigration and these bad outcomes. These studies are unable to rule out the possibility that other factors independently help cause the low density of health workers and the associated bad outcomes. Moreover, it is easy to imagine plausible explanations that could account for both poor health outcomes and high rates of emigration. Here is one

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[14] M. Rutten. Economic Impact of Medical Migration: An Overview of the Literature. *The World Economy* 2009; 32: 291-325: 320.

[15] M. Clemens, 2009. Skill Flow: A Fundamental Reconsideration of Skilled-Worker Mobility and Development. *Center for Global Development Working Paper;* 180: 1-47. Available at: http://www.cgdev.org/content/publications/detail/1422684/ [Accessed 28 Feb 2012]

hypothesis. Health workers may experience a great deal of stress and have poor working conditions in countries that have high disease burdens. Stress and poor working conditions could motivate health workers to emigrate. In the absence of evidence on the causal effects of medical emigration, it is unjustified to conclude that high rates of emigration cause poor health outcomes.

Some recent studies try to determine whether medical emigration *causes* poor health outcomes. These studies typically find that the emigration of health workers has neutral or small negative effects on health outcomes. Some studies even find that the emigration of health workers does not cause staff shortages.[16] What explains these counterintuitive findings?

Many other factors influence health outcomes besides the presence of health workers. The healthcare systems of poor countries might suffer from problems of poor management, poor sanitation and transportation systems, or misaligned incentives. If the healthcare systems of countries are dysfunctional in these ways, the presence of more health workers could have little effect on access to healthcare or health outcomes. This interpretation of the empirical evidence is suggested by the fact that large numbers of health workers are unemployed in low-income countries that suffer from shortages of medical personnel.[17] This is the case in part because regulations prevent healthcare providers from hiring new health workers. Sometimes regulations require providers to only hire health workers who are civil servants with tenure, which raises the costs of hiring new workers. In some poor countries, regulations discourage health workers from

[16] M. Clemens, 2007. Do Visas Kill? Health Effects of African Health Professional Emigration. *Center For Global Development Working Paper;* 114: 1-56. Available at: http://www.cgdev.org/content/publications/detail/13123/ [Accessed 28 Feb 2012];

[17] M. Kingma. Nurses on the Move: A Global Overview. *Health Serv Res* 2007: 1281–1298.

opening new clinics in the private sector. Consequently, the physical presence of more health workers might have few positive effects on health outcomes in the absence of other reforms.[18]

Furthermore, many of the people who actually provide healthcare in poor countries are not doctors and nurses.[19] They are often healthcare administrators and pharmacists and these groups may be less likely to emigrate. So, even if many doctors and nurses emigrate, the quality of healthcare may not significantly decline. Another reason why emigration might fail to result in massive shortages of medical care is that people initially sought out medical training in the first place in order to immigrate abroad. Otherwise, these people would have forgone this training. Medical emigration can also have good effects that counterbalance the costs. Health workers in rich countries send home remittances. One study finds that, while the emigration of physicians has a negative effect on infant and child morality rates, the remittances that these physicians and other emigrants sent home largely compensated for this effect because remittances have positive effects on infant and child mortality rates.[20] Finally, levels of literacy and education are important in mediating the effects of medical migration. A recent study finds that the supply of physicians in a country does decrease child morality and raise vaccination rates only "once literacy rates crossed the approximate threshold of 60%."[21] Moreover, the effect is small. According to some estimates in this study, the per capita

[18] Clemens, op. cit. note 15, p. 31-2.
[19] M. Kruk, et al. Are Doctors and Nurses Associated with Coverage of Essential Health Services in Developing Countries? A cross-sectional study. *Hum Resour Health* 2009.
[20] L. Chauvet, F. Gubert, & S. Mesplé-Somps. 2009. Are Remittances More Effective Than Aid to Improve Child Health? An Empirical Assessment Using Inter and Intra-Country Data. In *People, Politics and Globalization*. J. Lin & B. Pleskovic, eds. Washington, DC: World Bank 2009: 173-204.
[21] A. Bhargava, F. Docquier, & Y. Moullan. Modeling the Effects of Physician Emigration on Human Development. *Econ Hum Biol* 2011; 9: 172–183: 182.

number of physicians in many developing countries would need to increase by about fifty percent in order to reduce child morality rates by one percent.

Future research may show that medical emigration does result in serious harms. But the available evidence fails to establish that medical emigration has serious negative effects on health outcomes. Recall that, according to harm constraint, it is permissible to significantly restrict occupational liberty only if this is necessary to prevent proportionately much greater harms to other people. While medical migration certainly has costs, it is unlikely that these costs are grave enough to justify interfering with the occupational liberties of health workers. If health workers remain in their home countries, these workers will probably only modestly contribute to improving health outcomes on the whole. But, if the harm constraint is true, then it seems impermissible to significantly infringe on the occupational liberties of these workers in order to encourage health workers to make modest contributions to helping other people.

At this point, an objector might argue that medical emigration *sometimes* results in severe harms. By "severe harms," I mean harms that are sufficiently bad that our positive duties to prevent them can outweigh our negative duties to respect the occupational liberties of health workers. Immigration restrictions would be permissible when the migration of health workers causes severe harms. Perhaps the immigration agencies of rich states could determine when the migration of health workers would result in sufficiently harmful outcomes. Public officials of rich states could then deny these workers the opportunity to immigrate. Maybe immigration agencies could determine that the emigration of, say, surgeons from a certain poor country with few trained surgeons would be likely to bring about severe harm to other people in this

country. These agencies could then refuse to admit surgeons from this country. So, while a general prohibition on the immigration of health workers would be unjust, a selective policy that denies some workers, or certain categories of heath workers, the option of immigrating might still be justified.

I concede that immigration restrictions might, in principle, be justified on those occasions when the emigration of health workers results in severe harms. My argument is unable to conclusively rule out the permissibility of some immigration restrictions.

But this concession might have little practical relevance. It is unlikely that the public officials of recipient states are in good positions to determine when the emigration of health workers would result in severe harms to other people. A policy of selective immigration restrictions confronts grave epistemic problems. As I argued above, many variables affect health outcomes and it is difficult to disentangle the causal effects of health workers from other factors that influence health outcomes. It is often possible that an omitted variable can explain poor health outcomes instead of the emigration of health workers. Social scientists struggle to overcome this problem when they try to estimate the causal effects of medical migration in the aggregate. If social scientists often fail to overcome this epistemic problem, then it is surely optimistic to suppose that public officials will reliably succeed in doing so. Thus, public officials may lack the epistemic capacities to determine whether the presence or absence of particular health workers or particular categories of health workers in another country will prevent severe harms to other people. While immigration restrictions might be permissible under certain conditions, it is doubtful that public officials of recipient states have the epistemic capabilities to know when these conditions obtain. If public officials lack these

capacities, a policy of restricting immigration may be unjustified in practice, even if it is in principle permissible to restrict immigration in certain cases.

I will conclude this section with some clarifications. My view is that restrictions on the immigration of health workers are unjust. Yet I am not affirming the view that it is permissible for the governments of rich states to actively recruit health workers in poor countries. Rather, my position is that rich states should refrain from preventing businesses and non-profit organizations from recruiting these workers and these workers from accepting employment with these organizations. I am also not claiming that rich states should refrain from helping poor states in other ways through, for instance, development assistance. Instead, I reject the view that rich states should *either* assist poor states or restrict immigration. My view is consistent with the claim that rich states should admit health workers *and* assist countries in other ways. However, if rich states face a choice of either admitting health workers from poor countries or satisfying their positive duties of assistance, they should admit health workers from poor countries.

3. Two Objections

I will now consider two objections to my argument.

A. Negative and Positive Duties Revisited

In section 2, I assumed that the negative duties of rich states conflicted with their positive duties of assistance. But maybe this is the wrong way to characterize the competing duties at stake. Maybe, when rich states admit health workers from poor countries, these states violate negative duties to refrain from harming people in poor

countries or to refrain from contributing to injustice. Gillian Brock suggests an argument along these lines. Brock claims that, when rich states admit these workers, they violate a "negative duty we all have not to uphold or contribute to (current) injustice. In taking such a casual approach to worsening the already dire situation of the global worst-off with respect to their healthcare…. we are failing to discharge this negative duty appropriately."[22]

But it seems false to claim that rich states would violate a negative duty if they admit health workers. These states do not necessarily cause injustice in these cases. Rather, rich states permit injustice to happen. Consider an analogy. Imagine again that a child is drowning in a pond. Bradley could easily save this child. But another person, Susan, offers Bradley money if he immediately performs some task instead of saving the child. Robert could threaten Bradley with coercion in order to stop Bradley from accepting the job and to induce Bradley to save the child. But Robert refrains from doing so. In this case, it seems clear that Robert does not actually harm the child, although Robert obviously fails to help the child. Similarly, by permitting health workers to immigrate, rich states do not cause injustice or harm. It could be the case that the private organizations that actively recruit health workers from poor countries do violate negative duties to refrain from contributing to injustice or harm. Yet this claim fails to show that the states that allow this recruitment violate negative duties.

An objector might reply that my appeal to interpersonal cases, such as the case of Robert, Susan, and Bradley, omit morally important features of the actual emigration of healthcare workers. When health workers immigrate to rich states, these states benefit

[22] G. Brock. 2009. Health in Developing Countries and Our Global Responsibilities. In *The Philosophy of Public Health*. A. Dawson, ed. Burlington, VT: Ashgate Publishing: 73-83: 82.

from the presence of these workers. These workers help alleviate shortages in health workers, contribute to state finances, and benefit the recipient society in other ways. If this immigration also damages the provision of adequate healthcare in poor countries and this is an unjust situation, then rich states are benefiting from injustice. Many people have the intuition that, if we benefit from injustice, then this changes the moral situation. In particular, it seems that, when we benefit from injustice, we have stronger positive duties to help alleviate this injustice than we otherwise would. So, perhaps the members of rich states have stronger duties to assist the members of poor states when the emigration of health workers benefits the former group. In this sense, benefiting from injustice "reinforces" positive duties of assistance.

While it may be true that rich states have weightier duties of assistance in virtue of the fact that they benefit from injustice, this point fails to significantly affect my argument. At most, the fact that rich states benefit from injustice shows that their positive duty to assist people in poor countries is somewhat stronger than I suggested in section 2. But, even if an agent benefits from injustice, it still seems unjust for this agent to violate negative duties in order to satisfy this agent's positive duties to alleviate this injustice. Well-off citizens may benefit from the fact that many doctors want to work in hospitals in the affluent suburbs instead of hospitals in impoverished inner cities. It does not follow that well-off citizens should therefore campaign to restrict the occupational liberties of doctors in order to force them to work in inner cities. The negative duty to refrain from interfering with people's occupational liberty remains stronger than the competing positive duty. If this negative duty to respect the freedoms of potential immigrants is still

stronger than the reinforced positive duty to secure adequate healthcare for people abroad, then my arguments in section 2 essentially remain intact.[23]

B. Liability

My argument confronts another objection that involves the liability condition that I mentioned in section 2. I claimed that it might be permissible for an agent to significantly interfere with a person's occupational liberty if this person is appropriately liable to this interference. By "liable to interference," I mean that this person has waived or forfeited her rights against this interference. For instance, when someone commits a crime or fails to honor the terms of a contract, this person may become legally liable to damages or other forms of interference. When someone is liable to interference, it is relatively easier to justify interfering with this person because the moral reasons against interference are weaker. A proponent of the immigration restrictions could argue that emigrating health workers meet the relevant conditions for this liability to interference. If the moral reasons against interference with the liberties of health workers are relatively weak, then the positive duties of rich states could perhaps easily outweigh these reasons.

Brock suggests an argument along these lines. She says:

> as a beneficiary of the community's hospitality, nurturance, and protection, [the departing individual] has a duty to address the loss she has created for the

[23] Some people claim that, in addition to general positive duties of beneficence, rich states also owe compensation to the global poor because these states have harmed or wronged the global poor in the past. If this claim is correct, does this make any difference to my argument? I do not think so. Say that Bob owes compensation to Sarah because Bob harmed Sarah in the past. Suppose also that Bob could compensate Sarah by forcing another person, Jill, to work for Sarah for a year. This would clearly be wrong for the same reasons that it is wrong for an agent to infringe on someone's occupational liberties in order to satisfy general positive duties of beneficence. As Warren Quinn says, people have "rights not to be pressed, in apparent violation of their prior rights, into the service of other people's purposes." W. Quinn. Actions, Intentions, and Consequences: The Doctrine of Double Effect. *Philos Public Aff* 1989; 18: 334-351: 350-1.

> community that helped her become the person she now is, notably, one who has been educated to a sufficiently high level that she is able to take up well-paying opportunities in a global employment market.[24]

Brock's argument is that the community acquires a claim to compensation for the emigration of health workers because the community benefits these workers and the emigration of these workers imposes costs on their compatriots.[25] Brock's argument seems to rely on the following claim:

> *Benefits Account.* If a group of people A provides costly benefits to person B and B willingly accepts these benefits, then B is liable to interference that would likely induce B to provide certain services for A.

Considerations of reciprocity or fair play might motivate the benefits account. If you willingly and knowingly benefit from some government service, then you plausibly acquire a duty of fair play to the people who bear the costs of this service. This duty renders the duty-bearer liable to interference in order to induce this person to satisfy the duty. Health workers often benefit from government subsidies for their training and these workers may thereby acquire duties of reciprocity to their compatriots. If the benefits account is true, then these workers are liable to interference. Brock favors a compulsory service requirement for health workers. She argues that rich countries should help enforce this requirement by denying visas to the workers that have failed to complete the necessary amount of service in their home countries.

[24] A. Brock. Feasibility, Nationalism, Migration, Justification, and Global Justice: Some Further Thoughts. *Global Justice Network* 2011; 4: 50-76: 72.

[25] For a similar suggestion, see: I. Brassington. What's Wrong With the Brain Drain (?). *Dev World Bioeth* 2011. DOI: 10.1111/j.1471-8847.2011.00300.x

However, it is unclear why health workers must provide specific services for their compatriots in order to satisfy their duties. According to a standard interpretation, a duty of fair play only requires someone to bear a fair share of the costs of providing the relevant good. There may be many different ways of bearing these costs. To satisfy their duties, health workers can bear fair shares of the costs by paying taxes or contributing to society in some other way. Why should a fair share of the costs necessarily include providing a specific health-related service? Here is an analogy. Most citizens benefit from a functioning system of public roads. But citizens lack duties to personally help build public roads or provide other specific services. Instead, citizens can satisfy their duties of reciprocity by, of instance, paying taxes that finance the construction of public roads. As a general matter, it seems false that the beneficiaries of public programs must satisfy their debts to society by providing specific services.[26]

Suppose a physician benefits from government subsidies for her training, but decides to immigrate to a rich country. She then sends back remittances to her native country, which contributes to the economy and tax revenues. At first glance, it appears that this physician can satisfy her duties of fair play even though she immigrates abroad. In fact, many health workers who emigrate do contribute to the economy and, indirectly, the public finances of their home state. Michael Clemens reports that the "average African physician in Canada or the United States who was trained in his or her country of birth—including those who send no money— sends upward of US$6,500 per year to

[26] An objector might claim that people expect health workers to remain in their home countries and this expectation imposes responsibilities on health workers. But it is false that we are morally required to do what people expect us to do. An overbearing father might expect his daughter to become a doctor, but it seems that the daughter is not actually morally required to become a doctor merely in virtue of this expectation. We may have some moral reasons to comply with someone's expectations if we purposefully cultivate these expectations. But it is unclear whether most health workers purposefully cultivate the expectation that they will remain in the country where they receive their training.

family, friends, or charitable organizations in that country."[27] According to Clemens, we can expect the average African physician in the United States and Canada to send home approximately double the public costs of their medical training in remittances. If people can pay back their debts to society in many ways and emigrants can continue to contribute to their societies, then health workers might be able to immigrate *and* satisfy their duties of reciprocity. So, while it is true that health workers may have duties to bear a fair share of the costs of their training, we should refrain from immediately inferring that these people are liable to interference in the form of immigration restrictions.

Suppose, however, that it is only feasible for health workers to satisfy their duties of reciprocity by working in the healthcare sector in their home countries. Even if this claim is true, there are other problems for Brock's argument. My question in this paper is whether rich states should restrict the immigration of health workers from poor countries. Perhaps health workers have duties of reciprocity to their compatriots. But the fact that people have duties of reciprocity to their compatriots might not give other states moral permissions to force these people to satisfy these duties of reciprocity.

Here is an illustration of the problem. Imagine that a town has a high rate of violent crime. To reduce the crime rate, the residents of the town form an organization that patrols the area in the evening. Each resident is expected to participate by patrolling nightly for one month out of every year, although this is not a legal obligation—that is, the town government does not legally require residents to participate. This program dramatically reduces the crime rate in the area. As the members of this town willingly benefit from the good of public safety, residents acquire duties of reciprocity to bear a

[27] M. Clemens. The Financial Consequences of High-Skilled Emigration: Lessons from African Doctors Abroad. In *Diaspora for Development in Africa*. S. Plaza & D. Ratha, eds. Washington, DC: World Bank 2011:165-182: 175.

fair share of the burdens of providing this good. One resident, Ryan, willingly benefits from the good that the other members of the town provide. So, Ryan has a duty to contribute. But, before Ryan's allotted month comes up, Ryan decides to move to a neighboring city.

In this example, Ryan has an unsatisfied duty of reciprocity to his neighbors. But duties of reciprocity are agent-relative moral reasons. Ryan owes this duty only to the town's residents. The members of the city do not owe a duty of reciprocity to the residents of the town and Ryan does not owe duties of reciprocity to the members of the city. Why would the fact that Ryan has an unsatisfied duty to the members of the town explain why it is permissible for the residents of the city to stop Ryan from moving there? One possibility is that the members of the city become complicit in Ryan's wrongdoing by permitting him to move and people have moral reasons to avoid complicity. Yet it is unclear why permitting Ryan to move across a territory makes the members of the city complicit in Ryan's actions. It is true that the residents of the city neglect to go out of their way to actively discourage Ryan's wrongdoing. But, to be complicit in someone's wrongdoing, you must usually do more than neglect to take positive actions in order to prevent impermissible conduct. Complicity requires endorsement of or active participation in another person's wrongdoing. Complicity seems to require more than merely allowing someone to live in a territory.[28]

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[28] An anonymous referee points out that rich states may not merely passively benefit from the immigration of health workers: rich states may actively encourage this immigration and thus encourage health workers to violate their special obligations to their compatriots. But, even if rich states do actively encourage health workers to immigrate, they do not necessarily encourage them to violate their special obligations. If I am right that it is possible for people to satisfy their debts to society in multiple ways, then it is possible for people to satisfy their debts *and* immigrate. Furthermore, if there is something problematic about encouraging health workers to immigrate, then it seems like the appropriate response is for rich states to stop encouraging these workers to immigrate. Immigration restrictions would still be unjust in this scenario.

The fact that a person has violated duties to her compatriots might not give other states moral reasons to restrict her free movement. This point generalizes to other arguments for the conclusion that health workers are liable to interference that appeal to special duties. For example, suppose that health workers promise their compatriots that they will remain in the country. This promise may generate a moral duty to remain. But it is generally wrong for uninvolved third parties to force people to fulfill their promises.

Some people argue that, if health workers voluntarily consent to remain in a country for a certain period of time in exchange for accepting public subsidies for their training, then it is permissible for rich states to help poor states to enforce this contract by restricting immigration. The underlying premise in this argument seems to be:

> *Contractual Account*. If agent A provides costly benefits for person B and B voluntarily agrees to provide certain services in return, then B is liable to interference that would induce B to provide these services for A.

Arguments for immigration restrictions that appeal to the contractual account suffer from defects that are similar to those that affect Brock's argument. For one thing, the contractual account is unable to justify any actual immigration restrictions, as few health workers in poor countries have in fact agreed to remain in the country where they receive their training. So, at most, the contractual account could justify immigration restrictions if poor states required health workers to agree to a compulsory service requirement.

The more serious problem for arguments for restrictions that rely on the contractual account parallels a problem for Brock's argument. Even if poor states can permissibly require health workers to agree to mandatory service, this fails to show that rich states are under any duty to enforce the terms of these contracts. Consider a parallel

with the "unconscionability doctrine." In contract law, the unconscionability doctrine enables courts to refrain from enforcing contracts that are exploitative or manifestly unfair. Seana Shiffrin has powerfully defended the unconscionability doctrine in part by arguing that people should be free to form whatever contracts they like, but it is sometimes permissible for the state to refrain from assisting people in enforcing these contracts.[29] That is, the mere fact that two parties have agreed to a contract falls short of imposing duties on some third party to assist them in enforcing this contract. Shiffrin writes: "even were respect for autonomy to require noninterference with voluntary, but unconscionable, agreements, it would not necessitate assistance in making and implementing them."[30] Similarly, rich states should refrain from enforcing contracts that require health workers to complete mandatory service. The justification for this claim is just the argument that I have given in section 2: rich states have powerful moral reasons to refrain from interfering with the free movement of health workers and these moral reasons typically defeat the countervailing considerations. This claim is true even if the health workers have agreed to a contract that says that they must remain in their home states.

Perhaps some other argument for the conclusion that health workers are appropriately liable to interference is forthcoming. But it is difficult to see how any such argument can show that health workers are liable to interference *from rich states*. Maybe these arguments can show that the sending states may permissibly restrict the *emigration* of health workers. While I have failed to rule out this possibility here, an argument for this claim seems to face a high burden of proof. It is an established feature of

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[29] S. Shiffrin. Paternalism, Unconscionability Doctrine, and Accommodation. Philos Public Aff 2000; 29: 205-250.
[30] Ibid: 224.

international law that people have human rights to emigrate. It would, I suspect, require particularly powerful arguments to justify revising this part of international law. I will, however, refrain from considering this issue here.

4. Conclusion

Some bioethicists and political philosophers claim that rich states should restrict the immigration of health workers. In this essay, I have argued that it is unjust to restrict the immigration of health workers, even if this immigration contributes to bad outcomes for people in poor countries and even if compensation for these bad outcomes is unforthcoming. Moreover, I have tried to explain why this is so. The explanation goes: (a) the best justification of imposing immigration restrictions on health workers is that rich states have positive duties of assistance to help the people in poor countries and (b) these positive duties are defeated by negative duties to respect the occupational liberties of health workers.