EXPLORING LEGAL FRAMEWORKS TO MITIGATE THE NEGATIVE EFFECTS OF INTERNATIONAL HEALTH-WORKER MIGRATION

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INTRODUCTION

The shortage of health workers,[1] from sub-Saharan Africa to the rural United States, has gained increased attention in recent years. The worldwide medical community has raised alarms about current and projected global health-worker shortages, and some critics have spoken out about the social injustice of wealthy countries "poaching" health workers from the developing world.[2] Some have condemned health-worker migration from poor source countries to wealthy destination countries as a misallocation of resources, a "reverse foreign aid" in which the poor subsidize the rich.[3] Others, however, emphasize that the worldwide market for health workers is and ought to be a "free market" system and individuals, understandably, will follow the best employment opportunities.[4]

Although there is widespread acknowledgement of health-worker shortages, there is less agreement about whether and how regulatory frameworks ought to address the issue. Even critics who condemn the "brain drain" recognize the drawbacks of increasing legal restrictions on an individual's ability to move by slowing or halting opportunities for immigration.[5] Analysts also vary on how much emphasis should be placed on the human rights of those left behind in source countries without access to health workers. Developing countries' needs conflict with developed countries' desire to attract immigrant physicians and nurses to fill the gaps in their own health infrastructures, particularly to provide healthcare to the underserved within their borders.

This Note examines the legal framework that may affect this medical brain drain. Although the complex nature and extent of medical migration is difficult to encompass in this analysis, the Note will begin with an introduction to the problem of global health-worker shortages and medical migration

[1] Definitions of the term "health worker" may vary. *See infra* note 8 and accompanying text. The issue of medical migration in this Note concerns professionally-trained health workers, including doctors, nurses, and pharmacists. This term may sometimes over-generalize, as some discussions relate to the numerically greater category of nurses (particularly relative to the international discussion in Part I and Part IV), while the discussion of health workers relevant to U.S. immigration law focuses on physicians.

[2] Lincoln C. Chen & Jo Ivey Boufford, *Fatal Flows – Doctors on the Move*, 353 NEW ENG. J. MED. 1850, 1851 (2005) ("Moral outrage over the 'poaching' behavior on the part of rich countries has reached a crescendo.").

[3] Tina Rosenberg, *Reverse Foreign Aid*, N.Y. TIMES, Mar. 25, 2007, § 6 (Magazine), at 16.

[4] *See, e.g.*, Esi E. Ansah, *Theorizing the Brain Drain*, 30 AFR. ISSUES 21, 21 (2002) ("Internationalists perceive the brain drain as a mutually beneficial exchange of human and fiscal capital in a contemporary global labor market. Proponents of this perspective believe that human beings voluntarily seek the highest reward commensurate with their education and training, and the trend reflects voluntary choices made by migrants.").

[5] Chen & Boufford, *supra* note 2, at 1851 ("[S]imply blocking migration is neither effective nor ethical, since freedom of movement is a basic human right.").

patterns. The legal analysis will focus on two primary issues: the purpose and effect of U.S. immigration law on the migration of health workers entering the United States, and the role of international law in regulating the worldwide migration of health workers.

U.S. immigration law, particularly the waiver of the home residency requirement in the J-1 visa program, does not have the largest numerical impact on health-worker migration patterns, but it does reflect trends in health-worker migration. Historically, the J-1 visa program has emphasized cultural exchange, as opposed to the Conrad waiver program, which was designed to facilitate "gap filling" in the U.S. healthcare system. This evolution in U.S. immigration law exemplifies the tension between supporting human resource development in poor countries and filling health-worker shortages in the developed world. Commentators discourage using immigration laws as a vehicle for limiting health-worker migration, primarily due to concerns about further curtailing the freedom of migration for individuals.[6] U.S. immigration law is probably not an optimal vehicle to solve the medical brain drain problem, but the evolution of U.S. immigration law does exemplify the conflicts of interest that developing countries face with regard to migrating health workers. Furthermore, immigration laws, such as the Conrad program, are problematic if they perpetuate a short-term solution that detracts from the need to formulate a long-term U.S. policy to address the issue of health-worker shortages.

International law may have greater potential for addressing health-worker migration concerns. A human rights analysis reinforces the conflict between a "right to health" for source country populations and a "right to migration" for health workers. International trade agreements, such as the General Agreement on Trade in Services ("GATS"),[7] are another possible source of binding international legal authority on the subject. However, the most promising international regulatory tool may be the establishment of international codes of ethics and bilateral agreements between source and destination countries.

Any attempt to control health-worker migration through the law, whether through the less likely channel of national immigration laws or through more promising international agreements, will not be an effective solution standing alone. The problem of worldwide health-worker shortages needs to be addressed through a variety of supplemental policy considerations that will not fit strictly into any legal framework. These considerations include addressing the "push" and "pull" factors that are root causes of health-worker shortages and migration problems. This Note addresses the long-term strategies that may remedy the root causes of health-worker shortages and migration, but it also

[6] *See id.*

[7] General Agreement on Trade in Services, Apr. 15, 1994, 1869 U.N.T.S. 183, 33 I.L.M. 1167.

seeks to explore appropriate legal and quasi-legal mechanisms to alleviate, in the short term, the negative effects of health-worker migration.

In Part I, this Note explores health-worker shortage problems and the issues affecting the migration of health workers. Part II examines various perspectives on the best ways to solve these healthcare problems. Part III examines the history and current developments of U.S. immigration law as it relates to the immigration of International Medical Graduates ("IMGs"). This discussion is not comprehensive, particularly because it focuses on physicians rather than all health workers, but it illustrates the competing and evolving purposes of national immigration law as it relates to health workers. Part IV analyzes how instruments of international law – ranging from human rights law to international trade law and bilateral agreements – might mitigate the negative effects of health-worker migration.

Finally, Part V argues that multilateral or bilateral agreements between countries and international codes that seek to promote a mutual exchange of benefits are the best vehicles for addressing health-worker migration problems. Solutions to the medical brain drain problem remain elusive; however, this Note concludes that regulation through international law is currently the best forum through which to develop ways to mitigate the negative effects of health-worker shortages and unequal distribution of health workers. Although the legal framework of national immigration law has greater legally binding power for implementation, it faces greater constraints of self-interest. The framework of international law, while susceptible to the enforcement weaknesses of international law generally, may prove a better means to mitigate the negative effects of health-worker migration.

I. THE BRAIN DRAIN PROBLEM

A. *Global Health-Worker Shortages*

As a preliminary matter, the World Health Organization ("WHO") defines health workers as "all people whose main activities are aimed at enhancing health."[8] Thus, WHO's definition of health worker includes those providing direct health services, such as doctors, nurses, and pharmacists, but also encompasses those with a more indirect role in the delivery of healthcare, including cleaners, cooks, and financial officers.[9] WHO estimates that 4,250,000 health workers are needed to fill a worldwide shortage of health workers, and it has identified "[f]ifty-seven countries, most of them in Africa and Asia, [that] face a severe health workforce crisis."[10]

[8] World Health Organization, The Global Shortage of Health Workers and Its Impact (April 2006), http://www.who.int/mediacentre/factsheets/fs302/en/index.html.

[9] *Id.*

[10] *Id.*

B. *Comparative Analysis of Health-Worker Human Resources*

This shortage of health workers is a global problem, and even wealthy countries need additional health workers. But statistics demonstrate the comparative advantage that developed countries have over developing countries in terms of health-worker resources. The United States has about 5% of the world's population and employs 11% of the world's physicians.[11] In fact, there are more Indian doctors per capita in the United States (one for every 1325 people) than in India (one for every 2400 people).[12] Africa, with "25% of the world's disease burden," has just 3% of the world's supply of health workers.[13] Sub-Saharan Africa has even more dire health-worker shortages, with just "one physician for every 8000 people in the region."[14] When less developed countries face health-worker shortages, the challenges to healthcare infrastructure are greater because resources are severely limited. Francis Omaswa, Executive Director of WHO's Global Health Workforce Alliance, reinforced the obvious but often overlooked point that human resources are necessary for development: "Money cannot take drugs from the airport into the mouths of humans. You need people."[15]

C. *Migration of Health Workers*

Concerns over medical brain drain are not just about health-worker shortages in developing countries or the existing discrepancy between health workers in developed versus developing countries. These concerns arise because migration of health workers exacerbates human resource discrepancies. For instance, almost 10% of physicians in the United Kingdom are from Africa.[16] African doctors also emigrate to the United States; according to the *New England Journal of Medicine*, Ghana has thirteen doctors and ninety-two nurses for every 100,000 people (compared to the United States, which has 256 doctors and 937 nurses for every 100,000 people).[17] As of February 2007, 532 Ghanaian doctors were practicing medicine in the

[11] Chen & Boufford, *supra* note 2, at 1850.

[12] B.V. Adkoli, *Migration of Health Workers: Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka*, 10 REGIONAL HEALTH F. 49, 52 (2006).

[13] Mary Robinson & Peggy Clark, *Forging Solutions to Health Worker Migration*, 371 LANCET 691, 691 (2008).

[14] Edward J. Mills et al., *Should Active Recruitment of Health Workers from Sub-Saharan Africa Be Viewed as a Crime?*, 371 LANCET 685, 685 (2008).

[15] Joseph J. Schatz, *Francis Omaswa: Tackling the Shortage of Health Workers*, 371 LANCET 643, 643 (2008).

[16] Mills et al., *supra* note 14, at 685 ("An estimated [13,272] physicians trained in sub-Saharan Africa are practicing in Australia, Canada, the UK, and the USA.").

[17] Fitzhugh Mullan, *Doctors and Soccer Players – African Professionals on the Move*, 356 NEW ENG. J. MED. 440, 441 (2007).

United States – a figure that constitutes 20% of Ghana's physician workforce.[18]

In fact, "[a]bout 25% of the physicians practicing in the United States went to medical school abroad – as did roughly the same proportions in the United Kingdom, Canada, and Australia."[19] While these numbers include more than just physicians from developing countries, between 40% and 75% of IMGs come from low-income countries.[20] One study calculated the "emigration factor" to determine which source countries lost the greatest proportion of medical graduates to the four developed countries in question and found that six of the twenty "countries with the highest emigration factors are in sub-Saharan Africa."[21] The emigration factors for the Caribbean and the Indian subcontinent were also high.[22]

A study by Barbara Starfield and George Fryer found that "countries with large shortages of physicians disproportionately assist the United States in maintaining its primary care-specialist ratio."[23] The study found that the poorest African countries provide many primary care physicians to the United States.[24] The authors explained that in many source countries, the medical schools encourage emigration, and the governments offer few incentives for their medical graduates to stay.[25]

The physician migration phenomenon is not limited to doctors from poor countries coming to the United States or Britain. Regional migrations and stepping-stone migrations occur as well. Regional migrations are commonplace; for example, Asians might move to the United States, Egyptians might relocate to oil-exporting countries, and Eastern Europeans may cross European borders for employment.[26] In addition to regional migrations from poorer source countries to wealthier destination countries, worldwide stepping-stone migrations also occur, making medical migration more complex and difficult to track.[27] For example, Canadian health workers

[18] *Id.* Other countries report even higher migration; Liberia has lost an astounding 60% of its physicians to the United States and Britain. *Id.*

[19] *Id.* at 442-43.

[20] Fitzhugh Mullan, *The Metrics of the Physician Brain Drain*, 353 NEW ENG. J. MED. 1810, 1810, 1813 (2005) (finding that 40% of IMGs in Australia and slightly more than 75% of IMGs in the United Kingdom come from low-income countries).

[21] *Id.* at 1815.

[22] *Id.*

[23] Barbara Starfield & George E. Fryer, *The Primary Care Physician Workforce: Ethical and Policy Implications*, 5 ANNALS FAM. MED. 486, 488 (2007).

[24] *Id.* at 490.

[25] *Id.*

[26] Chen & Boufford, *supra* note 2, at 1850.

[27] Stepping-stone migrations refer to situations in which workers in less developed countries move to wealthier countries to fill a void in the market, leaving a void in their own

move to the United States where prospective incomes are higher, leading to a flow of South African health workers to Canada and a corresponding migration of other African countries' health workers to fill South Africa's human resource needs.[28]

The loss of human capital resulting from health-worker migration from developing countries can result in a real monetary loss and a continued drain on the source country. For example, "[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."[29] Between 1998 and 2002, Ghana lost a £35,000,000 investment in training health professionals who left to practice in the United Kingdom.[30] Although there are benefits to the source country when remittances are sent back, nothing ensures that this money will be returned to the health sector.[31]

Furthermore, experts predict the shortage of health workers will worsen in the coming years. According to one prediction, the patient-per-physician ratio in sub-Saharan Africa could almost triple between 2006 and 2012, decreasing the number of doctors treating HIV from 21,000 to 10,000.[32] While a doctor in the United States is expected to manage 2000 patients each year, sub-Saharan doctors may be left with 26,000 patients dependent upon them.[33]

D. *Push and Pull Factors*

Given these growing problems, it becomes important to understand the circumstances that cause health workers to emigrate from less developed countries to wealthier countries. Clearly, these circumstances are not limited to whether immigration laws will allow an individual to enter the wealthier country. A wide range of factors influence these decisions, including "push" factors that encourage immigrants to leave developing countries and "pull" factors that encourage them to settle in developed countries.[34]

The push factors are hardly surprising. Healthcare professionals find it difficult to practice in regions where they lack access to the appropriate

markets and incentivizing workers in still less developed countries than theirs to fill the void they leave.

[28] Robinson & Clark, *supra* note 13, at 692.

[29] Rosenberg, *supra* note 3, § 6, at 16.

[30] Editorial, *Finding Solutions to the Human Resources for Health Crisis*, 371 LANCET 623, 623 (2008).

[31] WORLD HEALTH ORG., HEALTH & HUM. RTS. PUBL'N NO. 4, INTERNATIONAL MIGRATION, HEALTH, AND HUMAN RIGHTS 13 (2003), *available at* http://www.who.int/hhr/activities/en/FINAL-Migrants-English-June04.pdf.

[32] Mills et al., *supra* note 14, at 687.

[33] *Id.*

[34] Paul F. Clark, James B. Stewart & Darlene A. Clark, *The Globalization of the Labour Market for Health-Care Professionals*, 145 INT'L LAB. REV. 37, 42 (2006).

technology, medicine, and tools to do their jobs.[35] The training programs in their home countries may be archaic and "run-down."[36] Health workers in developing countries may not have adequate salaries.[37] Violence, lack of political stability, and limited professional opportunities can also be push factors that motivate health workers to leave their home countries. Many health workers likely just want to live and work in the best possible circumstances. From a human rights perspective, preventing such mobility would seem to restrict human freedom and stifle an individual's innate desire to improve his or her own situation.[38] Mary Robinson and Peggy Clark phrase the dilemma succinctly: "Health workers have a clear human right to emigrate in search of a better life. Yet people in source countries hard hit by an exodus of health workers also have the right to health in their own countries."[39]

Critics consider active recruitment from sub-Saharan Africa and other developing regions to be the most offensive way developed countries "pull" health workers away from source countries. Recruitment agencies from developed countries advertise employment opportunities, provide recruitment tours and workshops, and establish offices that help health workers emigrate from developing countries.[40] Some critics have even argued that organized recruitment from Africa, and perhaps other resource-poor regions of the world, should be viewed as an international crime.[41]

II. PERSPECTIVES ON THE BRAIN DRAIN PROBLEM

There may be widespread agreement that a global shortage of health workers exists, that disparities in health-worker resources are problematic, and that these disparities are exacerbated by health-worker migration. But strong disagreement exists about whether countries like the United States or international organizations ought to take action to counteract the negative effects of health-worker migration. Moreover, there are strong doubts about

[35] *Id.* at 40.

[36] Schatz, *supra* note 15, at 643.

[37] *Id.*

[38] *See* JUDITH BUENO DE MESQUITA & MATT GORDON, MEDACT, THE INTERNATIONAL MIGRATION OF HEALTH WORKERS: A HUMAN RIGHTS ANALYSIS 15 (2005) (discussing the international right to freedom of movement).

[39] Robinson & Clark, *supra* note 13, at 691.

[40] Mills et al., *supra* note 14, at 685, 687. For a discussion of "pull" factors in a different context, see Laurie Garrett, *The Challenge of Global Health*, FOREIGN AFFAIRS, Jan./Feb. 2007, at 14, 28-29 (explaining how programs created by rich-country governments, NGOs, and U.N. Agencies divert local health workers in developing countries to work with international health programs rather than local initiatives by offering better pay and incentives).

[41] Mills et al., *supra* note 14, at 687 ("Active recruitment of health workers from African countries is a systematic and widespread problem throughout Africa and a cause of social alarm: the practice should, therefore, be viewed as an international crime.").

whether any action, either from the United States or an international organization, can effectively address the problems that cause these shortages.

First, some groups argue that attempts to equalize the distribution of health-worker resources by limiting their migration is not in the self-interest of the United States and similarly situated countries.[42] Proponents of this theory would emphasize that there is nothing unethical about this country's high demand for health workers. They suggest that accepting foreign workers to fill the gap, particularly when foreign health workers contribute to underserved populations in wealthier countries, is an appropriate response to health-worker shortages.[43] Each state may develop its own immigration policies, which will undoubtedly favor admission of immigrants who fill labor shortages.[44] These theorists further emphasize that it is in the self-interest of health workers to migrate to the country that will offer better working conditions, more pay, and numerous other benefits.[45]

Second, some scholars argue that attempts to artificially control migration or to equalize health-worker resources will be ineffective.[46] Migration patterns are too complex to track.[47] Also, some scholars might suggest that any attempt to compensate source country governments for the loss of migrating workers will be ineffective because developing countries are often corrupt or too inept

[42] *See, e.g.*, AM. MED. ASS'N, INTERNATIONAL MEDICAL GRADUATES IN THE U.S. WORKFORCE: A DISCUSSION PAPER 28 (2008), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf (describing "the vital role that the IMG physicians have played in health care delivery to the people of this country").

[43] *See id.* at 10 (describing how IMGs "have been welcomed by many communities and hospitals that are hard pressed to find U.S. trained physicians willing to practice there").

[44] *See* Ansah, *supra* note 4, at 21 (describing the internationalist model, whereby "all things being equal, migration will be based on the demand and supply forces in the labor market and how well a worker can take advantage of or use acquired skills").

[45] *See* Michael A. Clemens & Lant Pritchett, *Income per Natural: Measuring Development as if People Mattered More than Places*, at abstract (Ctr. for Global Dev., Working Paper No. 143, 2008) ("If economic development is defined as rising human well being, then a residence-neutral measure of well-being emphasizes that crossing international borders is not an *alternative* to economic development, it *is* economic development.").

[46] *See, e.g.*, Michael A. Clemens, *Do Visas Kill? Health Effects of African Health Professional Emigration* 38 (Ctr. for Global Dev., Working Paper No. 114, 2007). Clemens argues:

> [T]he world is complex, and superimposing an additional market failure – an impermeable border – onto the myriad other failures in developing countries does little to improve welfare in a second-, third-, or tenth-best economy. Punishing emigration, restricting quotas, and banning recruitment, while as plausible as import-substituting industrialization once was, and for similar reasons, may at best make no one better off and at worst make everyone worse off.

Id.

[47] *See id.* at 14 (discussing the difficulty in defining one as "African," as "a health worker," or as an "emigrant"); *supra* text accompanying notes 27-28 (discussing the added complexity of stepping-stone migrations).

to make appropriate use of compensation money sent from destination countries.[48] Finally, opponents of regulation might emphasize that problems in source countries are so widespread and systemic that attempts to encourage health workers to remain will not succeed.[49]

On the other hand, proponents of the regulation of health-worker migration suggest that equalizing the distribution of health workers is in fact in the self-interest of developed countries; limiting health-worker migration encourages developed countries to have a higher-quality, self-sustainable, and predictable supply of health workers.[50] Regulating health-worker migration also contributes to greater health, which may lead to diminished poverty in the developing world.[51] Finally, proponents of regulation may emphasize the interconnectedness of the global community.[52] Many advocates of increased regulation of health-worker migration do not speak in terms of self-interest at all; rather, they suggest there is a moral or ethical duty to promote social

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[48] *See* James Bovard, *Policy Analysis: The Continuing Failure of Foreign Aid*, CATO INSTIT., Jan. 31, 1986, http://www.cato.org/pubs/pas/pa065.html ("American foreign aid usually only strengthens oppressive regimes, allows governments to avoid correcting their mistakes, and bails out bankrupt state-owned enterprises around the world.").

[49] *See* Soumana Sako, *Brain Drain and Africa's Development: A Reflection*, 30 AFR. ISSUES 25, 26-27 (2002) (explaining the many "push" factors that may influence migrants to leave, including systemic factors such as "deteriorating socioeconomic infrastructure," famine, poor working conditions, and political violence).

[50] Some have questioned the competency of foreign doctors. *See* Kathleen N. Williams & Robert H. Brook, *Foreign Medical Graduates and Their Impact on the Quality of Medical Care in the United States*, 53 MILBANK MEMORIAL FUND Q. HEALTH & SOC'Y 549, 570 (1975) ("Inferences have been made, primarily on the basis of structural variables, that some [IMGs], especially the less than fully licensed, are likely to provide lower-quality care than fully qualified [U.S. Medical Graduates]."); David Rose, *Foreign Doctors Face Competence Inquiry*, TIMES (London), Aug. 10, 2007, at 14, *available at* http://www.timesonline.co.uk/tol/life_and_style/health/article2231550.ece. Although debates about the quality of foreign doctors may prove controversial, the desire to have a self-sustainable supply of health workers is, perhaps, a more widely accepted idea. *See Health Care Pinched by Nursing Shortage*, MSNBC.COM, Mar. 9, 2009, http://www.msnbc.msn.com/id/29595525/ ("The shortage has drawn the attention of President Barack Obama. During a White House meeting on Thursday to promote his promised health care system overhaul, Obama expressed alarm over the notion that the United States might have to import trained foreign nurses because so many U.S. nursing jobs are unfilled.").

[51] *See* David E. Bloom & David Canning, *The Health and Wealth of Nations*, 287 SCIENCE 1207, 1209 (2000) (arguing that "increased health is another aspect of human capital that also enters into production").

[52] *See* Lawrence O. Gostin & Allyn L. Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53, 57 (2008) ("Increasingly human activities have profound health consequences for people in all parts of the world, and no country can insulate itself from the effects. Members of the world's community are interdependent and reliant on one another for health security.").

justice and ensure that people in developing countries have access to health workers and to basic healthcare.[53]

But among those who advocate regulating health-worker migration, there remains disagreement about what action will be effective, while remaining just. Possible solutions to the brain drain problem include: attacking root causes of poverty that encourage source country health workers to leave; increasing the supply of health workers in the developed world; changing national immigration laws that affect foreign health workers; and forming international agreements (multi-lateral or bilateral) to address health-worker migration. The first two solutions may be the most important, the most just, and the most effective because they address the immediate causes of health-worker shortages and human resource imbalances. Such proposals would enable developed countries to meet their own health-worker needs and create incentives for health workers in developing countries to stay and work in their own countries. However, these are long-term solutions; it will take time for the developed world to build up its own health-worker supply, and it will take even more time for conditions in much of the developing world to evolve to the point that fewer health workers desire to leave. Thus, this Note will focus on the latter two frameworks that may affect health-worker shortage problems – U.S. immigration laws and international agreements.

III. U.S. IMMIGRATION LAW AND HEALTH-WORKER MIGRATION

Although the loosening or strengthening of immigration laws may affect migration patterns, immigration law is not the root cause of migration. Some Americans would likely argue that more stringent immigration laws are not an ideal, or even beneficial, way to curb the migration of health workers from developing to developed countries, either because more stringent laws would limit freedom of movement or because foreign health workers are an important part of the U.S. healthcare infrastructure. Some people argue that since foreign health workers are so important to U.S. infrastructure, immigration laws should increase the number of foreign health workers and the speed with which they could come to practice in the United States to fulfill this role.[54] The following discussion of U.S. immigration law focuses on IMGs entering the United States on a J-1 visa. The analysis of the J-1 visa, and the laws that waive its original home residency requirement, is not meant to suggest that changes in U.S. immigration law have instigated health-worker migration; rather, the legal analysis is meant to exemplify the tension between filling U.S. physician

[53] Chen & Boufford, *supra* note 2, at 1850 ("The migration of medical professionals reflects a balance of supply and demand – but it has ethical implications, too.").

[54] *See* Bo Cooper et al., *Critical Care: Immigration and the U.S. Healthcare Crisis*, HEALTH LAW. NEWS (Am. Health Lawyers Ass'n, Wash., D.C.), Jan. 2008, at 31 (discussing "current inadequacies of the U.S. immigration system for employment-based sponsorship of nurses" and encouraging immigration of international nurses "to alleviate the domestic nurse shortage").

shortages and adhering to the original spirit of exchange that the J-1 visa was thought to facilitate. This situation can likely be extrapolated to a worldwide scale, where health-worker shortages in developed countries lead to conflicts between the public interest needs of one's own country and the desire to facilitate human resources in the developing world.

A. *The Immigration Law Framework: Immigrant and Nonimmigrant Visas*

Examining the framework of U.S. immigration procedures places the immigration process relating to IMGs in a wider context. The visa system is divided into two classes. The first class is that of permanent residents, who are allowed to live and work in the United States permanently and have received an Alien Registration Receipt Card (commonly known as a green card).[55] The second class consists of nonimmigrant visas, which allow an individual to enter the country for a temporary period.[56]

Most green cards are distributed to noncitizens who have sponsoring relatives already in the United States, although quotas lead to long waits for admission, even with a sponsoring relative.[57] A second way of gaining a green card is through employment. To earn a green card through employment, an alien must show that he or she has a job offer from a U.S. employer and possesses the background necessary for the job; in most cases a Labor Certification (which asserts that "no qualified American [is] willing or able to take the job") is also required.[58] For those immigrants who do not obtain green cards, another possibility for legal entry into the United States, at least on a temporary basis, is through nonimmigrant visas. There are a variety of different temporary nonimmigrant visas.[59]

B. *Physicians and the J-1 Visa*

The J-1 visa is for exchange visitors who come to the United States to participate in an approved exchange visitor program; there are more than 1500 such programs.[60] These exchange programs – sponsored by schools, businesses, and other organizations – are "meant to foster international cooperation through exchange of information."[61] IMGs can be issued J-1 visas

[55] LAURENCE A. CANTER & MARTHA S. SIEGEL, U.S. IMMIGRATION MADE EASY 1/2-1/3 (10th ed. 2003).

[56] *Id.*

[57] *Id.* at 1/5.

[58] *Id.* at 8/1. Applicants seeking a green card through employment are further divided into categories, such as: Employment First Preference, which includes "workers of extraordinary ability," "outstanding professors and researchers," and executives from multinational companies; and Employment Second Preference, which includes professionals (such as physicians and engineers) who have advanced degrees. *Id.* at 8/3-8/4.

[59] *Id.* at 14/1-14/2 (offering a "complete list of nonimmigrant visas").

[60] *Id.* at 23/3.

[61] *Id.* at 23/1.

for the duration of their training programs, usually a maximum of seven years.[62] Such training programs are an essential step for any medical graduate who wishes to practice as a doctor in the United States because physicians must complete a Graduate Medical Education ("GME") program[63] for "state licensure and eligibility to sit for the American boards."[64] There are five requirements necessary to qualify for a J-1 visa; one must: (1) "be coming to the U.S." for a specific approved visitor exchange program; (2) already be accepted to the program; (3) "have enough money to cover [one's] expenses while in the U.S."; (4) "have sufficient knowledge of English" for the program; and (5) "intend to return home when [one's] status expires."[65] IMGs must also pass a U.S. National Board of Medical Examiners examination.[66]

The biggest disadvantage for J-1 visa applicants is the two-year home residency requirement that is part of the J-1 exchange visa.[67] This means that one must return to one's home country for two years before becoming eligible to apply for a green card, obtain a change of status, or be approved for an H visa,[68] even if one marries a U.S. citizen.[69]

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[62] *Id.* at 23/2.

[63] A GME program "refers to residency and clinical fellowship programs intended to provide physicians with advanced clinical training opportunities undertaken under the supervision of an attending physician." Robert D. Aronson, *The Evolution of the Conrad Waiver Program: Ten Years of State-Based J-1 Waivers to Physicians*, *in* IMMIGRATION & NATIONALITY LAW HANDBOOK, 187, 187 n.3 (Stephanie L. Browning ed., 2005).

[64] *Id.*

[65] CANTER & SIEGEL, *supra* note 55, at 23/3.

[66] *Id.* at 23/4.

[67] 8 U.S.C.§ 1182(e) (2006) provides as follows:

> No person admitted under [8 U.S.C. § 1101(a)(15)(J)] . . . or acquiring such status after admission (i) whose participation in the program for which he came to the United States was financed in whole or in part, directly or indirectly, by an agency of the Government of the United States or by the government of the country of his nationality or his last residence, (ii) who at the time of admission or acquisition of status under [8 U.S.C. § 1101(a)(15)(J)] . . . was a national or resident of a country which the Director of the United States Information Agency, pursuant to regulations prescribed by him, had designated as clearly requiring the services of persons engaged in the field of specialized knowledge or skill in which the alien was engaged, or (iii) who came to the United States or acquired such status in order to receive graduate medical education or training, shall be eligible to apply for an immigrant visa, or for permanent residence, or for a nonimmigrant visa under [8 U.S.C.A. § 1101(a)(15)(H) or (L)] . . . until it is established that such person has resided and been physically present in the country of his nationality or his last residence for an aggregate of at least two years following departure from the United States . . . .

Id.

[68] An H-1B visa refers to a visa for temporary specialty workers. H-1B status can be held for no more than six years and is limited by a quota. CANTER & SIEGEL, *supra* note 55, at 16/1-/2. The current numerical cap for H-1B visas is 65,000, although not all H-1B applicants are subject to the cap. U.S. Citizenship and Immigration Services, Cap Count for

C. *History of the Home Residency Requirement*

The historical development of the home residency requirement reinforces the idea that the exchange visa was intended to promote good will and cultural exchange by allowing foreign students and professionals to gain training in the United States, which they would then bring back to their home countries.

The idea of using exchange programs to promote good will began in 1948, when Congress adopted the United States Information and Educational Exchange Programs ("Smith-Mundt Act"),[70] which created an Exchange Visitor Program to expand the exchange of individuals, knowledge, and skills between the United States and other nations.[71] The Act was designed "to promote a better understanding of the U.S. and its people and culture to others around the world by exposing exchange students to the United States."[72] In *In re Chien*,[73] the Board of Immigration Appeals explained that the purpose of the Act was "to promote international good will by mutual exchange of persons to observe and study on the one hand and to teach important knowledge on the other."[74] The Board explained that in creating the program, "Congress anticipated that the alien would employ the knowledge and skill, thus acquired as the result of a stay here, in his own country."[75] The Act required visa holders to leave the United States upon completion of their training or education, with no provision for change of status applications or waivers.[76]

H-1B and H-2B Workers for Fiscal Year 2010, http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=138b6138f898d010VgnVCM10000048f3d6a1RCRD&vgnextchannel=91919c7755cb9010VgnVCM10000045f3d6a1RCRD (last visited Apr. 20, 2009). To qualify for an H-1B visa, one must have a job offer from a U.S. employer and work in an occupation that requires highly specialized knowledge, which usually means having a college degree. CANTER & SIEGEL, *supra* note 55, at 16/2. Physicians can qualify for H-1B visas and perform work involving patient care if they graduate from an accredited medical school, pass a certifying exam, and pass an English competency exam. *Id.* at 16/4.

[69] CANTER & SIEGEL, *supra* note 55, at 23/5.

[70] Pub. L. No. 80-402, 62 Stat. 6 (1948) (codified as amended at 22 U.S.C. § 1446 (2006)).

[71] *Id.* § 2, 62 Stat. at 6; *see also* AM. MED. ASS'N, *supra* note 42, at 4.

[72] Ella Marshall, *Taking Out the "Exchange" in Exchange Programs: Examining the Two-Year Home Residency Requirement Waiver for Foreign Medical Graduates*, 21 IMMIGR. & NAT'LITY L. REV. 663, 664 (2000).

[73] 10 I. & N. Dec. 387 (1963).

[74] *Id.* at 389.

[75] *Id.*; *see also* Russell G. Donaldson, Annotation, *Foreign Residence Requirement for Educational (Exchange) Visitors Under § 212(e) of Immigration and Nationality Act (8 USCS § 1182(e))*, 48 A.L.R. FED. 509, 517, 527 (1980).

[76] 22 U.S.C. § 1446; KARMA A. ESTER, CONG. RESEARCH SERV., IMMIGRATION: FOREIGN PHYSICIANS AND THE J-1 VISA WAIVER PROGRAM 10 (2004), *available at* http://www.immigration-lawyer-us.com/images/j-current-state.pdf.

In 1956, Congress amended the Smith-Mundt Act, establishing a two-year foreign residency requirement to ensure that exchange students leave the country before reentering as immigrants.[77] The Act allowed the Attorney General to waive this requirement if requested by a government agency, but such waivers were supposed to be granted only if related to the "defense and security of the U.S."[78]

The Mutual Educational and Cultural Exchange Act of 1961 ("Fulbright-Hays Act")[79] "expanded, strengthened, and better defined exchange programs authorized in earlier legislation."[80] The Act also created the J visa for nonimmigrant educational or cultural exchange visits.[81] Once again, the Act required that J visa holders return to their home countries (or countries of last residence) for two years before applying for H-nonimmigrant status or permanent residence.[82] In *Secretary of Defense v. Bong*,[83] the D.C. Circuit suggested that the Fulbright-Hays Act was meant to give aliens the chance to learn skills in the United States that could be used in the alien's home country.[84] "To the extent that a visiting exchangee does not return to his native land," the court continued, "a major policy of the Act is undercut."[85]

In 1970, Congress passed an Act "to amend the Immigration and Nationality Act to facilitate the entry of certain nonimmigrants into the United States."[86] This Act lessened the scope of the home residency requirement by limiting it to only certain categories of exchange visa holders, including those who came to the United States for graduate medical education.[87] In addition, the 1970 amendment modified the requirement to ensure that IMGs could not fulfill it by going to a country other than that of his or her nationality or last residence.[88]

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[77] An Act to Amend the United States Information and Educational Exchange Act of 1948, Pub. L. No. 84-555, 70 Stat. 241, 241 (1956) (codified as amended at 8 U.S.C. § 1182(e) (2006)).

[78] Marshall, *supra* note 72, at 665.

[79] Pub. L. No. 87-256, 75 Stat. 527 (codified as amended at 8 U.S.C. § 1182(e) (2006)).

[80] AM. MED. ASS'N, *supra* note 42, at 5.

[81] *Id.*

[82] ESTER, *supra* note 76, at 2, 10.

[83] 410 F.2d 252 (D.C. Cir. 1969).

[84] *Id.* at 255.

[85] *Id.*

[86] Pub. L. No. 91-225, § 2, 84 Stat. 116, 116 (1970) (codified as amended at 8 U.S.C. § 1182(e) (2006)).

[87] *Id.* Prior to this amendment, "the statute provided that all exchange visitors who fell within the category created in § 101(a)(15)(J)" were subject to the home residency requirement. Donaldson, *supra* note 75, at 515.

[88] 8 U.S.C. § 1182(e); *see* Marshall, *supra* note 72, at 665. The amendment also provided for waivers of the home residency requirement for visa holders who feared

Numerous cases have held that construing the home residency requirement leniently would be contrary to the purpose of the statute.[89] The statute does, however, allow waiver of the home residency requirement when doing so is in the public interest and when the foreign national's skills are required in the United States.[90] The strong presumption against leniency with regard to the home residency requirement bolsters the purpose of the requirement in facilitating exchange. However, such a presumption is rebuttable when waiver is found to be in the interest of the United States.[91]

The stated congressional intent of the earliest foreign exchange programs, which focus on the promotion of good will and the projected return of the foreign visitors, seems tacitly, if not explicitly, to acknowledge the potential problems of brain drain. Yet the self-interest of the destination country will ultimately outweigh, at least to some extent, the basic motives of facilitating exchange of information. F.J. van Hoek, an author connected with the Organisation for Economic Cooperation and Development, explains that although there is no free flow of human resources, "the restrictions that exist are certainly not those that would be required from a worldwide welfare economics viewpoint. In this context, the immigration laws of developed countries show the extent to which these countries exert definite pressure on the demand for high-level manpower."[92]

D. *Waiving the Home Residency Requirement for J-1 Exchange Visas*

Unlike many other exchange visitors, IMGs cannot obtain a waiver of the home residency requirement through consent in the form of a "no objection" statement from his or her home country.[93] Therefore, an IMG will likely be denied a waiver unless there are compelling circumstances (such as

persecution in their home countries or due to a U.S. public interest in retaining the J-1 visa holder. 8 U.S.C. § 1182(e); *see* ESTER, *supra* note 76, at 2.

[89] Donaldson, *supra* note 75, at 527-31; *see, e.g.*, Silverman v. Rogers, 437 F.2d 102, 107 (1st Cir. 1970) (upholding the Secretary of State's veto of waiver); Wei-Ming Chang v. U.S. Immigration & Naturalization Serv., 418 F.2d 1334, 1335 (9th Cir. 1969) (denying waiver of the two-year requirement); Nayak v. Vance, 463 F. Supp. 244, 244 (D.S.C. 1978) (denying waiver and upholding the two-year requirement); Nwankpa v. Kissinger, 376 F. Supp. 122, 125 (D. Ala. 1974) (upholding the Attorney General's broad veto power over such waivers); Gras v. Beechie, 221 F. Supp. 422, 425 (S.D. Tex. 1963) (denying waiver).

[90] *See, e.g.*, *In re* Ikemiya, 10 I. & N. Dec. 787, 788 (1964) ("[A] provision is made to permit the waiver of the foreign residence requirement on the request of an interested United States Government agency.").

[91] *See, e.g.*, *id.* at 787 (explaining that the applicant was "granted a waiver of the two-year foreign residence requirement for exchange visitors . . . on the recommendation of the Department of State pursuant to a request from the Department of Agriculture").

[92] F.J. VAN HOEK, THE MIGRATION OF HIGH LEVEL MANPOWER FROM DEVELOPING TO DEVELOPED COUNTRIES 34 (1970).

[93] Aronson, *supra* note 63, at 188.

persecution) or the IMG has a waiver recommendation from an Interested Government Authority ("IGA").[94] An IMG has a much greater chance of gaining a waiver through an IGA than through any claim of hardship or persecution.[95] Opportunities to waive the home residency requirement are limited because many foreign governments create and fund these J-1 visa programs in the hope that after their citizens obtain U.S. training, they will "eventually return and use their new skills to benefit their homeland."[96] If the United States liberally permitted program participants to remain in the country, "political discord between the U.S. and the other nations involved" could ensue.[97]

A number of requirements must be satisfied in order to obtain a J-1 visa waiver through an IGA. The main requirement to obtain an IGA waiver is that a doctor must agree to practice medicine in H-1B status only in a designated healthcare shortage area.[98] Although federal agencies were originally the only agencies that could recommend waivers, beginning in 1994 Congress allowed states to recommend waivers through the Conrad program.[99] This state waiver program was enacted, at least in part, "presumably owing to the states' traditional interest in safeguarding the health and welfare of their residents."[100] The Conrad program has since overtaken federal agencies as the primary source of IGA waiver sponsorship.[101]

E. *Physician Shortages and Access to Healthcare Challenges in the United States*

When IMGs remain in the United States, they prove highly useful. An American Medical Association ("AMA") report recognizes the two unique contributions of IMGs: their cross-cultural understanding, and their willingness to practice in rural areas through the J-1 waiver requirements.[102] IMGs'

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[94] CANTER & SIEGEL, *supra* note 55, at 23/14-23/15.

[95] *See id.* (explaining the very high standard an applicant must meet to receive a waiver on grounds of persecution).

[96] *Id.* at 23/5.

[97] *Id.*

[98] Aronson, *supra* note 63, at 193-94. For a discussion of H-1B status, see *supra* note 68.

[99] Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416, § 220, 108 Stat. 4305, 4319-20 (codified as amended at 8 U.S.C. §§ 1182, 1184 (2006)); Aronson, *supra* note 63, at 188.

[100] Aronson, *supra* note 63, at 188.

[101] *Id.* In the past, the United States Department of Agriculture often recommended waiver for physicians in rural areas, and Housing and Urban Development served the same role for physicians in inner-city communities. *Id.*

[102] AM. MED. ASS'N, *supra* note 42, at 11. The top source countries for IMG physicians are India (21%), the Philippines (9%), and Mexico (6%). *Id.* at 7. According to the AMA report, "20% of IMG graduates will return to their countries of origin, as has been the case for the past 10 years." *Id.* at 17.

willingness to work in primary care also fulfills a need unmet by U.S. graduates; in fact, the report states that "IMGs are an indispensable part of a functional primary health care delivery system."[103]

In the 1990s, many people believed there were too many physicians in the United States.[104] There were concerns that having too many physicians would result in overutilization of services, decreased physician incomes, and increased healthcare spending.[105] As a result, the United States adopted policies against funding medical training or creating new medical schools.[106] In recent years, however, views of physician oversupply have changed, and numerous studies suggest that there is now a shortage of physicians in the United States due to a range of factors including medical school debt, an aging workforce, medical malpractice insurance costs, and a desire for less demanding work schedules.[107] According to studies, "[t]he country needs to train 3,000 to 10,000 more physicians a year – up from the current 25,000 – to meet the growing medical needs of an aging, wealthy nation."[108] The issue of physician supply is more nuanced than some of the statistics predicting shortages might suggest, since the greatest predicted shortfalls are concentrated in a few specific locations and practice areas.[109] The National Health Service Corps estimates that fifty million Americans "live in communities without access to primary healthcare."[110]

[103] *Id.* at 13.

[104] Aronson, *supra* note 63, at 196 (citing COUNCIL ON GRADUATE MED. EDUC., SIXTH REPORT, MANAGED HEALTH CARE: IMPLICATIONS FOR THE PHYSICIAN WORKFORCE AND MEDICAL EDUCATION (1995)).

[105] *Id.*

[106] *Id.* Medicare provides funding to hospitals for the training of medical residents, thereby influencing the supply of doctors. Dennis Cauchon, *Medical Miscalculation Creates Doctor Shortage*, USA TODAY, Mar. 3, 2005, at 1A.

[107] Aronson, *supra* note 63, at 197.

[108] Cauchon, *supra* note 106. Studies calling attention to the shortage of physicians in the United States include a Council on Graduate Medical Education study which predicts "a shortage of about 85,000 physicians in 2020" and a 2003 survey in which eighty-nine percent of medical school deans reported a shortage in at least one specialty. COUNCIL ON GRADUATE MED. EDUC., SIXTEENTH REPORT, PHYSICIAN WORKFORCE POLICY GUIDELINES FOR THE UNITED STATES, 2000-2010, at xvi (2005); Richard A. Cooper et al., *Perceptions of Medical School Deans and State Medical Society Executives About Physician Supply*, 290 J. AM. MED. ASS'N 2992, 2993 (2003).

[109] *See* Cauchon, *supra* note 106.

[110] National Health Service Corps, About NHSC, http://nhsc.hrsa.gov/about/ (last visited Apr. 19, 2009).

F. *Recent Legislation: The Physicians for Underserved Areas Act of 2007*

Passed on January 12, 2007, the Physicians for Underserved Areas Act[111] attempted to address these shortages by extending the Conrad waiver program until June 1, 2008.[112] The House Report explains that the Act gives aliens who participate in U.S. medical residencies on J-1 exchange visas an exemption from the two-year home residency requirement if they practice for three years in an underserved area.[113]

Congressman Hostettler, Chairman of the Immigration Subcommittee, acknowledged that the J-1 visa home residency requirement was meant to encourage American-trained physicians to improve medical conditions in their own countries.[114] While he supported the bill extending the waiver program, he advocated for a two-year reauthorization rather than a permanent reauthorization to the waiver legislation.[115]

A bill known as the Conrad State 30 Improvement Act, currently in Committee, was introduced to the Senate on February 27, 2008.[116] The bill would eliminate the sunset provision of the Conrad program, making it permanent, in addition to other changes such as an increase in a state's allotment of waivers in certain circumstances.[117] In his speech introducing the bill, Senator Conrad argued that "[g]iven the looming deficit of doctors and an increasingly competitive global marketplace, it is vital that we maintain the incentives for qualified foreign physicians to serve patients in this country."[118] Thus, in addition to making the Conrad program permanent, the bill increases incentives for foreign physicians, expands the Conrad program, and makes it more flexible for states.

Since some U.S. immigration laws currently attempt to facilitate the migration of foreign doctors to fill health-worker shortages in the United States, U.S. immigration law is probably not the best avenue through which to address concerns about the brain drain of health workers.

IV. INTERNATIONAL LAW AND HEALTH-WORKER MIGRATION

Although recent U.S. legislation focuses almost entirely on the need to fill health-worker shortages within the United States, scholars and international activists have increasingly focused on worldwide health-worker shortages and health-worker migration.

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[111] Pub. L. No. 109-477, 120 Stat. 3572 (2007).

[112] *Id.*

[113] H.R. REP. NO. 109-715, at 2 (2006).

[114] *Id.* at 6 (statement of Rep. John Hostettler, Chairman, Immigration Subcomm.).

[115] *Id.* ("[T]he J visa waiver program is only a temporary fix to a much larger problem. Congress must also focus on other ways to address the shortage.").

[116] 154 CONG. REC. S1272 (daily ed. Feb. 27, 2008) (statement of Sen. Conrad).

[117] *Id.*

[118] *Id.*

A. *International Human Rights Law*

International human rights law is relevant to health-worker migration in several ways. First, human rights abuses are a substantial root cause of health-worker migration.[119] Second, human rights language "is often invoked when considering the right of health workers to freedom of movement."[120] Finally, although human rights language is not used as often to discuss the communities that lose migrating health workers, this loss contributes to the violation of the right to health that is outlined in the International Covenant on Economic, Social and Cultural Rights ("ICESCR").[121] Thus, the most relevant human rights in the health-worker migration discussion are the rights to health, freedom of movement, and labor rights.[122]

ICESCR article 12 recognizes a universal right "to the enjoyment of the highest attainable standard of physical and mental health."[123] General Comment No. 14,[124] adopted by the Committee on Economic, Social and Cultural Rights, clarifies that this standard, and therefore this right, will vary according to a State's resources, but it "is a right to facilities, goods, services and conditions necessary to promote and protect health."[125] Thus, to further this right, states must make quality health resources geographically accessible.[126] Health workers are a necessary part of ensuring that this right can be realized, at least to the greatest extent possible.[127] The ICESCR places the obligation on source countries (as signatories) to recognize a right to health, but destination states must also respect the right to health in other countries.[128] Engaging in active recruitment, and allowing private agencies to do so, may be a violation of the right to health.[129] Thus, states "where private

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[119] BUENO DE MESQUITA & GORDON, *supra* note 38, at 7. An in-depth analysis of this issue is beyond the scope of this Note, but as these human rights abuses remain a root cause of the medical brain drain problem, remedying them is essential to solving the problem.

[120] *Id.*

[121] International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3. It should be noted that the United States is not a party to this Covenant.

[122] BUENO DE MESQUITA & GORDON, *supra* note 38, at 10.

[123] International Covenant on Economic, Social and Cultural Rights art. 12, *supra* note 121, 993 U.N.T.S. at 3; BUENO DE MESQUITA & GORDON, *supra* note 38, at 13.

[124] United Nations Economic and Social Council, The Right to the Highest Attainable Standard of Health, http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument (last visited Apr. 20, 2009).

[125] BUENO DE MESQUITA & GORDON, *supra* note 38, at 14.

[126] *Id.*

[127] *Id.*

[128] *See id.* at 16-19.

[129] *Id.* at 19 (observing that while international human rights law binds states, it can also bind third parties in an indirect way because "[s]tates must take legislative and appropriate

recruitment companies are headquartered, have obligations to take legal or other political measure[s] to regulate their activities."[130]

Notwithstanding the right to health, the right to leave one's country is also recognized in article 12 of the International Covenant on Civil and Political Rights.[131] Since restricting freedom of movement is probably not "the least intrusive" way to achieve goals related to health-worker migration, international human rights law would not sanction this measure, even to bolster the right to health.[132]

Finding balance between conflicting human rights presents challenges for the human rights framework. Policymakers may well ask whether providing a right to health by infringing on the right of movement is "moral and compatible with human rights."[133] Even if such a measure improved health in impoverished countries, it would prevent health workers who want to leave their countries from doing so, and it could "exacerbate shortages in staffing in high-income countries."[134]

Judith Bueno de Mesquita and Matt Gordon outline specific mechanisms of human rights law that could be used to influence health-worker migration.[135] Treaty bodies that review signatory states' reports could issue non-binding recommendations to serve as policy guides.[136] A Special Rapporteur on the right to health, similar to that appointed by the Commission on Human Rights, could conduct investigations and request action on health issues.[137] Regional human rights bodies could establish accountability procedures for complaints. International courts could also have a role.[138] More extreme measures include a proposal to make "unethical" recruitment criminal; binding international treaties, such as the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women, provide a legal basis for criminalizing such recruitment practices.[139] Through these mechanisms, and through the recognition of treaty obligations, a human rights framework can be a source of accountability for health-worker management. In addition, this framework recognizes the human rights of all stakeholders,

measures to ensure, as far as possible, that private actors within their jurisdiction do not interfere with these human rights in other countries").

[130] *Id.* at 32.

[131] International Covenant on Civil and Political Rights art. 12, Dec. 19, 1966, 999 U.N.T.S. 171, 176 ("Everyone shall be free to leave any country, including his own.").

[132] BUENO DE MESQUITA & GORDON, *supra* note 38, at 32.

[133] *Id.* at 35.

[134] *Id.*

[135] *Id.* at 21-22.

[136] *Id.* at 21.

[137] *Id.*

[138] *See id.* at 22 (discussing a case in which the African Commission on Human Rights considered the issue of "access to health care facilities and services").

[139] Mills et al., *supra* note 14, at 687.

regardless of nationality, and suggests that "it is the legal obligation of countries of origin and countries of destination under human rights law to seek such solutions."[140]

B. *The General Agreement on Trade in Services*

The World Trade Organization's GATS[141] treats healthcare services as other commodities in the market for international trade.[142] "GATS comprises a set of multilateral, legally enforceable rules covering trade in services designed to encourage liberalization of service markets."[143] The treaty includes the most favored nation principle, which says that service suppliers from different source countries must be treated equally.[144] There are four trading modes in GATS, and mode 4 covers the "provision of health services by individuals in another country on a temporary basis."[145] Because of the public health implications of health-worker movement, liberalizing "trade" in healthcare-service workers may require special considerations. There is some concern that GATS could "constrain sending governments' flexibility in human resource planning in the health sector,"[146] but since developing countries rarely use the GATS section on professionals, that concern seems premature.

Fewer countries have signed on to mode 4 than to the other modes.[147] Proponents of mode 4 suggest that its emphasis on the temporary movement of workers could facilitate return of workers to their home countries, while opponents argue that committed countries would have less ability to regulate incoming health workers.[148] GATS will likely facilitate migration in another way as well, by contributing to the harmonization of certification requirements – although opponents say such an "alignment" will lead to lower certification

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[140] BUENO DE MESQUITA & GORDON, *supra* note 38, at 62.

[141] General Agreement on Trade in Services, *supra* note 7, 1869 U.N.T.S. at 183, 33 I.L.M. at 1167.

[142] Editorial, *supra* note 30, at 623.

[143] Stephen Bach, *International Migration of Health Workers: Labour and Social Issues* 28 (Int'l Labour Office, Working Paper No. 209, 2003), *available at* http://www.medact.org/content/health/documents/brain_drain/Bach%20Health%20worker%20Migration%20WP%20209.pdf.

[144] *Id.* It should be noted that GATS includes different liberalization commitments that are made by each country ranging from "no commitment" to "full commitment." *Id.* (defining the different liberalization commitments).

[145] *Id.* Mode 1 deals with cross-border supply and would cover telemedicine, mode 2 involves "consumption abroad," or medical tourism, and mode 3 deals with a commercial presence, such as a foreign-owned provider. *Id.* Mode 4 is most relevant to this discussion.

[146] Kimberly Hamilton & Jennifer Yau, *The Global Tug-of-War for Health Care Workers*, MIGRATION INFO. SOURCE, Dec. 1, 2004, http://www.migrationinformation.org/Feature/print.cfm?ID=271.

[147] Bach, *supra* note 143, at 29.

[148] *Id.*

standards.[149] Supporters of mode 4, and all of GATS, argue that increased liberalization leads to lower prices for consumers, facilitating access to healthcare, particularly in developed countries such as the United States.[150] Others suggest that mode 4 will lead to lower wages for developed-country workers and make it more difficult for any country to predict its human resource needs accurately.[151]

C. *The Commonwealth Code of Practice for the International Recruitment of Health Workers*

Several nations have adopted codes in an attempt to increase regulation of health-worker recruitment. The Commonwealth[152] nations codified a common approach to the issue in the Commonwealth Code of Practice for the International Recruitment of Health Workers.[153] They seek to raise awareness of the Code[154] and promote the Code to non-Commonwealth countries as well through such organizations as WHO, the International Labour Organisation, and the International Council of Nurses.[155] While the Code is not a legal document, it sets out guidelines by which Commonwealth countries should abide,[156] and it is meant to be used as the basis for bilateral agreements or national codes.[157] The Code's stated purpose is to consider "the potential impact of such recruitment on services in the source country" and "discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages" while protecting the individual rights of health workers to migrate and "safeguard" the conditions that migrants face when they reach destination countries.[158]

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[149] *Id.*

[150] *Id.*

[151] *Id.*

[152] The Commonwealth is a voluntary organization of fifty-three countries that includes almost one-third of the global population; it encompasses countries that were once part of the British Empire, so it has both developed and developing member nations. Ann Keeling, Dir., Soc. Transformation Programmes Div., Commonwealth Secretariat, Address at Promoting Global Solutions to Health Worker Migration: Policy Innovations for Sending and Receiving Nations 6-7 (Sept. 12, 2006) [hereinafter Keeling, Address], *available at* http://www.kaisernetwork.org/health_cast/uploaded_files/un_physicians_welcome-0912061.pdf.

[153] The Commonwealth, *Commonwealth Code of Practice for the International Recruitment of Health Workers*, at 3 (May 18, 2003) (on file with Boston University Law Review) [hereinafter *Commonwealth Code*].

[154] Keeling, Address, *supra* note 152, at 50 (explaining that the Commonwealth has been successful in disseminating information to high-level officials but not to migrants).

[155] *Commonwealth Code*, *supra* note 153, at 3.

[156] *Id.* at 4.

[157] Keeling, Address, *supra* note 152, at 50.

[158] *Commonwealth Code*, *supra* note 153, at 4.

In recruiting efforts, the Code specifically calls for creating transparency about the number and type of recruits sought, disregarding health workers who have contractual obligations with their source countries, and disseminating accurate information to recruits.[159] In addition, the Code urges governments to reciprocate to the countries from which they recruit health workers in various ways, including programs that provide financial assistance, technology, or transfer of skills.[160] The Code also encourages temporary migration that facilitates a migrant's return.[161] The issue of financial compensation is particularly contentious for Commonwealth member states, and some low- and middle-income countries argue that debt relief or aid programs are an insufficient form of compensation.[162] Furthermore, the issue is complicated by the fact that compensation may be extremely difficult to calculate, in part due to data collection challenges.[163] A final challenge is that the Code has not been implemented globally.[164] Therefore, if health workers are merely migrating to non-Code countries, inequities and lack of regulation will persist.

D. *The United Kingdom's Code of Practice*

The United Kingdom, itself a member of the Commonwealth, has its own Code of Practice for the international recruitment of healthcare professionals.[165] This Code, which was the first national recruitment guidance code, states that "[a]ny recruitment agency that wishes to supply the [National Health Service] . . . will also need to comply with the Code of Practice."[166] Agencies have twelve months to comply with the Code and implement new contracts reflecting such compliance.[167] Compliance with the Code, therefore, becomes a contractual obligation for independent recruitment agencies. The Code states that "[d]eveloping countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the U.K.

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[159] *Id.* at 4-5.

[160] *Id.* at 5.

[161] *Id.*

[162] Keeling, Address, *supra* note 152, at 53.

[163] *Id.* at 51-53. Data collection is hampered by difficulties in defining who health workers are, which may lead to the data failing to capture radiographers or paramedics, since the focus is on doctors and nurses. *Id.* at 51. In addition, there are challenges in tracking statistics of those who resign from health worker professions but stay in-country and those who migrate but take unskilled jobs. *Id.* at 51-52. Keeling also notes that migration from one developing country to another will mean that the destination country lacks sufficient funds to compensate the source country. *Id.* at 53.

[164] *Id.* at 53-54.

[165] U.K. DEP'T OF HEALTH, CODE OF PRACTICE FOR THE INTERNATIONAL RECRUITMENT OF HEALTHCARE PROFESSIONALS 3 (2004).

[166] *Id.* at 6.

[167] *Id.* at 5.

to support recruitment activities."[168] Though individuals who apply voluntarily are considered for employment, individuals from countries on the list compiled by the Departments of Health and International Development will not be targeted for recruitment.[169] In addition, the Code requires comparable professional proficiency to that of a U.K.-trained individual, as well as English proficiency, while offering recruits protections of U.K. employment law and comparable training opportunities.[170]

E. *The International Recruitment of Health Personnel: Draft Global Code of Practice*

A Draft Global Code of Practice on the International Recruitment of Health Personnel is currently under development. A 2004 World Health Assembly Resolution directed the Director-General of WHO to formulate the Code.[171] The Secretariat outlined a draft at the First Global Forum on Human Resources in March 2008, and in September 2008, the Secretariat initiated a public hearing on the draft.[172] The Code seeks to establish voluntary practices for the international recruitment of health personnel, to provide guidance for other bilateral and international legal instruments, and to facilitate international discussion on the issue.[173] Although the Code is not legally binding, the drafters clearly hope that the Code will be an instrument to further develop international norms on the issue and encourage the development and adoption of other legally binding instruments.[174]

The drafters state that "[n]othing in this code should be interpreted as impinging on the rights of health personnel to migrate to countries that wish to admit and employ them."[175] The Code states that member states should "create a self-sufficient health workforce," while also calling for increased transparency and fairness in the recruitment and treatment of health workers from other states.[176] Urging member states to create bilateral and multilateral agreements that will "mitigate the potential negative impact of international recruitment of health personnel," the Code specifically suggests targeted development assistance, "support for training in source countries," "twinning of health facilities," and support for return migration.[177] However, the Code

[168] *Id.* at 7.

[169] *Id.*

[170] *Id.* at 8.

[171] World Health Org. [WHO], *International Recruitment of Health Personnel: Draft Global Code of Practice*, ¶ 3, EB124/13 (Dec. 4, 2008) [hereinafter WHO, *International Recruitment*].

[172] *Id.* ¶¶ 4-6, 10.

[173] *Id.* art. 1, at 7.

[174] *Id.*

[175] *Id.* ¶ 3.3.

[176] *Id.* ¶¶ 3.4-.6.

[177] *Id.* ¶ 5.2.

recognizes that states should also attempt to retain their own health workers.[178] Finally, and perhaps most concretely, the Code prescribes gathering data, exchanging information, and reporting to the Secretariat on the issue of health personnel migration.[179]

F. *American Public Health Association Ethical Restrictions*

While not a formal national code, the American Public Health Association ("APHA") did propose a resolution for adoption in 2006 in reaction to perceived ethical problems with the international recruitment of health workers.[180] APHA "[r]ecognizes the regrettable absence in the U.S. of a rational, unified national health system that can adopt [an] ethical recruitment policy" and anticipates that without action, international recruitment will intensify.[181] Additionally, the resolution recognizes the "right of health workers to migrate as guaranteed them by the 1948 Universal Declaration of Human Rights" and the "right to the highest standard of health" laid out in the ICESCR.[182] APHA encourages "U.S. health worker employers, including public and private hospitals, long-term care facilities, and outpatient facilities, to voluntarily adopt a code of ethics that guides their judicious management of the recruitment and employment of health professionals . . . from developing countries."[183] APHA recommends that countries adopt codes in accordance with international standards.[184] In addition, APHA urges the U.S. government to "subsidize health professional class size expansions and provide incentives to better distribute the health professionals in the U.S." and to contract "only with health care delivery organizations that have developed and are abiding by a code."[185] To address the lack of data, APHA also urges the U.S. government to compile a report on recruitment practices and require healthcare employers to report on their recruitment practices.[186]

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[178] *Id.* ¶ 6.2 (suggesting that countries may retain these workers by improving their economic status).

[179] *Id.* ¶¶ 7.1-.4, 8.3.

[180] American Public Health Association, Ethical Restrictions on International Recruitment of Health Professionals to the U.S. (2006), http://www.apha.org/programs/globalhealth/section/advocacy/globalihtest2.htm. The resolution reiterates that almost 25% of American physicians are trained abroad, with 64.4% of them coming from low or lower-middle income countries, and that 4% of U.S. nurses are trained abroad (although this number is rapidly increasing). *Id.*

[181] *Id.*

[182] *Id.*

[183] *Id.*

[184] *Id.*

[185] *Id.*

[186] *Id.*

G. *Bilateral and Regional Agreements*

World Health Assembly resolution 57.19 encourages the use of bilateral agreements regarding healthcare-worker migration.[187] One such bilateral agreement is the United Kingdom-South Africa Memorandum of Understanding. The Memorandum was signed in 2003 to address the flow of health workers from South Africa to the United Kingdom, and discusses ethical recruiting by the United Kingdom, collaboration and assistance between the countries, and "time-limited placements between countries."[188] As part of the agreement, South African personnel can spend time learning and practicing in National Health Service organizations.[189] "This strategy will go a long way in reducing the brain-drain from South Africa while at the same time ensuring that South African health professionals have an opportunity to get international exposure."[190]

Another agreement is the Caribbean Community Single Market and Economy Agreement ("CSME"), established in 1989 to promote circulation of goods and services between member countries.[191] The Agreement provides for a single registration mechanism and permits nurses to work in any member country after passing one examination.[192] It also establishes the Caribbean Health Education Accreditation Board to monitor medical training programs in all member countries.[193] The CSME aims to limit health-worker losses from the Caribbean by providing for workers to be employed overseas for a period of three years on a rotational basis and then to return to the Caribbean.[194]

Finally, the Pacific Code of Practice for the Recruitment of Health Workers in the Pacific Region is a non-binding agreement adopted in March 2007, with "guidelines for the ethical recruitment of health workers abroad."[195] The Code addresses issues such as bonding,[196] as well as monitoring elements such as

[187] World Health Assembly [WHA] Res. 57.19, ¶ 1(3) (May 22, 2004).

[188] Robinson & Clark, *supra* note 13, at 692.

[189] Manto Tshabalala-Msimang, S. Afr. Minister of Health, Speech During the Signing of the Memorandum of Understanding Between South Africa and the United Kingdom (Oct. 24, 2003), http://www.doh.gov.za/docs/sp/2003/sp1024.html.

[190] *Id.*

[191] Robinson & Clark, *supra* note 13, at 692.

[192] *Id.*

[193] *Id.*

[194] Barbara Stilwell et al., *Migration of Health-Care Workers from Developing Countries: Strategic Approaches to Its Management*, 82 BULL. WORLD HEALTH ORG. 595, 598 (2004).

[195] Robinson & Clark, *supra* note 13, at 692.

[196] Bonding, one potential source of regulation, is described as "a contractual obligation by the recipient of training towards the country or institution where their training is provided." BUENO DE MESQUITA & GORDON, *supra* note 38, at 57. Similarly, in-kind obligation requires the training recipient to serve for a certain period of time in the home

reporting.[197] Although these codes represent a step in the right direction, Robinson and Clark suggest that all of these regional or bilateral agreements need better "incentives and enforcement mechanisms."[198]

V. THE BEST RESPONSE TO HEALTH-WORKER MIGRATION PROBLEMS: AGREEMENTS AND CODES PROMOTING EXCHANGE OF BENEFITS

Health-worker migration can be viewed through many different perspectives: as an issue of balancing the different human rights of stakeholders; as a commodity in the global market; as a problem of the commons, in which countries must decide whether to place self-interest above global interest; and as an opportunity for individuals to immigrate to more developed countries. A spectrum of reactions to health-worker migration exists, ranging from arguments that health-worker migration is not a problem at all (or at least that it cannot be solved) to arguments that it is an alarming issue that must be addressed as quickly as possible. The latter view is gaining increased attention and support in the international community.

Most people would agree that the global shortage of health workers, particularly in underserved areas, is a serious problem in both low- and high-income countries. Optimal management would provide for equitable distribution of health-worker resources that can protect the health of populations across the world, while also recognizing the autonomy of workers. There are a number of options, in terms of both form and content, for the regulation of international health workers, which can occur at the domestic level or through international agreement.

First, it is important to note that current U.S. immigration law, and the Conrad program in particular, reflect how high-income countries use immigrant health workers to fill shortages of health personnel. The waiver of the J-1 home residency requirement exemplifies how domestic immigration law responds to the availability of health-worker resources.[199] Historically, U.S. immigration law relevant to exchange visas, including those of health workers, seemed to have a greater emphasis on a temporary international exchange of people, leading to a more lasting exchange of skills and ideas.[200]

country's public health system. *Id.* However, many low-income countries lack the ability to trace and enforce such contracts. *See id.*

[197] WHO Secretariat of the Pacific Community, *Human Resources for Health: The Pacific Code of Practice for Recruitment of Health Workers in the Pacific Region and the Regional Strategy on Human Resources for Health 2006-2015*, at 7, PIC7/7 (Jan. 31, 2007), *available at* http://www.wpro.who.int/NR/rdonlyres/55261EEF-6512-42B5-AEEA-D8A4A5E6C8F7/0/HRH.pdf.

[198] Robinson & Clark, *supra* note 13, at 693.

[199] *See supra* Part III.F.

[200] *See supra* Part III.C; *see also* 22 U.S.C. § 1446 (2006) (enacting an Exchange Program with the purposes of increasing "mutual understanding" and promoting "cooperat[ion] with other nations" in education and training).

The law acknowledged the beneficial role the United States could have in training health workers who would then bring skills back to the citizens of their home countries.[201] Yet despite this historical underpinning, the overall framework of U.S. immigration law gives priority to the self-interest of the admitting country. Immigration laws grant admittance to immigrants who can provide needed skills and services. Particular time periods and circumstances may lead to a heightened emphasis on this aspect of the law. Currently, U.S. immigration law related to health workers is geared toward a self-interested gap-filling mechanism rather than a focus on exchange.

Elimination of immigration policies such as the Conrad program would be a poor remedy. It is also an unlikely one; concerns about medical brain drain from developing countries conflict with concerns about access to health workers for those in the United States, particularly underserved Americans in inner cities and rural areas.[202] As a result, domestic support for increased restriction of health-worker immigration seems improbable. In addition to voicing concerns about healthcare for underserved Americans, opponents of regulation criticize attempts to restrict an individual immigrant's opportunities and freedom of movement.[203] Without an international dialogue, immigration laws will probably be further molded to meet the health-worker needs of the United States.

Although aspects of U.S. immigration law, such as the Conrad program, probably will not and should not be eliminated, some changes – including the permanent implementation of the program – are disconcerting. There is a danger that these immigration policies, in attempting to "plug the gap" of health-worker shortages, diminish the possibility of finding a permanent solution to fill these vacancies in a self-sustainable way. Furthermore, such laws can detract from the original intent of exchange visas, which were designed to be circular processes facilitating exchange and operating in a context that would benefit both source and destination countries. F.J. van Hoek expands the inquiry by establishing the connection, or rather the disconnection, between aid policies and immigration laws. "If aid policies are really inspired by a desire to promote growth in the less developed countries – to the final benefit of all – there is an evident need for reconsideration of the immigration policies and legislation of many industrialised countries."[204]

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[201] *See supra* Part III.C; *see also In re Chien*, 10 I. & N. Dec. 387, 389 (1963) (interpreting the Smith-Mundt Act in light of the fact that "Congress anticipated that the alien would employ the knowledge and skill, thus acquired as the result of a stay here, in his own country").

[202] *See* Cooper et al., *supra* note 54, at 31 (discussing "current inadequacies of the U.S. immigration system for employment-based sponsorship of nurses" and encouraging immigration of international nurses "to alleviate the domestic nurse shortage").

[203] Chen & Bouffard, *supra* note 2, at 1851 ("[S]imply blocking migration is neither effective nor ethical, since freedom of movement is a basic human right.").

[204] VAN HOEK, *supra* note 92, at 13-14.

Creative solutions in domestic immigration law could encourage compromise between source and destination countries. Such solutions include allowing dual citizenship, removing penalties for health workers who return home while in the process of seeking a more permanent immigration status, and advertising employment opportunities that exist in source countries. Source countries' laws on emigration can also play a role in this process, especially through bonding. As van Hoek expresses this dichotomy:

> It is difficult to agree with those authors who suggest that governments of developing countries should simply close their doors to potential emigrants; there is even less reason to agree with those who, based on a sacred rule of personal freedom and the universality of science, pretend that no obstacles whatsoever should be permitted.[205]

One solution might be for source countries to enforce contractual arrangements requiring that a health worker remain or return to work in the home country that funded his or her training. However, for such contracts to work, the source country must have strong legal enforcement capabilities and the ability to track workers.[206]

The sphere of international law and agreement has the advantage of engaging participants and negotiators with a more global view. Such a perspective places less emphasis on the self-interest of the health-worker needs of one's own country and greater emphasis on global compromise.[207] The major disadvantage, however, is that such agreements are not likely to have the same legally enforceable power as domestic immigration laws. Ironically, in the international sphere, sources of regulation that currently have the greatest legally binding power may also have the least practical effect on regulating the migration of health workers. Perhaps through the development of international codes and norms, national governments will adopt legally binding mechanisms for implementation.

International human rights treaties are considered legally binding, and are valuable in establishing a framework of asserting rights, but these treaties may lack the specificity to have a practical effect on health-worker migration. The right to the "highest attainable standard of health"[208] gives a concrete, legally-based claim to the interests of source country populations that lose migrating health workers.[209] However, the human rights approach has limitations in that

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[205] *Id.* at 41 (footnote omitted).

[206] Clark, Stewart & Clark, *supra* note 34, at 59 (observing that implementing and enforcing bonding provisions has been difficult).

[207] *See* Gostin & Taylor, *supra* note 52, at 61 ("[A] 'statist' approach . . . insufficiently harnesses the creativity and resources of nonstate actors and civil society more generally.").

[208] International Covenant on Economic, Social and Cultural Rights art. 12, *supra* note 123, 993 U.N.T.S. at 3.

[209] *Id.* ("The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."); BUENO DE MESQUITA & GORDON, *supra* note 38, at 62 ("Where the migration of health workers is a

many low-income countries simply do not have the resources to bring this right to health to fruition. Similarly, a human right guaranteeing freedom of movement may allow people to leave their home countries, but it will have little practical effect if destination countries close their borders. Nevertheless, the human rights framework does provide an important foundation and reflects the conflict between the right to health for source country populations and the right to freedom of movement for health workers. This conflict gives rise to challenges in developing an appropriate regulatory mechanism for the migration of health workers.

In addition, although the GATS agreement is legally binding, it has limited use in this context.[210] Its aim is to liberalize trade, including trade in health services, as a means to achieving greater global economic prosperity.[211] However, in the context of health-worker migration, unique concerns exist about the impact of liberalized service exchanges, which impact the infrastructure and health of the population that a migrating health worker leaves to pursue preferable employment opportunities.[212] Furthermore, few countries have agreed to mode 4 of GATS, the portion that covers "presence of natural persons."[213] Mode 4 may be beneficial, however, in that it provides for a temporary exchange of workers.[214] Thus, to the extent that the temporary nature of the exchange is tracked and enforceable, mode 4 could redirect attention toward the benefits of the temporary exchange of health workers.

Finally, the most widely discussed and the most promising of the potential frameworks for regulating health-worker migration are codes of ethics for the international recruitment of health workers and bilateral or multilateral agreements.[215] An ideal regulatory framework would maximize effectiveness through bilateral agreements between developed and developing countries, as well as multilateral agreements amongst developed countries on physician migration policies. Robinson and Clark argue that the most promising solutions are bilateral agreements, which may include temporary or "circular" migration, partnership arrangements between hospitals, and support for source-country health workers.[216]

result of, or causes, inequality or other human rights problems, States parties to international human rights treaties have legally binding obligations to redress this situation.").

[210] *See supra* Part IV.B.

[211] Bach, *supra* note 143, at 28.

[212] *See* WORLD HEALTH ORG., *supra* note 31, at 14 ("[T]here are risks associated with liberalization, as not all countries are poised to transform the potential gains into health benefits for the majority of people.").

[213] Bach, *supra* note 143, at 28.

[214] *Id.* at 29 ("[I]t has been argued that by facilitating the temporary movement of health professionals this could diminish the incentive for permanent migration and relocation . . . .").

[215] *See supra* Part IV.C-G.

[216] Robinson & Clark, *supra* note 13, at 692.

Bilateral agreements still have the disadvantage of not encompassing stepping-stone health-worker migration – if only two countries are parties to an agreement, a third intermediary country may still be serving as a source of pull and push between low- and high-income countries with shortages. Bilateral agreements do, however, have a number of advantages. Bilateral agreements require dialogue that gives source countries (i.e., the populations left behind, rather than just the migrating health worker) the opportunity to seek some form of compensation for investments in health workers.[217] Such agreements encourage exchange, whether through individual workers or through other compensatory measures. Robinson and Clark argue that stopping or slowing the out-migration of health workers from developing countries will never be an achievable goal; rather, the international community should focus on partnerships between source and destination countries and try to increase health workers globally to meet the needs in both developed and developing countries.[218]

Codes of conduct, which may be criticized for lacking enforcement mechanisms, nevertheless have potential for the regulation of health-worker migration. Codes, such as the United Kingdom's Code of Practice, can respond to the problems of health-worker migration in a variety of ways, such as specifically forbidding active recruiting in low-income countries with large health-worker shortages.[219] Such a mechanism might have less effect in a privatized country such as the United States, but a public payor or provider can agree only to form binding contractual obligations with private recruitment agencies that abide by the code and do not recruit from specified countries. In this way, even a non-binding code can indirectly regulate the binding contracts of private entities. While such codes do not prohibit health workers from seeking to migrate of their own accord,[220] they do provide an important step by preventing companies and governments from actively enticing health workers to leave their home countries.

Even within the framework of international and national codes and bilateral agreements, there is debate about the specific content of such regulatory mechanisms. Perhaps the most contested point is whether a code or agreement should include provisions for compensation or restitution paid by a destination country to a source country.[221] In a Physicians for Human Rights report on the

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[217] *See, e.g.*, WHO, *International Recruitment*, *supra* note 171, ¶ 5 (discussing bilateral agreements that can support a "mutuality of benefits").

[218] Robinson & Clark, *supra* note 13, at 691.

[219] *See supra* Part IV.D.

[220] *Id.* at 3 ("The Code is sensitive to the needs of recipient countries and the migratory rights of individual health professionals. The Code does not propose that governments should limit or hinder the freedom of individuals to choose where they wish to live and work.").

[221] Keeling, Address, *supra* note 152, at 53 (explaining that "calculating any sorts of financial compensation would be nearly impossible"). *But see* PHYSICIANS FOR HUMAN

subject, the group urges wealthy countries to reimburse developing countries for the expenses they incur in the medical training of health personnel that leave the country.[222] Opponents argue that problems with data collection make it nearly impossible to calculate a fair, accurate level of compensation for a source country.[223] Beyond the compensation issue, however, there are more nuanced ways of facilitating exchange in a bilateral or multilateral agreement or code. *The Lancet* authors state that destination countries should "support[] repatriation of professionals who have left the country, training initiatives, the building and staffing of new health schools, and support for the development of retention frameworks," which include better salaries and incentives to work in rural areas.[224]

CONCLUSION

These "hard" or "soft" legal mechanisms are not the ultimate solution to the health-worker shortage problem. One integral element of the solution that is repeated frequently is the need for a living wage for healthcare workers in developing countries.[225] The United States and other developed countries must also become self-sufficient in the healthcare sector so they can "harmonize" their interests.[226] Some scholars would argue that no regulatory or legal scheme will stop health-worker migration until low-income countries eliminate the push factors that motivate workers to leave. While these are the ultimate solutions that reach the root causes of migration, such solutions will take time to implement and will present an ongoing challenge. In the meantime, and even while these alternatives advance, regulatory schemes such as international agreements and recruitment codes that establish a more cohesive system for the management, equitable distribution, and growth of limited health-worker resources will benefit those who are most in need of access to health workers.

RIGHTS REPORT, AN ACTION PLAN TO PREVENT BRAIN DRAIN: BUILDING EQUITABLE HEALTH SYSTEMS IN AFRICA 61 (2004), *available at* http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf ("Wealthy nations should reimburse developing countries for the training costs and health impact of health professionals who migrate from developing to developed countries.").

[222] PHYSICIANS FOR HUMAN RIGHTS REPORT, *supra* note 221, at 61.

[223] Keeling, Address, *supra* note 152, at 53.

[224] Mills et al., *supra* note 14, at 688.

[225] Linda Doull & Fiona Campbell, *Human Resources for Health in Fragile States*, 371 LANCET 626, 626 (2008).

[226] Chen & Boufford, *supra* note 2, at 1851.