

Health Worker Shortages and Inequalities: The Reform of United States Policy

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The United States and other rich countries have done very little to address the dire global shortage of health workers. In some instances, the conduct of the world's richest countries has exacerbated the shortages experienced in poor countries. We advocate that the Obama Administration adopt two principal strategies to assist with solving the global health workforce crisis. The first strategy requires that a significant part of the U.S.'s development assistance for health be shifted towards building health systems in partner countries, in particular training and employing health workers to deal holistically with the most pressing health problems experienced by the poor. Secondly, the U.S. should pursue a high level of national self-sufficiency in its health workforce and not continue its heavy reliance on recruitment of migrant health workers to fulfil the demand for health workers in the U.S..

THE UNITED STATES AND THE GLOBAL SHORTAGE OF HEALTH WORKERS

It is truly difficult to comprehend the extent of the shortage of health workers across the globe. Although there is no precise estimate of the full extent of the shortage, the World Health Organization (WHO) claims that there is an immediate global need for an additional 4.3 million health workers.¹ This need for 4.3 million is concentrated in 57 of the world's poorest countries, which cannot meet the very low benchmark of 2.5 doctors, nurses and midwives for each 1000 people. In Africa, there are, on average, only 1.08 doctors, nurses and midwives per 1000 population. In real terms, this means that there are 17 doctors, 71 nurses and 20 midwives for each 100,000 people in Africa.² The current rate of health worker production in these countries is such that the deficit will never be met and will only continue to grow. These numbers are shocking because of what they mean for the capacity of most people, but particularly the poorest, in these countries to live a life of good health, to function well and to flourish. Without a sufficient health workforce, people in these countries will suffer and die from wholly preventable and treatable diseases.

The United States and other rich countries have done very little to address the global shortage of health workers. They have made laudable contributions to global health but building strong, competent, sustainable health workforces in poor countries has not been one of them. In fact, some conduct of the world's richest countries has exacerbated the shortages experienced in poor countries. In particular, the failure of the U.S. and the European Union to educate an adequate number of their own health workers to serve in their domestic health systems has resulted in these highly developed countries relying on, and encouraging, the

recruitment and migration of large numbers of health workers, including from countries which are experiencing extreme health worker shortages.

Under the changed leadership of President Obama, the U.S. is reviewing its place in the global political order. The global health community is urging the President and his Administration that this review should encompass a reconsideration and reinvigoration of the role of the U.S. in improving international health.³ We firmly agree that the new President should reorient the U.S.'s foreign assistance policies and programmes, focusing on health system development and health workforce development in the world's poorest countries. We advocate two principal strategies for the U.S., and its rich allies, to assist with solving the global health workforce crisis. These strategies have been designed to address some of the underlying causes of the health worker crisis: the lack of trained health workers, the lack of employment opportunities for health workers, the horrendous conditions in some poor country health systems which cause health worker attrition, the migration of capable and committed health workers from poor countries to richer countries.

Our first strategy requires that a significant part of the U.S.'s development assistance for health be shifted towards building health systems in partner countries, in particular training and employing health workers to deal holistically with the most pressing health problems experienced by the poor. The U.S. should move away from operating assistance programs which focus on treating a single disease, such as HIV/AIDS, and which provide training for staff to deal with one disease only. Unless rich countries, like the U.S., maintain and, in fact, increase their investment in health system building in poor countries, many countries will not be able to muster the resources necessary to create even the most basic health infrastructure.

Secondly, the U.S. should pursue a strategy to reduce the detrimental impact of health worker migration. In this regard, the U.S.'s contribution to improving health systems will have a positive impact: health workers are less likely to migrate from satisfying jobs in functional health systems. This contribution needs to be urgently accompanied by the U.S. reviewing its domestic health workforce policy. The U.S. has failed to seek a high level of national self-sufficiency in its health workforce and has been prepared to rely on migrant health workers to fulfil the demand for health workers in the U.S..

Although the migration of health workers from poor countries is not a major cause of the current health worker deficit, migration of health workers does exacerbate the shortages experienced in some countries. The U.S. has failed to set comprehensive health workforce policy for many years and has completely under-funded its health worker education programs. There is huge demand in the U.S. for entry to nursing education programs but there are no places available to these applicants. The U.S. faces a massive nursing shortage but the federal government has done very little to address this problem through domestic education and labour policy. Its answer can no longer be migrant labour only. The U.S. needs to start building its own workforce to benefit the American people and other countries who can ill-afford to lose trained health workers to the U.S.. At the same time, the U.S. needs to ensure that it protects the rights of migrant health workers on whose services the U.S. is so dependent. The protection should

be provided both at the stage of them engaging with recruitment services to gain entry to the U.S., and then once they have arrived and are working in the U.S..

In this article, we start by outlining the scope of the health worker shortages afflicting some of the world's poorest countries. We then explain some of the particular causes of the shortages in these countries. Our analysis of some of the causes of the current shortage lays the groundwork for our recommendations to President Obama and his Administration.

THE DIRE HEALTH WORKER DEFICIT AND THE WORLD'S POOREST COUNTRIES

The WHO's estimate that there is a global shortage of 4.3 million health workers only includes countries with "critical" shortages and is therefore a gross underestimate of the full extent of the world's health workforce deficit. The pressing need for additional trained health workers is arguably much greater. Admittedly, not every country is experiencing a health workforce shortage,⁴ but the problem does affect rich, middle-income and poor countries alike. The United States, the United Kingdom, Australia and New Zealand all claim that they are desperately in need of more physicians, nurses and all different types of health workers.⁵ At the same time, Zimbabwe, Haiti, Madagascar, Iraq, Afghanistan, India, Cambodia, and Indonesia are suffering from an extreme lack of health workers.⁶

We accept that all of these countries are experiencing health worker shortages – according to their own benchmarks – which potentially have debilitating consequences for their communities. However, the use of vastly different standards for determining health workforce sufficiency means that the countries claiming to have shortages may not be at all similar in terms of the nature of their people's health status and needs, the functionality of their health systems, the size and composition of their health workforces, the relative and absolute severity of their claimed health worker deficit, and, very importantly, the human consequences of their health worker shortages. The focus of this article is on the situation in countries with a "critical" lack of health workers, in particular the situation in Sub-Saharan Africa.

It is generally agreed that there is "no single global norm or standard for health worker density."⁷ There is no formula for the number and mix of health workers (for example, the nurse-to-doctor ratio), which must be present to ensure that a health system runs effectively. Determining the optimal health workforce composition for a particular country involves a complex analysis of factors relating to demand, supply, productivity and the priority allocated to prevention, treatment, and rehabilitation in national health policies.⁸ The Joint Learning Initiative's (JLI) basic "guideline" (and, according to them, it is not a "definitive benchmark") states that 2.5 health workers (counting only doctors, nurses and midwives) per 1000 population are required to provide basic health interventions and meet the Millennium Development Goals for health.⁹ The guideline is based on research from around the world regarding health worker density and the attainment of 80 percent coverage for deliveries by skilled birth attendants or for measles immunization.¹⁰

If countries, as many do, aim to offer a range of health services for prevention and treatment of disease beyond the bare minimum reflected in the MDGs, many additional health workers beyond 2.5/1000 population would be required.¹¹ Whilst the benchmark has some limitations,¹² it has been valuable in identifying those countries whose health workforce is inadequate to deliver even the most basic immunization and maternal health services. Using the benchmark, the JLI found that in 57 countries, there are 2.4 million too few physicians, nurses and midwives to provide essential health interventions.¹³ The JLI suggests, and the WHO accepts, that there are, in fact, 4.3 million too few health workers in these 57 countries, taking into account the other health workers required to work with the doctors, nurses and midwives providing these basic interventions. Of these 57 countries, 36 are in Africa.¹⁴ Other countries falling below the JLI benchmark include those listed in the opening paragraph of this section, as well as countries such as Pakistan, Lao People's Democratic Republic, Myanmar, Cambodia, Papua New Guinea, Morocco, Yemen, El Salvador, Honduras, Nicaragua and Peru.¹⁵

In absolute terms, the greatest need for health workers to meet the JLI standard is in South-East Asia, because of high populations in India, Bangladesh and Indonesia, where there needs to be a 109 percent increase in health workers.¹⁶ In relative terms, the greatest need is in Sub-Saharan Africa, where there needs to be a 140 percent increase in health workers to reach the level proposed by JLI.¹⁷ On average, each of these 57 countries with critical shortages needs an additional 75,000 health workers to deliver only the most basic interventions to their people. The cost of training all of the additional physicians, nurses and midwives is US\$136 million per year for each of the 57 countries which fall below the JLI benchmark. Employing the newly trained health workers is at least an additional cost of US\$311 million per country per year.¹⁸

In Africa, the depth of the health worker deficit is truly breathtaking. It is difficult to fathom and equally difficult to solve. There are only 53 countries in Africa and, as stated above, 36 of these fail to meet the JLI standard of 2.5 doctors, nurses and midwives per 1000 people. In 2001, the WHO found that there were only 1.08 doctors, nurses and midwives per 1000 population, which, in real terms, means that there are 17 doctors, 71 nurses and 20 midwives for each 100,000 people in Africa.¹⁹ This compares with the situation in OECD member countries, which have 300 physicians/ 100,000 population and 890 nurses/ 100,000 population.²⁰ Some African countries are in a better or worse position than the averages for the Continent as a whole. For example, in Malawi, there are 2 doctors/100,000 people.²¹ The situation is very similar in Mozambique where there are 3 doctors for every 100,000 people²² and 32 nurses per 100,000 people.²³ In terms of other health workers, Uganda has only 2.8 general surgeons and 0.37 physician anaesthetists for each *1 million persons*.²⁴ Liberia has a pharmacist ratio of 1 to 85,000 people. This is 77 times lower than in the U.S.. In Zambia, some district health centres have no medical staff at all.²⁵ However, the situation in South Africa is less dire, where there are, on average, 4.85 physician and nurses to each 1000 people.²⁶ In Seychelles, there are 9.44 physicians and nurses to each 1000 people.²⁷

In Africa, as in many countries, the scarcity of health workers is most intense in rural and impoverished areas, and in health facilities that serve the poor.²⁸ Many health workers congregate in cities and even then avoid working in particularly poor communities, preferring the higher wages and better conditions in private for-profit or not-for-profit health centres and hospitals.²⁹ The WHO suggests that, globally, under 55 percent of people live in urban areas, but more than 75 percent of doctors, over 60 percent nurses and 58 percent of other health workers live in urban areas.³⁰ Some parts of rural South Africa have 14 times fewer doctors than the national average.³¹

The poor health worker/ population ratio nationally and regionally in Africa is compounded by the continent's grave disease burden. Not only are there are inadequate numbers of health workers to assist each man, woman and child, but there is more disease to be addressed by a limited number of health workers and a small pool of funds in Africa. Inevitably, the disease burden grows when there are so few human and other resources available to respond to the existing health problems. Sub-Saharan Africa is said to have 10 percent of the world's population, *24 percent of the world's disease burden*, 3 percent of the world's health care workers and less than 1 percent of the world health's expenditure.³² The U.S. is estimated to have 37 percent of the world's health workers, more than 50 percent of the world's health financing, but only *10 percent of the global disease burden*.³³ This means that, in the U.S., there are 3.7 percent of the world's health workers for each 1 percent of the global disease burden. In Africa, there are 0.001 percent of the world's health workers for each 1 percent of the global disease burden.³⁴

It must be recognized that it is the need to treat HIV/AIDS which particularly exacerbates the workforce shortage in Africa.³⁵ It has been projected that there could be a three-fold increase in the number of patients per physician for the delivery of HIV services in Africa and that each physician would need to see 26,000 patients per year. This is an impossible expectation. By comparison, in the U.S., one physician is expected to manage about 2000 patients per year or 20 – 25 patients per day.³⁶ In a context where human resources for health are so stretched, Africa's health system cannot, or can only barely, offer the most essential health interventions to prevent and treat disease amongst its people.

The problem of health worker shortages afflicts public sector efforts, but can sometimes also hamper health initiatives sponsored by other states, international organizations, non-government organizations and public-private partnerships.³⁷ Because of a lack of staff, hospitals may be forced to close, medical clinics operate for reduced hours,³⁸ patients queue for many hours for treatment, new patients cannot be accepted,³⁹ and new health programs never get off the ground. Workforce shortages may make it difficult to respond to health crises, such as epidemics, natural disasters and conflict,⁴⁰ let alone to conceptualize and implement public health programs⁴¹ or to move to new paradigms of care required for effectively treating chronic diseases, such as HIV/AIDS.⁴² Because of the lack of health workforce capacity, only 19 percent of African countries have at least 80 percent of their populations immunized for measles. In Africa, on average, 910 women die for every 100,000 live births.⁴³ Médecins Sans Frontières reports that, due to the lack of health workers, anti-

retroviral treatment for HIV/AIDS is not reaching 85,000 people in Malawi, 235,900 people in Mozambique, 735,000 people in South Africa, and 39,300 in Lesotho.⁴⁴ Without ARVs, these people will experience terrible suffering and many will die. Some of them may try to scrape together monies to pay for health services in the private sector⁴⁵ – which will usually be better-staffed – but this may cause (even further) impoverishment.⁴⁶

At present, there is a “disturbingly large chasm”⁴⁷ between what scientific development theoretically enables us to do to prevent morbidity and mortality and what is being done in many countries of the world. This contrast is most stark in some of the poorest countries, like those in Africa, where people are ill and dying from diseases that are wholly preventable and/or treatable using very simple, inexpensive methods. The WHO reports that, in many instances, there are adequate supplies of drugs and technologies available to improve health, but health workforce shortages have replaced finance as “the most serious obstacle” to realizing national health agendas.⁴⁸

THE CAUSES OF CRITICAL SHORTAGES OF HEALTH WORKERS

As one would expect, there is no single cause of the shortage of health workers around the globe. Instead, a multitude of interconnected causes have combined to produce the shortage of 4.2 million health care workers in 57 countries where some of the world’s poorest people live.⁴⁹ There is a reasonably sophisticated understanding of the factors that are creating the health workforce deficits in each of these countries. Some of these factors are crosscutting. Other causal factors specifically affect a particular country or a particular region of a country or have a special causal potency in one situation and not another. We believe in the importance of understanding the local complexity of the causes of the shortage as a springboard for developing country-specific solutions that are responsive, practical and sustainable. In this section, we outline some of the factors that are recognized as contributing to the dire shortages of health workers. We are not reviewing the full array of matters which are fuelling the shortages. Instead, we have focussed on those drivers of the deficit in the countries with critical shortages, which, in our view, the U.S. can make efforts to address.

Health System Development and Financing

In many countries with critical health workforce shortages, there has been serious, long-term under-development of the education and health systems. Responsibility for the lack of strategic planning and financial investment in the health workforce in these countries can be firstly laid at the feet of the country governments. However, many of these countries are recipients of financial and technical assistance from other states, multilateral organizations, non-governmental organizations, and international public-private partnerships for health. These actors have also failed to alleviate the health workforce shortages, despite the problem so obviously demanding their attention. Some of these actors have done worse, and caused or exacerbated the shortages.

Firstly, health workforce education has been a low priority and money has not been committed to construct or upgrade buildings or equipment, to secure sufficient clinical sites for training, to support increased residency places for medical graduates, to offer competitive terms and conditions to attract and retain teaching faculty, to graduate secondary school students who are equipped to pursue further study,⁵⁰ and to support students to attend health worker education programs. At present, Africa is producing only 10 – 30 percent of the number of health care workers it requires.⁵¹

Secondly, even where there are an appropriate number and mix of trained health workers, there may not be jobs available for them in their country of origin, despite the population experiencing widespread unmet health needs. There is sometimes significant levels of unemployment among health workers.⁵² The availability of jobs for health care workers depends on money being available to pay their salaries and other benefits. In Mozambique, graduating nurses from Tete nursing school waited four years to be employed by the government, despite workforce shortages being one of the major obstacles to nearly 234,000 people getting access to anti-retroviral treatment.⁵³

Many poor or middle income countries will be in receipt of international health assistance from donors, including states, multilateral organizations, non-governmental organization, or public-private partnerships. These donors have found that inadequate human resource capacity is an obstacle to achieving their mission.⁵⁴ However, whilst they may be willing to source drugs and equipment, bring in some of their own workers, or upskill and employ local workers to provide their preferred suite of services, these donors have been largely ineffective in overall health system strengthening in partner countries.⁵⁵ They have been reluctant to fund or offer pre-service health worker education to local people and they have been largely unwilling to fund the employment of more local health care workers in the general health system.⁵⁶ They have acknowledged the problem but have done very little to seriously address it.

A prime example is the President's Emergency Program For AIDS Relief (PEPFAR). PEPFAR's efforts to build health systems were found to be seriously lacking by the Institute of Medicine in 2007. Despite PEPFAR having a stated commitment to health system strengthening, having spent over \$350 million on health workforce development in 2006, and having trained or retrained more than 50,000 people,⁵⁷ it was found by the IOM to have not done enough to build the supply of health care workers in PEPFAR program countries.⁵⁸

Donor upskilling of existing health care workers in an additional area of health care practice, such as treatment of HIV/AIDS with ARVs, is undoubtedly beneficial to the community. But many countries had too few health care workers to deliver the basic health care required by the community *before* the roll-out of new treatment regimes. The training of health care workers to deliver more services can bring treatment efficiencies, but it can also impose a huge burden on overworked staff to deal with a greater range of health problems and even more patients. The effect of training in new health procedures may well be the diversion of health worker time from indigenous health concerns to donor-identified health priorities.

At worst, international health assistance programs can “rob” local health systems of staff who are attracted by higher wages, better conditions and specialist training to health clinics funded and operated by donors.⁵⁹ The maldistribution of health care workers within a country can be severely exacerbated when they move to take up “new and lucrative job opportunities that have emerged for doctors and nurses with non-governmental organizations and foreign aid agencies.”⁶⁰ For example, in Ethiopia, a government public health specialist in Addis Ababa could earn four to five times more by joining an international non-governmental organization.⁶¹ Furthermore, donor programs tend to employ health care workers to deliver the health interventions to treat the diseases selected as the programmatic focus by the donors. Very few donors fund the employment of health care workers to work within the public health system to address the overall disease burden affecting the population. A notable exception has been in Malawi, which secured financial support for its emergency human resources plan for the health sector and reached a special agreement with the IMF and other institutions to increase health worker salaries without changes to the entire civil service wage bill.⁶²

A Sustainable Health Workforce

The inability of employers of health workers to create safe, satisfying and rewarding work conditions is a significant factor in the health care worker shortage in all countries. We know that health workers are very likely to reduce their hours at, or leave, health care workplaces that do not guarantee proper working conditions.⁶³ Some health care workers will migrate to other countries in pursuit of a better work environment. Others will abandon the health profession entirely.⁶⁴ The attrition of the health workforce is a very pressing issue. At a time when many countries are failing to produce sufficient numbers of new health workers, it is essential that urgent steps are taken to secure the existing pool of health care workers and ensure that avoidable causes of health worker attrition are swiftly addressed.

A key issue for many, but not all, health care workers is poor remuneration.⁶⁵ Many health care worker salaries in poor and middle-income are very low.⁶⁶ Many health care workers wait months to receive their salaries.⁶⁷ Many workers' motivation wanes when they feel unrewarded for their work and, consequently, absenteeism increases.⁶⁸ This only exacerbates the workplace challenges if it leaves the facility short-staffed. Other workplace conditions have a similar negative impact on employee retention. In many poor countries, inadequate medicines, equipment and resources make it very difficult for health care workers to provide quality patient care.⁶⁹ In Zimbabwe, some nurses work without gloves and an adequate drug supply, and food for in-patients is rationed.⁷⁰ In these conditions, patients are less likely to recover and more likely to die. It is stressful for workers not to have the basic “tools of the trade” available to them and demoralizing to know that their efforts are impaired. Workers are also burdened by long hours and very heavy workloads, which produce fatigue and burnout.⁷¹ In Africa, many staff work double shifts and work through their holidays in order to make up for staff shortages.⁷² At the same time as dealing

with increasing amounts of work under challenging conditions, many health care workers, particularly nurses, report dissatisfaction with many aspects of the workplace culture and management.⁷³

Another factor having a devastating impact on the health workforce in some of the poorest countries is the illness and death of health care workers and their families, and their lack of support and services.⁷⁴ Buchan and Calman call this “Critical Challenge #1” for the global shortage of registered nurses.⁷⁵ The impact of this challenge is felt most acutely in Sub-Saharan Africa in countries with a high incidence of HIV/AIDS.⁷⁶ In South Africa, 14 percent of health care workers are HIV positive.⁷⁷ In Lesotho, Mozambique, and Malawi, death is the leading cause of health worker attrition with a significant proportion being HIV-related.⁷⁸ Death is a reason for 38 percent of exits from the Zambian health workforce.⁷⁹ Health care workers may find themselves infected with disease because of lack of adequate protections in the workplace.⁸⁰ The stress of a heavy workload under adverse conditions, with many patient deaths, may also give rise to mental health problems for health care workers.⁸¹ Health care workers, like other members of the communities, cannot always access the health goods and services they need to deal with their health conditions. Many health care workers will also be absent from work or leave the workforce altogether to care for sick family members. Recognition of the impact of health care worker illness and death has led to some health clinics for health care workers and their families being established, which has shown benefits in terms of reduced absenteeism.⁸²

International Migration and Recruitment of Health Workers

In some countries, the migration of their health care workers to other countries for the purposes of employment exacerbates the “acuteness” of their shortage of health professionals.⁸³ We endorse the OECD finding that international migration of health care workers is “neither the main cause nor would its reduction be the solution to the worldwide health human resources problem.”⁸⁴ In fact, it has been found that all African-born doctors and nurses working in OECD countries represent no more than 12 percent of the total estimated shortage for the African region. In relation to South East Asia, which suffers the largest absolute shortage of health care workers, the percentage is even lower at 9 percent.⁸⁵ Migration is therefore only one, amongst many, contributing factors to the global shortage of health care workers. Migration is an age-old phenomenon, the entitlement of every person to leave their country of residence, and, in many instances, of enormous benefit to the individuals involved and their source and destination communities. We therefore do not want to overstate the role of health worker migration as a cause of the shortage. We nonetheless recognize that migration does have an adverse impact on health system capacity in countries where there are low numbers of health workers and/or low health worker-to-population ratios. It is therefore important to seek to reduce the negative conditions that contribute to a health worker’s decision to migrate.

Despite significant difficulties in developing a complete picture of health worker migration patterns limitations in country data, there is agreement that

the number of people migrating is higher than ever before and the majority of those migrating are skilled persons, including health professionals.⁸⁶ The recent report by the OECD has shed light on some aspects of the international movement of health workers in OECD countries.⁸⁷ On average, 10.7 percent of employed nurses and 18.2 percent of employed doctors in OECD countries were foreign-born. In absolute terms, the U.S. has the largest number of foreign-born doctors (200,000) followed by the UK (50,000).⁸⁸ For nurses, the U.S. is the most important receiving country with about 337,000 nurses, followed by the UK (82,000), Canada (49,000) and Australia (47,000).⁸⁹ In the U.S. in 2006, almost 21,000 foreign-educated nurses entered the profession, being about 16 percent of all newly registered nurses in the U.S. in that year.⁹⁰ In the U.S., more than 50 percent of foreign-born doctors and 40 percent of foreign-born nurses are from Asia.⁹¹ Nurses born in the Philippines and doctors born in India make up the greatest proportion of the immigrant health workforce in the OECD.⁹²

India, Nigeria, Haiti and Pakistan are the only countries with critical health workforce shortages which are in the top 25 countries for numbers of their doctors and nurses migrating to OECD countries.⁹³ However, African and Caribbean countries are disproportionately affected by out-migration of health professionals because of the low number of health care workers in these countries. Most of the countries with expatriation rates above 50 percent are from the Caribbean, except Fiji, and five African countries: Mozambique, Angola, Sierra Leone, United Republic of Tanzania and Liberia.⁹⁴ French and Portuguese-speaking African countries also have some of the highest expatriation rates to OECD countries for doctors.⁹⁵ English-speaking countries like Malawi, Kenya and Ghana are discussed frequently in international fora on health worker migration, but their expatriation rates are lower than many French and Portuguese-speaking African countries.⁹⁶ However, it should be acknowledged that even if a country has low expatriation rate, the loss of even one health worker may have an enormous impact because of the low density of health workers to population.⁹⁷

The WHO claims that there is "remarkable uniformity" in reasons for health workers migrating.⁹⁸ Migrating health professionals are often motivated by the same factors relating to the inadequacy of their employment conditions which cause other dissatisfied health professionals to leave the profession entirely.⁹⁹ These "push" factors relating to poor terms and conditions of employment were discussed in detail above.¹⁰⁰ These professional or workplace-specific "push" factors in the health worker's country of origin may be accompanied by concerns about the country's political, economic and social conditions¹⁰¹ and the presence of war, social unrest or high levels of crime.¹⁰² Migrant workers go in search of a more peaceful and prosperous life for themselves and their families, looking for personal security, the chance to improve their and their family's financial position, settle debts and save for the future, and the opportunity to access higher quality education for their children and extended family.¹⁰³ The stories told by nurses to Mireille Kingma would suggest that most nurses would choose to stay actively employed in their countries of origin if conditions were better there.¹⁰⁴

Opportunities for migrating health workers abound in many countries around the world. A very significant reason why these opportunities exist in such

large numbers is because many countries have failed to set and pursue the goal of attaining a significant level of self-sufficiency in the production and maintenance of a health workforce.¹⁰⁵ Workforce self-sufficiency envisages that a country meets most or a large part of its demand for health workers by training an adequate number of its citizens and residents to be health professionals and employing those persons in the country's health sector. Workforce self-sufficiency does not envisage that a country's entire health workforce will be locally trained, nor does workforce self-sufficiency exclude the employment of persons who have been educated as health professionals in another country.

The U.S. has failed to implement a policy of national self-sufficiency and therefore relies heavily on health workers, particularly nurses, from other countries migrating to the U.S. to meet the U.S. health system's insatiable demand for health workers. Whilst many countries have health worker shortages and are not pleased to lose health workers to other countries, the migration of health workers to the U.S. has the most harmful impacts on those countries which have critical workforce shortages and who can ill-afford to lose a single health worker from their system. This is not a "happy merry-go-round" with workers coming and going from countries in equal numbers. There are very few or no health care workers moving to the poorest countries. Their stock of health care workers is rarely replenished through migration. They are not destinations of choice for obvious reasons. Very few U.S.-resident health workers emigrate each year to close the gaps in other countries' health systems.¹⁰⁶ The U.S. is aware that its approach to health worker migration brings benefits to the U.S. but is highly detrimental to many poor countries and undercuts their efforts to build a basic health system. That said, the U.S. has not taken any steps to reduce its reliance on migrant labor or to compensate, in some manner, the countries which have been most seriously affected by migration of their workers to the U.S.. The U.S. has issued large numbers of visas for health workers,¹⁰⁷ enables the health worker recruitment industry to operate unregulated,¹⁰⁸ and does very little to protect the rights of the migrant health workers who have come to the U.S..¹⁰⁹

A RESPONSIBLE US RESPONSE

There is scope for the U.S. government, under the leadership of President Obama, to make a greater contribution to resolving the desperate shortages of health workers in some of the world's poorest countries. In this section, we outline two areas of intervention for the U.S., whilst acknowledging that there will be many other ways in which the U.S. can assist with this critical issue. Our first recommendation relates to the U.S. re-orienting its development assistance program to offer technical capacity and funds for countries to build functional, sustainable health workforces to meet their people's basic health needs. There are major changes required to the current US approach to global health in order to achieve this goal. The U.S. will also need to convince a range of other actors to change their global health strategies if strong health systems are to be built up around the world. Our second recommendation relates to the U.S. assisting to reduce the negative incidents of migration and its detrimental impact on poor country health systems and migrating health workers. Our suggestions for

addressing this issue, in fact, center on the U.S. “getting its own house in order” in terms of the sufficiency of its domestic health workforce. We also recommend complementary strategies that relate specifically to the U.S. regulating recruiters of migrant health workers and protecting migrant health workers’ terms and conditions. We argue that the U.S. should reject the discriminatory strategy used in the UK of bans or limits on recruitment of workers from select countries.

Health Workforce Development in the World’s Poorest Countries

The most important contribution that the U.S. can make to resolving the shortage of health workers in poor countries is to provide financial and technical support for the development of local health workforces in countries experiencing extreme shortages. There are many reasons generally proffered for the U.S. providing assistance to improve global health,¹¹⁰ but the U.S. efforts to build overseas health worker capacity should be specifically understood as the U.S. “giving back” to countries who have lost health workers to the U.S. through migration.¹¹¹ The U.S. health system and the U.S. people have benefited from the arrival of migrant health workers who have filled gaping holes in the U.S. health system. These are holes in the health system which the U.S. could have addressed through US workforce development but which it has used migrant labour to fill. This question of US health workforce self-sufficiency is discussed in detail below.

At the same time that the U.S. has benefited from the supply of migrant labor, the migrants’ home countries have suffered considerable losses: the public expenditure (if any) on the health worker’s education, the opportunity cost of the health services which could have been provided by the health worker if they had remained in their home country, the impact on other health workers of the departure of a colleague which may affect morale and, if they are not replaced, increases the remaining workers’ workloads, and the overall sustainability of the health system in the face of an increased shortage of health workers. In recognition of the U.S.’s gains and the poor countries’ losses through the migration of health workers, the U.S. should assist these countries to build and strengthen their health workforces. This financial and technical aid should not be seen only as US benevolence or a general US commitment to redressing global poverty. It is, in part, about the U.S. repaying countries that have assisted the U.S..

Increased U.S. support for health workforce building should be directed to addressing the underlying causes of the health worker shortages. To assist with training more health workers, employing more health workers and preventing the attrition and migration of health workers, any U.S. program for assistance must include funding and technical assistance for health workforce needs analysis, health workforce strategic planning (including the significant potential offered by task-shifting),¹¹² education of new health workers, training of existing health workers,¹¹³ creation of funded positions for health workers, increases in health worker remuneration,¹¹⁴ access to health care and psychological services for health workers,¹¹⁵ and health sector reforms to improve workplace policies and systems.

Considerable efforts are being made by states, multilateral organizations, and non-governmental organizations to pool resources and share knowledge and experience about successes and failures in implementing the measures for building human resources capability in the health sector in poor countries.¹¹⁶ However, in order for the U.S. to deliver the types of assistance that is required to address the most critical health worker shortages, the U.S. will need to reorient its international health assistance program in two fundamental ways.¹¹⁷ The first requirement is a reorientation of U.S. development assistance from its narrow single disease orientation to a genuine focus on health systems. The second challenge for the U.S. concerns the inadequate financial contribution which the U.S. makes to global health.

To start with, the U.S. health assistance program has focussed too heavily in recent years on strategies to address specific diseases, with the concentrated attention being on HIV/AIDS, followed by tuberculosis and malaria.¹¹⁸ From 2004–2008, projects to combat HIV/AIDS, tuberculosis and malaria received US\$19.7 billion from the U.S. government. In the same period, USAID programs for children's and women's health received only \$4.6 billion. In 2008, 70 percent of the U.S.'s overseas development assistance (ODA) for health was spent on HIV/AIDS programs.¹¹⁹ The U.S. support for treating HIV/AIDS involves an unprecedented financial commitment by a government to a single disease. It is reported that since the launch of the PEPFAR, the program has brought a life-saving drugs to 1.73 million people and tripled the number of HIV-infected people receiving treatment in Sub-Saharan Africa. This is a truly remarkable achievement, but there is no doubt it has been possible only because other global health issues, including prevention of HIV infections, have been relegated to the sidelines.¹²⁰ There is now the additional concern about how the U.S. is going to maintain the HIV treatment program which it has so successfully managed to implement.¹²¹ How can it now reduce its funding when this would most likely mean that people have to cease their life-saving ARV treatment?

In addition to having applied most of its energy and resources to a limited set of diseases, the U.S. has been criticized by the Institute of Medicine for its failure to make good on its promises of health workforce development through PEPFAR. The U.S. is not well-practiced in highly effective human resource scale-up. For the U.S. to start to contribute to resolving the health workforce crisis in the world's poorest countries, it should revise its entire set of global health priorities to address the basic survival needs of the world's poorest people.¹²² Survival needs are those matters essential to maintaining restoring human capability and functioning, and include sustainable health systems, vaccines, essential medicine, sanitation and sewage, pest control, clean air and water, and tobacco reduction. Rather than the U.S. trying to "add and stir" health system development into its current programmatic priorities, we recommend that it adopt the basic survival needs for the poor and vulnerable as its guiding priorities. These strategic priorities can encompass many of the U.S.'s current activities relating to HIV, TB and malaria but it places them within a different framework which takes a more holistic approach to health and well-being. The survival needs framework seeks to assure to all people the essential conditions underpinning good health and disease prevention.

The building of sustainable health systems within the survival needs framework places emphasis on the primary health care.¹²³ This health care orientation needs to be reflected into planning, training and employing a health workforce with adequate numbers of the types of health workers who can best deliver primary care. For many of the countries which do not meet the JLI health workforce benchmark, this will be a different mix of health workers to that required in the U.S., with the possibility of including larger numbers of community health workers, volunteers and “survivors” of diseases as part of the trained health workforce in these countries.¹²⁴ The engagement of more community health workers in the health system will certainly reduce the burden involved in preparing the huge numbers of health workers which are required in countries with critical health worker shortages. With countries having a greater capacity to provide primary care, they should be able to both address the single diseases which are the current U.S. focus and the other most important health issues which people face.

Secondly, the U.S. should consider revising upwards its financial commitment to global health and workforce development. We acknowledge that this is a particular challenge in the current global economic environment for a country like the U.S., but the U.S. has, for some time prior to the current crisis, failed to meet its international commitments to development finance. In the Monterrey Consensus, developed countries were urged to “to make concrete efforts” to meet the target of giving 0.7 percent of Gross National Income (GNI) to developing countries and 0.15 – 0.2 percent of GNI to Least Developed Countries.¹²⁵ The UN Millennium Project 2002 set the target of 0.54 percent of Gross National Income to meet the MDGs.¹²⁶ However, the U.S. contributed only 0.16 percent of GNI in 2007, which is below even the lower target of 0.54 percent and below the rich country average of 0.45 percent.¹²⁷ This contribution places the U.S. last among G8 countries excluding Russia and compares poorly with the UK and France, which devote 0.5 percent of GNI and Norway, which dedicates 0.9 percent of GNI.¹²⁸ The U.S. is admittedly the largest country donor in absolute dollars terms and it is on track to meet the commitment it made at the G8 meeting at Gleneagles to double aid to Sub-Saharan Africa by 2010.¹²⁹ It devoted 23 percent of its ODA to health in 2006 which is more than the average proportion of spending on health aid by other advanced economies which is only 0.16 percent¹³⁰

We support the IOM recommendation that the U.S. double its annual commitment to global health between 2008 and 2012 from \$7.5 billion to \$15 billion, which equates to 0.16 percent of ODA (the average rich country expenditure on ODA for health) where the U.S.’s required ODA is calculated at 0.54 percent of U.S. GNI of \$15 trillion (as it was forecast in 2008).¹³¹ We also support the allocation of an increased proportion of these funds to health system strengthening and health workforce development in particular. Increasing the U.S. international aid commitment to global health is more important than ever in the current financial environment. The Doha Declaration in December 2008 called on “all donors to maintain and deliver on their ODA commitments and... on the international community, including the World Bank and the IMF,... to help developing countries and countries with economies in transition to

strengthen their economies, maintain growth and protect the most vulnerable groups against the severe impacts of the current crisis.”¹³² Many countries are already highly dependent on U.S. aid and to lose that assistance would be a blow to their health systems.¹³³ However, the current contraction in the global financial system is also undermining the economic stability of many poor countries and their ability to finance their own health system needs, with private financial flows, foreign direct investment,¹³⁴ remittances and exports from developing countries all falling.¹³⁵ Many of these countries have also been affected by rising food prices and fluctuating commodity prices. Individuals in these countries will be looking more frequently to their governments for support with their health care needs and these governments will need the financial support of partners like the U.S..

Reducing Detrimental Health Worker Migration

The U.S.'s contribution to improving the capacity and quality of poor country health systems is one of the most significant ways in which the U.S. can stem the flow of health workers who are spurred to leave their homes by atrocious work and living conditions. As well as improving some of the conditions which “push” health workers out of their home country health systems, the U.S. must work more conscientiously on reducing the main “pull” factor within its control: its poor levels of domestic health worker production and its reliance on migrant health workers to compensate for the shortcomings of its health education system. If the U.S. were to meet a considerable proportion of its demand for health workers from its citizens and residents, then it would cease exerting such a forceful “pull” effect on health workers in other countries. The U.S. is the world's major importer of health workers. If this were to change, then it is less likely that health workers would be drawn out of their home countries to the U.S. health system. Conditions in health workers' home countries must be simultaneously improved or health workers will seek to leave their countries anyway. In the latter situation, the risk is that the health worker will end up employed outside the health profession and wasting their training, knowledge and expertise.¹³⁶

To date, the U.S. has completely failed in its responsibility to produce an adequate health workforce to meet its people's health needs. Health workforce planning has been poorly executed in the U.S., with predictions about supply and demand being largely incorrect.¹³⁷ There has also been an entrenched unwillingness on the part of successive US federal governments to set national self-sufficiency as a policy target and to provide the financial support necessary to produce the numbers and types of workers which the U.S. health system is craving. The U.S. has plugged the gaps in its health system with increasing recruitment of migrant health workers. However, the U.S. still has shortages of nurses and physicians, as well as other types of health workers.¹³⁸ The short supply of health workers is due to worsen: U.S. will have a deficit of 1,016,900 registered nurses (36 percent of the required supply)¹³⁹ and 200,000 physicians (20 percent of the required supply) by 2020.¹⁴⁰

Rather than amplifying its efforts to recruit health workers from other countries, the U.S. should seek to produce a large proportion of the health workers required in the U.S. health system. There are thousands of students in the U.S. wanting to complete nursing degrees but very limited government funding to create the educational capacity to accommodate these students.¹⁴¹ There are also insufficient numbers of residency positions for all medical graduates. Although the Obama Administration has promised an extra \$330 million for increasing the number of physicians, nurses and dentists in medically underserved areas,¹⁴² this does not fully address the domestic workforce shortage. The Administration should give more comprehensive consideration to health workforce planning and policies as part of its larger agenda of health system reform¹⁴³ and should finance US educational institutions to train large numbers of local health workers. It should be recognized that the benefits of building a sufficient domestic health workforce flow, first and foremost, to the U.S. and its residents. Other countries who currently lose large numbers of health workers to the U.S. will also benefit from the achievement of U.S. health workforce self-sufficiency.

In addition to pointing its efforts towards reducing the “push” and “pull” factors which influence health workers’ decisions to seek employment in the U.S. health system, we consider it essential that the U.S. legislate to protect the rights of migrant health workers, both when they are in the process of seeking entry to and employment in the U.S. *and* when they have arrived and are employed in the U.S.. There is some evidence of poor treatment of migrant health workers by recruiters and employers. Academy Health’s interviews with foreign-educated nurses in the U.S. revealed instances of very poor conduct by recruiters, including pressuring nurses to sign recruitment contracts “on the spot” and without the chance to review the contracts, failing to provide nurses with a copy of the recruitment contract, substituting terms in the contract (including in relation to the city in which the nurse would be located and the basis of the nurse’s employment in the U.S.) without the nurses’ consent, using different versions of the contract depending on whether they were dealing with the nurse or an official agency, making oral promises and not honouring them, disappearing after taking money from nurses for professional registration test fees, and using “break fees” in a harsh manner.¹⁴⁴ Recruiters which act as “staffing agencies” (which means that they contract out the nurse’s services to a health care provider and pay the nurse for her services), have been found to pay the nurse less than she would receive if she were employed directly by the health care provider, to offer no or more restricted health benefits, and to offer no vacation or sick leave. Recruiters have also been known to withhold a foreign-educated nurse’s visa documents to “encourage” the nurse to comply with the recruiter’s requests. In health care organizations, foreign-educated nurses say that they are offered very poor clinical orientation, they are assigned the less desirable tasks, they are expected to work overtime, and their home country experience is not recognized.¹⁴⁵

Once the migrant health worker is in the U.S., all of the U.S. labour and other protective standards apply to the migrant health worker. These include, for example, Fair Labour Standards Act, Title VII of the Civil Rights Act, Age Discrimination in Employment Act, Equal Pay Act, and Occupational Health and

Safety Act. Although there is a strong labour protection framework in the U.S., there may be other barriers to migrant workers taking the benefit of these provisions. In this regard, unions, migrant worker support groups, health worker associations, and labour rights organizations have a role to play in educating migrant workers about their entitlements and assisting them to claim the protection afforded by the laws.

However, the major regulatory gap is in respect of recruitment activities, whether they are undertaken by individuals or companies or through an organization taking some other legal form. At present, there is no federal law regulating the specific conduct of recruitment agencies. There is state legislation in relation to “nursing referral service agencies” and “nurse staffing agencies” in Maryland and District of Columbia respectively.¹⁴⁶ This legislation requires that these agencies be licensed and grants them powers to seek information about a health worker who wants to be placed in a health care organization. The legislation is completely inadequate to protect against the instances of unfair conduct described by foreign-educated nurses to Academy Health. There is currently no legislation anywhere in the U.S. which requires all health personnel recruitment agencies to be licensed and to observe specific standards of fair dealing with health workers, particularly migrant workers, throughout the recruitment relationship.

We support the recently published *Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses* ('FEN Code')¹⁴⁷ and suggest that it could form the basis for legislation to set standards for health personnel recruitment agencies' dealings with local *and* migrant health workers.¹⁴⁸ The FEN Code includes provisions relating to recruitment advertising, the information to be disclosed to the recruit, the procedural requirements for a fair contract, the fee arrangements, dispute resolution processes, and professional and personal support to be provided to the recruit. We argue that the legislation could also model consumer protection statutes which prohibit misleading and deceptive conduct, intimidation, harassment, coercion and like conduct by providers of goods or services. These concepts have relevance in the context of health worker recruitment, where the recruiter will usually only be paid or receive complete payment if they succeed in bringing the health worker to the U.S. and delivering them, ready and willing to work, to the health care organization. The legislation will need to include appropriate machinery for the enforcement of the requisite standards for health personnel recruitment agencies, which is missing from the Code at present.

The legislation should also be drafted to explicitly to apply to dealings between recruiters and health personnel which occur entirely outside the U.S., when the recruitment company is incorporated in the U.S. or is acting as an agent of a U.S. recruitment company.¹⁴⁹ This will ensure that recruitment conduct which occurs offshore does not fall outside the reach of the legislation.

One of the most challenging policy questions generated by the severe health worker shortages in poor and middle-income countries is whether a country like the U.S. should ban or limit the recruitment of health workers from those countries. This is the step taken by the National Health Service (NHS) of the UK and the NHS Scotland, which provide in their codes of conduct that “No

active recruitment will be undertaken in developing countries by UK commercial recruitment agencies, or by any agency sub-contracted to that agency, or any healthcare organization unless there exists a government-to-government agreement that healthcare professionals from that country may be targeted for employment.”¹⁵⁰ The UK lists 153 countries which must not be targeted for health worker recruitment.¹⁵¹ The list has been generated by the UK Department of Health and the UK Department for International Development and is said to be based on the OECD and Development Assistance Committee “list of aid recipients”.

“Active recruitment” is not exhaustively defined, but an example is given which suggests a broad interpretation: “a recruitment agency advertises employment opportunities within the UK health care sector and then acts in such a manner as to secure employment for that individual”.¹⁵² If the approach of the World Federation of Public Health Professionals were adopted, “active recruitment” would include “placing advertisements in locations (including websites) known to target professionals in developing countries, listing openings with a recruitment agency known to primarily operate in developing countries, placing a recruiting station at a conference that attracts primarily developing country health professionals, ... onsite recruitment in developing countries and contracting with “for profit” recruitment agencies.”¹⁵³ The UK Code allows that health care organizations “may consider unsolicited applications direct from an individual in a developing country if that individual is making an application on their own behalf and not using a third party, such as a recruitment agency.”¹⁵⁴ The UK has complemented its UK Code with agreements with specific states, such as South Africa, to “enhance their bilateral relations in respect of Public Health and Health Care Policy.”¹⁵⁵

In contrast, the draft *WHO Code of Practice on the International Recruitment of Health Personnel* does not state that members should prohibit active recruitment of health workers in countries with health worker shortages. It suggests that countries enter into bilateral and multilateral agreements which “should maximize the benefits and mitigate the potential negative impact of international recruitment of health workers through the adoption of appropriate measures”¹⁵⁶ and that “the special needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages ... should be considered.”¹⁵⁷

The UK approach privileges the interests of the source country government and the people requiring the services of health workers in the source country over the interests of individual health workers wishing to migrate. Arguably, the UK Code is also intended to protect the UK’s investment in health system development in poor and middle-income countries and avoid situations in which health workers, trained with UK financial support, leave their home countries and move to UK for employment. On a generous reading, the UK Code could be said to protect the interests of health workers by improving the health systems in which they work. The argument goes that by reducing migration to the UK, there will be more health workers remaining in the country which should

contribute to a stronger country health system which will provide a better place of work for the country's health workers.

We do have concerns that the ban on recruitment from certain countries neglects the interests of individual health workers and disproportionately subjugates their interests to the needs and concerns of the government and the community in the source country. The health workers in the listed developing countries are discriminated against and treated much less favourably than health workers in non-listed countries, most of which happen to be the world's richest countries. Although health workers from the listed developing countries can still apply for employment as health workers in the UK, the UK Code requires that they make the application for employment themselves, without the assistance of a recruitment agency. This means that if a health worker is a nurse in a rich country like Australia, she can receive information about migration opportunities for health workers to the UK, and receive assistance from a recruitment agency with immigration, professional accreditation, travelling to the UK, and settling into a new country. But if you are a nurse in a poor country like Fiji, you have to work out on your own whether there are any jobs available for nurses in the UK, the requirements for working as a nurse in the UK, the application process for visas and accreditation tests, travel and accommodation. If you a nurse from a middle-class or rich family in Fiji, you will probably have a much better chance of finding (and paying for) the information or assistance you require than a nurse from a poor family. We are concerned that the UK ban on recruiters working to bring health workers from listed countries operates, in reality, by creating barriers to entry for health workers of certain nationalities: "you can still come but no one is going to help you to get here". The ban works to solve the health worker shortage simply by making it extremely difficult for people in poor countries to leave their countries and migrate to the UK.

The best reading of the ban is that it seeks to protect health workers in poor countries from recruiters who are overwhelmingly concerned about their own financial and other interests and who convince health workers to migrate who, but for the efforts of recruiters, would be happy to stay in their home countries. It is true that recruiters do make their living from securing the migration of health workers to the destination and they will offer all kinds of inducements and encouragements and will apply some pressure to 'seal the deal'. As discussed above, we agree that recruiters need to be regulated to prevent misleading and deceptive conduct, intimidation, harassment, and coercion of prospective migrant health workers.

However, we are not convinced that health workers need to be "protected" from recruiters by banning them from operating in certain countries. We do not agree that the only reason that health workers migrate is *because* recruiters convince them to do so. The autonomous decision-making capacity of the health worker should not be ignored in this discussion. Recruiters have business to do in poor countries *because* health workers want to leave unbearable living and working conditions and *because* there are lots of employment vacancies in rich countries, which have underinvested in the development of their local health workforce. It would be expected that many health workers decide that they wish to migrate, independently of the overtures of any recruiter. For these health

workers, the recruiter is the conduit for their departure and arrival in the new country. We doubt that people stop wanting to migrate because you remove the recruiters from a country. Removing recruiters may eliminate some instances where a health worker would only migrate because of pressure placed on him or her by the recruiter. However, the more significant effect of removing recruiters may be that local health workers in poor and middle-income countries lose equitable access to the information and infrastructure which would facilitate their application for employment-based entry to a new country.

Given that migration of health workers is not the most significant cause of the health worker shortage, the imposition of the UK-style ban which operates in a deeply discriminatory way – admittedly, for the good of poor and middle-income countries struggling with broken health systems – is a disproportionate response to the health worker shortage. It is a significant invasion of the principle of non-discrimination and it is not addressing the most pressing aspects of the problem of the health worker shortage. We see the shortage as an issue of the utmost importance for the global community but we do not believe that the rights and interests of individual health workers in developing countries should be sacrificed in this way in order to keep up the numbers of health workers in these countries. This issue needs to be approached from a different direction. We therefore recommend that the Obama Administration does not replicate the UK Code approach. Instead, we strongly recommend that the U.S. pursue a vigorous program of health system strengthening in countries with drastic shortages of health workers as part of its international assistance agenda and that the U.S. plan for, and finance, the building of a large domestic health workforce. It is these two factors that will have a much greater impact on the health worker shortage than imposing bans on recruitment of migrants of particular nationalities.

CONCLUSION

The shortage of health workers is debilitating the health systems of many countries, but particularly some of the world's poorest places and people. This is one of the most important issues in global health at the present time. It is an issue which transcends national boundaries, both in its incidence and its causes, and it is a problem which will not be resolved unless there is extensive international collaboration by state and non-state actors. Lives are on the line.

There is a clear opportunity available to the Obama Administration to discontinue some of the U.S.'s policies which have exacerbated the shortage and to implement robust domestic and foreign policies which will make a positive difference in this area. The policy changes must at least include building the U.S.'s domestic health workforce capacity and improving the level and effectiveness of the U.S.'s international assistance program for health system strengthening and health workforce capacity-building. There will be other strategies for the U.S. to pursue but action in these areas would tackle some of the most potent causes of the current health workforce crisis.

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¹ World Health Organization, "Establishing and Monitoring Benchmarks for Human Resources for Health: the Workforce Density Approach," *Spotlight on Statistics*, Issue 6 November 2008; Joint Learning Initiative, Harvard University, *Human Resources for Health: Overcoming the Crisis*, Global Equity Initiative, 2004, 33. The WHO defines a health worker as "all people engaged in actions with the primary intent of enhancing health." However, it focuses its data collection on paid on "health service providers" and "health management and support workers." Even then, its data is most fulsome in relation to doctors and nurses and generally limited in relation to other health service providers and health management and support personnel. World Health Organization, *World Health Report 2006: Working Together for Health* (Geneva: World Health Organization, 2006), 3.

² WHO Executive Board. *Human Resources in Health: Report by the Secretariat*. 114th session, provisional agenda item 4.4, EB114/17, 29 April 2004, 2. Buchan J, Calman L. *The Global Shortage of Registered Nurses: An Overview of Issues and Actions* (Geneva: The Global Nursing Review Initiative, 2004), 12. Jennifer Prah Ruger draws on Aristotelian principles to assert that there should be a re-orientation of the right to health to focus on the health of the individual and human flourishing as the end to be achieved. She recommends that Amartyr Sen's "capability approach" should be used to assess the capacity and effectiveness of health care policy in securing an individual's capability to function well if he or she so chooses: Jennifer Prah Ruger, "Toward a Theory of the Right to Health: Capability and Incompletely Theorized Arguments," *Yale Journal of Law & the Humanities* 18 (2006): 273-326.

³ See, for example, Larry O. Gostin, "International Development Assistance for Health: Ten Priorities for the Next President," *Hastings Center Report* 38, no. 5 (2008): 10 – 11; Institute of Medicine, *The U.S. Commitment to Global Health: Recommendations for the New Administration* (Washington, DC: The National Academies Press, 2009); Nancy Birdsall, ed., *The White House and the World, A Global Development Agenda for the Next US President* (Washington, DC: Center for Global Development, 2008); Laurie Garrett, *The Future of Foreign Assistance Amid Global Economic and Financial Crisis: Advancing Global Health in the U.S. Development Agenda* (New York: Council on Foreign Relations, 2009).

⁴ World Health Organization. *The World Health Report 2006*, 1.

⁵ Jean-Christophe Dumont and Pascal Zurn Dumont, *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration. International Migration Outlook, Part III*. (Paris: Organisation for Economic Co-operation and Development, 2007).

⁶ World Health Organization. *Establishing and Monitoring Benchmarks for Human Resources for Health*; Joint Learning Initiative, Harvard University. *Human Resources for Health: Overcoming the Crisis*, 33.

⁷ Joint Learning Initiative, Harvard University, *Human Resources for Health: Overcoming the Crisis*, 32; World Health Organization. *The World Health Report 2006*, 4.

⁸ Buchan and Calman, *The Global Shortage of Registered Nurses*, 20.

⁹ Joint Learning Initiative, Harvard University. *Human Resources for Health: Overcoming the Crisis*, 24. The JLI is a collaboration of more than 100 “global health leaders” who came together as part of a “learning exercise to understand and propose strategies for workforce development.” Through a series of working groups, the JLI conducted literature reviews, research, and consultations, and very importantly, spoke with many health workers. The JLI states that “equity in global health would form the bedrock value for all JLI endeavors. This report this represents not simply an analytical product but also an expression of our collective social commitment,” *Human Resources for Health*: vvii – viii.

¹⁰ World Health Organization, *The World Health Report 2006*, 11.

¹¹ Joint Learning Initiative, Harvard University, *Human Resources for Health: Overcoming the Crisis*, 23 – 24.

¹² *Ibid.* On JLI’s own admission, the benchmark does not control for other inputs to health, including technology and drugs, and does not take into account the role of community health workers. It is also the case that some countries’ health outputs are worse than the research suggests is possible with 2.5 health workers/ 1000 population (for example, Venezuela and Kenya) and some countries perform better than the benchmark envisages (for example, Mozambique, Gambia, Eritrea) because of the impact of other social and economic factors.

¹³ Joint Learning Initiative, Harvard University. *Human Resources for Health*, 33; Bridget M. Kuehn, “Global Shortage of Health Workers, Brain Drain Stress Developing Countries,” *Journal of the American Medical Association* 298, no. 16 (October 24/31, 2007): 1853.

¹⁴ Joint Learning Initiative, Harvard University. *Human Resources for Health*, 30; World Health Organization, *The World Health Report 2006*, 12.

¹⁵ World Health Organization, *WHO Estimates of Health Personnel: Physicians, Nurses, Midwives and Dentists, Pharmacists* (Geneva: WHO, 2004).

¹⁶ World Health Organization, *The World Health Report 2006*, 12

¹⁷ *Ibid.*

¹⁸ *Ibid.*, 13.

¹⁹ WHO Executive Board. *Human Resources in Health: Report by the Secretariat*, 114th session, provisional agenda item 4.4, EB114/17, 29 April 2004, 2; Buchan and Calman, *The Global Shortage of Registered Nurses*, 12.

²⁰ Organization for Economic Development. *The Looming Crisis in the Health Workforce: How Can OECD Countries Respond?* OECD Health Policy Series, 2008, 14.

²¹ Edward J. Mills, William A. Schabas, et al., “Should Active Recruitment of Health Workers from Sub-Saharan Africa Be Viewed as a Crime?” *The Lancet* 371, no. 9613 (2008): 685 – 88; World Health Organization, *Global Atlas of the Health Workforce*, March 2008, Available at <<http://www.who.int/globalatlas/default.asp>> (Accessed January 15, 2009).

²² World Health Organization, *Global Atlas of the Health Workforce*.

²³ World Health Organization, *Global Atlas of the Health Workforce*. But note that MSF puts the nurse to population ratio in Mozambique as low as 20/100,000: Médecins Sans Frontières, *Help Wanted: Confronting the Health Care Worker Crisis to Expand Access to HIV/AIDS Treatment: MSF Experience in Southern Africa* (Johannesburg: Médecins Sans Frontières, 2007), 3.

²⁴ Médecins Sans Frontières, *Help Wanted*, 627.

²⁵ Joseph J. Schatz, “Zambia’s Health Worker Crisis,” *The Lancet* 371, no. 9613 (2008): 638 – 39.

²⁶ World Health Organization, *Global Atlas of the Health Workforce*.

²⁷ *Ibid.*

²⁸ Buchan and Calman, *The Global Shortage of Registered Nurses*, 5; F. Omaswa, “Human Resources for Global Health: Time for Action Now,” *The Lancet* 371, no. 9613 (2008):625 –26. The problem is spread throughout the world. In Nicaragua, 50 percent of the country’s health personnel are in the capital Managua, whereas only 20 percent of the country’s population is

located there. In Mexico, it is estimated that 15 percent of doctors are unemployed or underemployed yet rural posts remain unfilled. In Viet Nam, the national average is 1 health worker/1000 population but 37 of Viet Nam's 61 provinces fall below the national average, while at the other extreme, one province counts almost 4 health workers /1000 population: World Health Organization, *The World Health Report 2006*, 8.

²⁹ Yogan Pillay and Percy Mahlati, "Health-Worker Salaries and Incomes in Sub-Saharan Africa," *The Lancet* 371, no. 9613 (2008): 632.

³⁰ World Health Organization, *The World Health Report 2006*, 8.

³¹ Médecins Sans Frontières, *Help Wanted*, 8.

³² World Health Organization, *The World Health Report 2006*, 8.

³³ *Ibid.*

³⁴ Health worker density varies in the different regions of the world: 2.3 health workers to 1000 population in Africa, 24.8/1000 in the Americas, 4.0/1000 in the Eastern Mediterranean, 4.3/1000 population in South East Asia, 5.8/1000 in the Western Pacific, 18.9/1000 in Europe. World Health Organization, *The World Health Report 2006*, xvii. However, these regional averages, of course, mask significant discrepancies between countries in each region. For example, in the Americas, nurse ratios in North America are 10 times greater than in South America and 6 times greater than in Central America.

³⁵ World Health Organization and World Bank, *High-Level Forum on The Health Millennium Development Goals: Improving Health Workforce Performance, Issues for Discussion: Session 4, 2003*, 4. Buchan and Calman, *The Global Shortage of Registered Nurses*, 24.

³⁶ Mills, Schabas, et al., "Should Active Recruitment of Health Workers from Sub-Saharan Africa Be Viewed as a Crime?", 685.

³⁷ See generally Médecins Sans Frontières, *Help Wanted*; Institute of Medicine. *PEPFAR Implementation: Progress and Promise* (Washington, DC: The National Academies Press, 2007). Allen Moore, J. Stephen Morrison, *Health Worker Shortages Challenge PEPFAR Options for Strengthening Health Systems* (Washington, DC: The Center for Strategic and International Studies, 2004).

³⁸ M. Awases et al., *Migration of Health Professionals in Six Countries: A Synthesis Report* (Brazzaville, Congo: World Health Organization, 2004), 58.

³⁹ Academy Health, *US-Based International Nurse Recruitment: Structures and Practices of a Burgeoning Industry*, November 2007, 18. Schatz, "Zambia's health worker crisis."

⁴⁰ World Health Organization, *The World Health Report 2006*, xix – xx.

⁴¹ *Ibid.*

⁴² *Ibid.*

⁴³ "Human Resources in Health: Report by the Secretariat," WHO Executive Board, 114th session, provisional agenda item 4.4, EB114/17, 29 April 2004, page 2.

⁴⁴ Médecins Sans Frontières, *Help Wanted*, 4, 6, 8, and 10.

⁴⁵ Awases et al., *Migration of Health Professionals in Six Countries: A Synthesis Report*, 58.

⁴⁶ Each year, 150 million people experience "financial catastrophe" as a result of having to pay for health care. World Health Organization, *Paying for Health Services* (Fact Sheet, Social Health Protection, 2007).

⁴⁷ World Health Organization. *The World Health Report 2006*, xix

⁴⁸ *Ibid.*, 20.

⁴⁹ *Ibid.*, 12.

⁵⁰ Till Bärnighausen, David E. Bloom, Salal Humair, "Human Resources for Treating HIV/AIDS: Needs, Capacities, and Gaps," *AIDS Patient Care and STDs* 21, no. 11 (November 2007): 799-812.

⁵¹ International Organization for Migration, *Migration and Human Resources for Health: From Awareness to Action* (International Dialogue on Migration, 2006), 15

⁵² World Health Organization, *The World Health Report 2006*, xviii.

⁵³ Médecins Sans Frontières, *Help Wanted*, 6.

⁵⁴ *Ibid.* Institute of Medicine, *PEPFAR Implementation: Progress And Promise* (Washington, DC: The National Academies Press, 2007).

⁵⁵ Médecins Sans Frontières, *Help Wanted*, 3.

- ⁵⁶ The Millennium Challenge Account committed \$US 140 million to improve the physical infrastructure at various health facilities, but it is estimated that 600 additional health care workers will be needed to staff these new and rehabilitated health structures and the Millennium Challenge Account has made no plans to source these people: Médecins Sans Frontières, *Help Wanted*, 11.
- ⁵⁷ Moore and Morrison, *Health Worker Shortages Challenge PEPFAR Options for Strengthening Health Systems*, 6.
- ⁵⁸ Institute of Medicine, *PEPFAR Implementation: Progress and Promise*, 14 – 15, 244, 255.
- ⁵⁹ Médecins Sans Frontières. *Help Wanted*, 6; Moore and Morrison, *Health Worker Shortages Challenge PEPFAR Options for Strengthening Health Systems*, 7.
- ⁶⁰ Schatz, “Zambia’s health worker crisis.”
- ⁶¹ David McCoy, “Salaries and Incomes of Health Workers in Sub-Saharan Africa,” *The Lancet* 371, no. 9613 (2008): 678.
- ⁶² Médecins Sans Frontières. *Help Wanted*, 5.
- ⁶³ Nurse turnover rates are high in hospitals and nursing homes in the U.S., Canada and the UK, see Linda H. Aiken, “US Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency,” *Health Services Research* 43, no. 2 (June 2007): 1314.
- ⁶⁴ Buchan and Calman, *The Global Shortage of Registered Nurses*, 21.
- ⁶⁵ Linda Aiken et al., “Nurses’ Reports on Hospital Care in Five Countries,” *Health Affairs* 20, no. 3 (May-June 2001): 48.
- ⁶⁶ Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, 75; Schatz, “Zambia’s health worker crisis.”
- ⁶⁷ Buchan and Calman, *The Global Shortage of Registered Nurses*, 6 and 29.
- ⁶⁸ *Ibid.*, 24. Médecins Sans Frontières, *Help Wanted*, 7;
- ⁶⁹ *Ibid.*, 21.
- ⁷⁰ The International Council of Nurses and Florence Nightingale International Foundation, *The Global Nursing Shortage: Priority Areas for Intervention* (Geneva: The Global Nursing Review Initiative, 2006), 8.
- ⁷¹ Mills and Schabas et al., “Should Active Recruitment of Health Workers from Sub-Saharan Africa Be Viewed as a Crime?” 687. Some of the additional workload comes from meeting reporting requirements for multiple donors. World Health Organization, *The World Health Report 2006*, 21.
- ⁷² Médecins Sans Frontières, *Help Wanted*, 4.
- ⁷³ World Health Organization, *The World Health Report 2006*, xxiii
- ⁷⁴ Mills and Schabas et al., “Should Active Recruitment of Health Workers from Sub-Saharan Africa Be Viewed as a Crime?” 685.
- ⁷⁵ Buchan and Calman, *The Global Shortage of Registered Nurses*, 5.
- ⁷⁶ *Ibid.*
- ⁷⁷ *Ibid.*, 24.
- ⁷⁸ Médecins Sans Frontières, *Help Wanted*, 3.
- ⁷⁹ Schatz, “Zambia’s health worker crisis.”
- ⁸⁰ Médecins Sans Frontières, *Help Wanted*, 17.
- ⁸¹ *Ibid.*
- ⁸² *Ibid.*
- ⁸³ Dumont and Zurn, *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration*, 163.
- ⁸⁴ *Ibid.*
- ⁸⁵ *Ibid.*, 178.
- ⁸⁶ Barbara Stilwell et al., “Migration of Health Care Workers from Developing Countries: Strategic Approaches to its Management,” *Bulletin of the World Health Organization* 82, no. 8 (August 2004): 596.
- ⁸⁷ Michael A. Clemens, and Gunilla Pettersson, “New data on African health professionals abroad,” *Human Resources for Health* 6, no. 1 (2008): 1 - 11; Fitzhugh Mullan, “The Metrics of the Physician Brain Drain,” *New England Journal of Medicine* 353, no. 17 (2005): 1810 – 19.

⁸⁸ Dumont and Zurn, *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration*, 164.

⁸⁹ *Ibid.*, 165

⁹⁰ Linda H. Aiken and Robyn Cheung, *Nurse Workforce Challenges in the United States: Implications for Policy*, Organisation for Economic Co-operation and Development, Health Working Papers No. 35, 2008, 22.

⁹¹ Dumont and Zurn, *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration*, 172.

⁹² *Ibid.*, 175. In the U.S., the main source country for nurses is also the Philippines (76,000) but this is expected to decline and India is expected to become a more significant player in terms of a source of nurses for the U.S. labor market. India is already the main source of physicians to the U.S.. See Aiken and Cheung, *Nurse Workforce Challenges in the United States*, 26.

⁹³ Dumont and Zurn, *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration*, 175.

⁹⁴ *Ibid.*, 176.

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ Awases, *Migration of Health Professionals in Six Countries*, 53.

⁹⁸ World Health Organization, "International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries," A59/18, 59th WHA, 4 May 2006.

⁹⁹ Larry O. Gostin, "The International Migration of Nurses: Human Rights and Global Justice," *Journal of the American Medical Association* 299, no. 15 (2008): 1827 – 29; Pillay and Mahlati, "Health-worker salaries and incomes in sub-Saharan Africa," 632 – 34; Buchan and Calman, *The Global Shortage of Registered Nurses*, 27.

¹⁰⁰ Awases et al., *Migration of Health Professionals in Six Countries*, 54. World Health Organization, *The World Health Report 2006*, 99. In the Philippines, there are incidents of doctors retraining as nurses to enable them to migrate. See Aiken, "U.S. Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency," 1300.

¹⁰¹ Clemens and Pettersson highlight the correlation between the depletion of a country's store of physicians and economic development by pointing to the fact that Kenya, Tanzania and Zimbabwe all experienced decades of economic stagnation in the late 20th century and by its end, each had lost more than half of its physicians. They say that African countries with greater stability such as South Africa, Botswana and Cote D'Ivoire managed to keep their doctors. Clemens MA, Pettersson G. "New data on African health professionals abroad." *Human Resources for Health* 2008; 6(1): 8.

¹⁰² Clemens and Pettersson also point to a correlation between the depletion of a country's store of physicians and economic and political instability. Angola, Congo-Brazzaville, Guinea-Bassau, Liberia, Mozambique, Rwanda, Sierra Leone all experienced civil war in the 1990s and all lost more than 40 percent of their physicians by 2000: Clemens and Pettersson, "New data on African health professionals abroad," 8.

¹⁰³ Centers for Disease Control, International Organization for Migration, World Health Organization, *Health and Migration: Bridging the Gap* (International Dialogue on Migration, 2005), 74.

¹⁰⁴ Mireille Kingma, *Nurses on the Move: Migration and the Global Health Care Economy* (New York: ILR Press, 2006). Ch 2.

¹⁰⁵ Stilwell et al., "Migration of Health Care Workers from Developing Countries: Strategic Approaches to its Management."

¹⁰⁶ Aiken and Cheung, *Nurse Workforce Challenges in the United States: Implications for Policy*, 30.

¹⁰⁷ U.S. nurse recruiters and other interests continually lobby Congress for increases in the number of registered nurse visas. In 2005, Congress agreed to carry over 50,000 unused employment-based visas for nurses that had been allowed in previous years but never used. In 2006, the American Hospital Association asked Congress to make available 90,000 unused employment-based visas for skilled professionals, such as nurses. Aiken, "US Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency," 1304. In August 2008, the U.S. House Judiciary

Sub-Committee approved an increase in the number of nurse visas. However, there has been no further progress on the matter. See L. Nylen and L. Gensheimer, "House Panel Votes to Increase Visas on Foreign Nurses," *CQ Today Online News*, August 1, 2008. There is also the common situation of people entering the country on one type of visa, such as a student visa, and then successfully applying for a visa with work rights which allows them to be employed as a health worker. See Aiken, "U.S. Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency," 1305.

¹⁰⁸ Academy Health, *US-Based International Nurse Recruitment: Structures and Practices of a Burgeoning Industry*, November 2007, 4. International recruitment began to increase in about 1998 when demand for nurses started to rise. See Aiken, "US Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency," 1303. Academy Health suggests that there has been a ten-fold increase in the number of nurse recruitment firms located in the U.S. between 1997 and 2007. These figures do not include health care organizations which operate their own international recruitment services.

¹⁰⁹ See Academy Health. *US-Based International Nurse Recruitment*, 21 - 25.

¹¹⁰ See Larry O. Gostin, "Meeting the Survival Needs of the World's Least Healthy People: A Proposed Model for Global Health Governance," *Journal of the American Medical Association* 298, no. 2 (2007): 225 - 8; Larry O. Gostin, "Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health," *Georgetown University Law Journal* 96, no. 2 (2008): 331 - 92; Ruth Levine, "Healthy Foreign Policy: Bringing Coherence to the Global Health Agenda," in Birdsall N. (ed.) *The White House and the World*; Thomas Pogge, "Symposium: World Poverty and Human Rights," *Ethics & International Affairs* 19, no. 1 (2005): 1 - 8.

¹¹¹ Solomon Benatar, "An Examination of ethical aspects of migration and recruitment of health care professionals from developing countries," *Clinical Ethics* 2, no. 1 (2007): 2-7; James Dwyer, "What's Wrong with the Global Migration of Health Care Professionals? Individual Rights and International Justice," *Hastings Center Report* 37, no. 5 (2007): 36 - 43.

¹¹² World Health Organization, *Task Shifting: Rational Redistribution of Tasks among Health Workforce Teams* (Geneva: WHO, 2008); Médecins Sans Frontières, *Help Wanted*.

¹¹³ "Twinning" programs between US universities and hospitals and health worker training programs in other countries offer great potential for building the knowledge and skills of health workers in countries seeking to develop their health workforce. The programs upskill workers to provide services to the community but also to act as educators of other health professionals in their home countries: see Nigel Crisp, Bience Gawanas, and Imogen Sharp, "Training the Health Workforce: Scaling Up, Saving Lives," *The Lancet* 371, no. 9613 (2008): 689 - 91.

¹¹⁴ For reasons of sustainability, there is reluctance amongst international donors to pay for salaries of health workers in the general public health system of a partner country. However, in Malawi, a six year Emergency Human Resources Programme was funded at a cost of US\$278million by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the UK Department for International Development, the Malawi Government and other international donors. The programme has a number of facets: increase in gross salaries for 11 selected professions, external stop-gap recruitment of physicians and nurses, and significant expansion of domestic training capacity. By the end of 2005, some 5400 doctors, nurses and other key staff were receiving salary top-ups and there had been a reduction in outflow of staff from the public sector. Over 700 new health workers had been recruited. There were plans for infrastructure development and the employment of teaching staff for Malawi training schools with a view to increasing training capacity by 50 percent, tripling the number of doctors and doubling the number of nurses in training. See World Health Organization, *The World Health Report 2006*, 22.

¹¹⁵ See, for example, the program to assist nurses with managing grief which is being operated by Georgetown University's Faculty of Nursing and Health Studies under a grant from PEPFAR. See "Mission Toward Patient Care Takes Flight Through Nurses SOAR! Program and Classes, Mallinson's Training Reaches Students and Professionals." Available at <http://explore.georgetown.edu/news/?ID=33477> (Accessed March 1, 2009).

¹¹⁶ See, for example, the Global Health Workforce Alliance, <http://www.who.int/workforcealliance/en/> (Accessed March 1, 2009).

¹¹⁷ There are recommendations that the U.S. make many changes to its international health assistance program beyond the two which are discussed here. For a more comprehensive review of the recommended reforms, see Birdsall, ed., *The White House and the World*; Institute of Medicine, *The U.S. Commitment to Global Health*; Larry Gostin, "International Development Assistance for Health."

¹¹⁸ Ruth Levine, "Healthy Foreign Policy."

¹¹⁹ Institute of Medicine. *The U.S. Commitment to Global Health*.

¹²⁰ Larry Gostin, "President's Emergency Plan for AIDS Relief: Health Development at the Crossroads," *Journal of the American Medical Association* 300, no. 17 (2008): 2046-2048.

¹²¹ Institute of Medicine, *PEPFAR Implementation: Progress and Promise* (Washington, DC: The National Academies Press, 2007), Mead Over, "Opportunities for Presidential Leadership on AIDS: From an 'Emergency Plan' to a Sustainable Policy," in Birdsall ed., *The White House and the World*.

¹²² Larry O. Gostin, "Why Rich Countries Should Care About the World's Least Healthy People."

Larry O. Gostin "Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health."

¹²³ See World Health Organisation, *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6 – 12 September 1978* (Geneva: WHO, 1978); World Health Organization, *Primary Health Care. Now More Than Ever* (Geneva: WHO, 2008); World Health Organization, *The Financial Crisis and Global Health, Report of a High-Level Consultation*, INFORMATION NOTE/2009/1, 21 January 2009.

¹²⁴ Médecins Sans Frontières. *Help Wanted*, 13. World Health Organization, *The World Health Report 2006*, 23.

¹²⁵ United Nations, "Report of the International Conference on Financing for Development," A/CONF.198/11, Monterrey, Mexico, 18-22 March 2002. This was endorsed in the Doha Declaration: United Nations General Assembly, "Doha Declaration on Financing for Development: Outcome Document of the Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus", A/63/L.57, 12 December 2008.

¹²⁶ UN Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (New York: UNP, 2005), 56 – 8.

¹²⁷ OECD Development Cooperative Directive, *Aid Statistics, Donor Aid Charts – Australia, 2006 – 2007*. Available at <http://www.oecd.org/dataoecd/42/31/41731730.jpg> (Accessed February 4, 2009).

¹²⁸ Institute of Medicine. *The U.S. Commitment to Global Health: Recommendations for the New Administration*. OECD Development Cooperative Directive. *Aid Statistics, Donor Aid Charts – Australia, 2006 – 2007*. Available at <http://www.oecd.org/dataoecd/42/31/41731730.jpg> (Accessed February 4, 2009).

¹²⁹ Group of Eight, *Africa* (Gleneagles: G8, 2005). Annex II.

¹³⁰ Institute of Medicine. *The U.S. Commitment to Global Health*.

¹³¹ *Ibid.*

¹³² United Nations General Assembly, "Doha Declaration on Financing for Development: Outcome Document of the Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus," A/63/L.57, 12 December 2008.

¹³³ World Health Organization, *The Financial Crisis and Global Health*.

¹³⁴ Institute of Medicine, *The U.S. Commitment to Global Health*.

¹³⁵ World Health Organization, *The Financial Crisis and Global Health*.

¹³⁶ Kingma, *Nurses on the Move*, 184.

¹³⁷ Richard A. Cooper, *The U.S. Physician Workforce: Where Do We Stand?* Organisation for Economic Co-operation and Development, Health Working Paper No. 37, 2008, 23, 27. Cooper is scathing in his criticism of U.S. planning for the physician workforce, saying, "There is probably no example of a more poorly-conducted or more deliberately distorted planning activity in the history of the world." 27.

¹³⁸ Aiken and Cheung, *Nurse Workforce Challenges in the United States*, 31; Cooper, *The U.S. Physician Workforce*, 33

¹³⁹ United States Department of Health and Human Services, Health Resources and Services Administration, *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* (2004).

¹⁴⁰ Cooper, *The U.S. Physician Workforce*, 25.

¹⁴¹ The American Association of Colleges of Nursing reported that more than 30,000 applicants seeking baccalaureate nursing education in the U.S. could not be accommodated in 2005. For the same year, the National League for Nursing claimed that as many as 150,000 applicants were turned away from all nursing programs. This figure has not been adjusted for the occurrence of applications by the same person to more than one nursing program. Aiken and Cheung, *Nurse Workforce Challenges in the United States*, 19. Buerhaus, "Current and Future State of the U.S. Nursing Workforce," *Journal of the American Medical Association* 300, no. 2 (2008): 2422 – 26, 2423

¹⁴² Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise* (Washington, DC: Office of Management and Budget, 2009), 69.

¹⁴³ Institute of Medicine, *HHS in the 21st Century: Charting a New Course for a Healthier America* (Washington, DC: The National Academies Press, 2008).

¹⁴⁴ Academy Health. *US-Based International Nurse Recruitment: Structures and Practices of a Burgeoning Industry*, 21 – 24.

¹⁴⁵ *Ibid.*

¹⁴⁶ D.C. CODE §§ 44-1051.01 – 44-1051-18. CDCR 22-4900 – 22-4999. MD. HEALTH GENERAL CODE ANN. §§ 19-4B-01 – 19-4B-06. COMAR 10.07.07 – 10.07.10.

¹⁴⁷ Academy Health, *Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States* (2008).

¹⁴⁸ If the U.S. were to comply with the forthcoming World Health Organization, *Draft WHO Code of Practice on the International Recruitment of Health Personnel* (2008) ("WHO Code"), there are additional provisions in the Code which could be included in domestic legislation. For a discussion of the draft WHO Code, see Allyn Taylor, "The Draft WHO Code of Practice on the International Recruitment of Health Personnel," *The American Society of International Law Insights* 12, no. 23 (2008).

¹⁴⁹ This would be permissible as an exercise of nationality jurisdiction by the U.S. under international law: *Barcelona Traction, Light and Power Co, Ltd Case* [1970] ICJ Rep 3.

¹⁵⁰ United Kingdom Department of Health. *Code of Practice for the International Recruitment of Healthcare Professionals* (December 2004), 10; NHS Scotland, *Code of Practice for the International Recruitment of Healthcare Professionals in Scotland* (2006). Page 10 (together, "UK Code"). The approach of prohibiting active recruitment in countries with health workforce shortages is expressly endorsed by The World Federation of Public Health Associations, *Ethical Restrictions on International Recruitment of Health Professionals from Low-Income Countries* (Geneva, 2005). In Part II, "Best Practices", the FEN Code sets an "aspirational goal" for signatories to the FEN Code of "avoiding active overseas recruitment in those countries or areas within countries that are experiencing either a temporary health crisis during which health professionals are in dire need or a chronic shortage of health workers. Chronic shortages have been defined by the WHO...": Academy Health, *Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States* (2008).

¹⁵¹ NHS Employers. *List of Developing Countries*. Available at <<http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Code-of-Practice/Pages/developing-countries.aspx> (Accessed March 25, 2009).

¹⁵² United Kingdom Department of Health. *Code of Practice for the International Recruitment of Healthcare Professionals* (December 2004), 15.

¹⁵³ The World Federation of Public Health Associations, *Ethical Restrictions on International Recruitment of Health Professionals from Low-Income Countries* (Geneva, 2005).

¹⁵⁴ United Kingdom Department of Health, *Code of Practice for the International Recruitment of Healthcare Professionals* (December 2004), 10.

¹⁵⁵ Memorandum of Understanding between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the Reciprocal Educational Exchange of Healthcare Concepts and Personnel (2003).

¹⁵⁶ World Health Organization, *Draft WHO Code of Practice on the International Recruitment of Health Personnel* (2008) article 5.2.

¹⁵⁷ World Health Organization, *Draft WHO Code of Practice on the International Recruitment of Health Personnel* (2008) article 3.7.