HERE . . . FISHY, FISHY, PHYSICIAN: THE EFFECT OF EUROPEAN UNION MANDATES ON PHYSICIAN MOVEMENT IN THE EUROPEAN UNION

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I. INTRODUCTION

It is no secret that European nations have made great progress since World War II; a war that left many of them in shambles.[1] Shortly after the War, "[f]ew could have envisaged the way in which the creation of the European Coal and Steel Community (ECSC) in 1951, by the Treaty of Paris, would lead on to five decades of European institution building and European policy-making."[2] An essential policy allowing for the free movement of European workers between European countries was particularly important to this development.[3] The free movement of workers created a potentially potent labor force that would not only shape the organization of the European Community's economic structure, but also heavily affect the movement of health services among its countries.[4] Particularly, "[e]mployers and managers, in member state medical care systems, [were then] able to look beyond the boundaries of their own national labour markets and within the member states of the EU for the labour they need[ed]."[5] Although European Union (EU) mandates supporting the free movement of workers may allow physicians the freedom to seek education and employment in other Member States, the failure of the EU to establish a strong policy or legal solution to address the potentially negative outcomes of these mandates may damage the health care workforces of some of its Member States.[6]

This Note will discuss whether the EU's mutual recognition of physician

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1. *See* ED RANDALL, THE EUROPEAN UNION AND HEALTH POLICY 3 (2001).

2. *Id.*

3. Sallie Nicholas, *The Challenges of the Free Movement of Health Professionals*, *in* HEALTH POLICY AND EUROPEAN ENLARGEMENT 82, 83 (Martin McKee et al., eds., 2004).

4. RANDALL, *supra* note 1, at 53. *See also* Monika Strózik, *Poland*, *in* THE HEALTH CARE WORKFORCE IN EUROPE: LEARNING FROM EXPERIENCE 87, 97 (Bernd Rechel et al., eds., 2006) (indicating "[a] key issue in the chapter on the 'free movement of persons' was the mutual recognition of professional qualifications. In general, existing training programmes complied with EU regulations").

5. RANDALL, *supra* note 1, at 53.

6. Melanie Bourassa Forcier et al., *Impact, Regulation and Health Policy Implications of Physician Migration in OECD Countries*, 2 HUM. RESOURCES FOR HEALTH 12 (2004), *available at* http://www.human-resources-health.com/content/2/1/12 (last visited Jun. 10, 2008).

qualifications and the resulting physician movement in the EU poses enough of a threat to the health care workforces of EU Member States[7] to require the EU to legally address the potentially negative outcomes.[8] Section I of this Note will analyze the development of health policy in the EU and the different mandates that have affected and continue to affect its development. The latter part of this Section will explore some of the potentially damaging effects of these policies. Section II will discuss how Member States Spain and the United Kingdom (UK) implement EU laws allowing physicians from EU states to move freely in and out of their borders and how these laws affect their respective physician workforces. This Section will also demonstrate the effect EU laws allowing for physician movement have on the more underdeveloped countries of the EU, particularly those new Member States who acceded to the EU in 2004.[9] Section III will offer counterarguments regarding why laws allowing for potential physician movement, especially in the wake of the latest enlargement, pose no threat to the new and old Member States of the EU and why these laws may benefit the Member States of the EU. Section IV will then provide a number of legal solutions[10] to the problems that physician movement in the EU arguably creates.

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7. In to the early 21st Century, EU Member States included: Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, France, Finland, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, and United Kingdom. Gloria Moreno-Fontes Chammartin & Fernando Cantu-Bazaldua, *Migration Prospects After the 2004 Enlargement of the European Union*, 19 (International Migration Programme Working Paper No. 73), http://www.ilo.org/public/english/protection/migrant/download/imp/imp73.pdf (last visited Jan. 28, 2008). Bulgaria also recently acceded to the EU in 2007. Europa.eu, Bulgaria, http://europa.eu/abc/european_countries/eu_members/bulgaria/index_en.htm (last visited Mar. 18, 2008).

8. It is important to note the scope of this Note. Scholars have articulated many theories for explaining the shortcomings and strengths of the health care workforces of the Member States. Physician migration and the free movement of physicians is one of these theories. *See* Carl-Ardy Dubois et al., *Introduction: Critical Challenges Facing the Health Care Workforce in Europe*, *in* THE HEALTH CARE WORKFORCE IN EUROPE: LEARNING FROM EXPERIENCE 1, 11 (Bernd Rechel et al., eds., 2006) (noting "[f]undamental weaknesses in planning the workforce in the past are manifest through a legion of difficulties: cyclical shortages of many health professionals; widespread vacancies, especially in isolated rural areas; and maldistribution of the workforce, creating difficulties in ensuring an equitable provision of care"). This Note will seek only to discuss physician migration, its feared adverse effects on the workforce supplies of Member States, and some ways in which the EU and its Member States can mitigate those potential effects.

9. Ten countries acceded to the EU in 2004, including: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovak Republic and Slovenia. Chammartin & Cantu-Bazaldua, *supra* note 7, at 19.

10. This Note will propose a legal solution to the proposed problem as opposed to many policy solutions others have proposed. *E.g.*, James Buchan, *Migration of Health Workers in Europe: Policy Problem or Policy Solution*, *in* HUM. RESOURCES FOR HEALTH FOR IN EUROPE 41, 60 tbl. 3.5 (Carl-Ardy Dubois et al., eds., 2006), *available at* http://www.euro.who.int/Document/E87923.pdf.

A. *The Development of Health Policy Towards Physicians in the EU*

The Treaty of Rome, which a handful of western European countries signed in 1957, aimed specifically to prevent another war between European countries after the two World Wars had left the region in disarray.[11] Afterward, the signatories of the Treaty not only dedicated themselves to peace, but also to the free movement of goods and services.[12] Specifically, the "governments that signed the Treaty of Rome in 1957 committed themselves to the mutual recognition of qualifications, as it is of little use to professionals to be able to move if they [could not] work when they arrive[d in other Member States]."[13] To facilitate this policy, the European Union has implemented different means to simplify licensing requirements.[14] The EU "gives every European Union citizen a fundamental, personal right to move and reside freely within the territory of the Member States. No visas or work permits are required."[15]

Although the signatories of the Treaty of Rome placed a great emphasis on the free movement of goods and services, the signers failed to make any significant commitment to public health.[16] European countries referred to public health as merely a justification to block the movement of goods when such movement potentially threatened a given aspect of public health in one of the Member States.[17] At this time the "competence [of the EU] in the broader area of health was considered by most commentators to be extremely limited."[18]

Despite the EU's non-interventionist approach to its health policy in its treaties, the European Commission (EC) issued two Directives in 1975, known as the "Doctors Directives," to facilitate the free movement of physicians between the Member States.[19] The Directives primarily addressed the mutual recognition of qualifications for physicians who were licensed in one country, but sought to practice in another.[20] EU lawmakers supplemented these Directives in 1986 with other directives addressing the training of physicians.[21]

After the EC issued these directives, the EU showed more, but still passive, willingness to intervene into the health affairs of its Member States.[22]

11. Martin McKee et al., *The Process of Enlargement*, *in* HEALTH POLICY AND EUROPEAN UNION ENLARGEMENT 6, 9 (Martin McKee et al., eds., 2004).

12. Nicholas, *supra* note 3, at 83.

13. *Id.*

14. Forcier et al., *supra* note 6.

15. *Id.*

16. McKee et al., *supra* note 11, at 9-10.

17. *Id.*

18. *Id.* at 10.

19. *Nicholas, supra note 3, at 83. See infra* notes 93-95.

20. *Id.*

21. *Id.*

22. *See generally* Ben Duncan, *Health policy in the European Union: How it's Made and How to Influence It*, 324 BRIT. MED. J. 1027 (2002), *available at* http://www.pubmedcentral.nih.gov/articlerender.fcsi?artid= 1122958.

In 1992, the EU affirmatively stated its health policy objectives in a provision of the Maastricht Treaty.[23] This provision, Article 129, held a "mandate of 'encouraging cooperation between member states' and 'if necessary, lending support to their actions' in public health."[24] Article 129 also gave the EU the power "to spend money on European level health projects but [it was] forbidden to pass law[s] harmonising public health measures in the member states."[25]

EU lawmakers enhanced these provisions and the health policy power of the EU, under the Amsterdam Treaty of 1997.[26] Under Article 152 of this treaty, "the EU was commanded to ensure 'a high level of human health protection' in the 'definition and implementation of all policies and activities' and to work with member states to improve public health, prevent illness[,] and 'obviate sources of danger to human health.'"[27] However, subsections four and five of the Article diluted the strength of the mandate, requiring the EU to "fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care."[28] Although these treaties lacked the strength to coerce countries to adopt certain measures, these treaties have set a general basis for the development of a health policy in the EU.

In the last decade, the Court of Justice of the European Communities (ECJ) has also played a role in the development of health policy in the EU.[29] The court has recently made specific rulings facilitating the development of an EU policy toward the free movement of workers as well as the free movement of health services.[30] Two 1998 decisions, *Decker v. Caisse de Maladie des Employes Prives*[31] and *Kohll v. Union des Caisses de Maladie*,[32] were of significant importance to this development.[33] Two other cases, decided in 2001, substantiated the principles set forth in 1998 and revealed the Court's belief that some regulation of health care in the EU should occur through the

23. *Id.* The EU traditionally failed to regulate state health care policies because the Member States governed their own health care systems. *Id.*

24. *Id.* (quoting Treaty on European Union, art. 129(1)(as in effect 1992)(now article 152), July 29, 1992, 1992 O.J. (C 191)).

25. *Id.* (quoting Treaty on European Union, art. 129(4)(as in effect 1992)(now article 152)).

26. *Id.*

27. Duncan, *supra* note 22, at 1027(quoting Treaty of Amsterdam Amending the Treaty on European Union, The Treaties Establishing the European Communities and Certain Related Acts, art. 152(1), October 7, 1997 O.J. (C 340)).

28. Treaty of Amsterdam, art. 152(4-5).

29. Elias Mossialos & Martin McKee, *Is a European Healthcare Policy Emerging? Yes*, 323 BRIT. MED. J. 248 (2001), *available at* http://bmj.bmjjournals.com/cgi/content/full/323/7307/248.

30. *Id.*

31. Case C-120/95, Decker v. Caisse de Maladie des Employes Prives, 1998 E.C.R I-01831.

32. Case C-158/96, Kohll v. Union des Caisses de Maladie, 1998 E.C.R I-01931.

33. Mossialos & McKee, *supra* note 29.

EU itself.[34] The EU has shown a passive approach to the regulation of health care; however, it has also encouraged the free movement of health professionals and services among its member states. A deeper look at some EU mandates reveals this emphasis and its weaknesses.

B. EU Mandates Affecting Physician Movement in the EU

1. Treaties

One must understand the legal system of the EU to a certain degree to appreciate the effect different legal mandates may have on physician movement. EU lawmaking authority is primarily formed by a series of treaties.[35] "Once ratified, the Treaties determine the competence at EU level and what remains the responsibility of Member States."[36] The treaties tend to speak in generalities and require some interpretation, which the European Commission[37] offers through legislation it proposes to the Council of Ministers[38] and the European Parliament.[39] Both of these bodies must generally approve legislation.[40] In the event of a dispute, reconciliation measures exist to address the differences.[41]

EU treaties have shaped EU health policy in a weak fashion over the last two decades.[42] The Treaty of Maastricht was the first time the EU indicated it was willing to intervene in the health policies of its Member States in a treaty.[43] "Article 129 [of the Treaty] made provision for community action to prevent diseases, in particular major health scourges."[44] Moreover, the Article "provided the basis for a programme of action in health promotion, information, education and training in public health."[45] Although the Article took a broad approach to a narrow health issue (major health scourges) confronting the EU, "it specified that health protection should form a part of the Community's other policies . . . ."[46] Other provisions of the Article hampered any progressive

34. Case C-157/99, BSM Geraets-Smits v. Stichting Ziekensfonds VGZ and HTM Peerbooms v. Stichting CZ Groep Zorgverzekeringen, 2001 E.C.R I-05473.

35. McKee et al., *supra* note 11, at 10.

36. *Id.*

37. The European Commission may be defined as "a body of international civil servants [from the EU], headed by a president and commissioners appointed by the Member States." *Id.*

38. The Council of Ministers is composed of individuals who represent the governments of the Member States. *Id.*

39. The members of the European Parliament are "directly elected by the citizens of Europe." *Id.*

40. McKee et al., *supra* note 11, at 10.

41. *Id.*

42. *See id.* at 11-12.

43. *Id.* at 11.

44. *Id.*

45. *Id.*

46. McKee et al., *supra* note 11, at 11.

result, allowing Member States to coordinate the individual policies each chose to enact, but forbidding Member States to harmonize their legislation.[47]

The reception by the Member States of the new Article was lukewarm at best.[48] There was "concern about the ambiguous position of health services; with some arguing that policies to promote health that ignore the contribution of health services are untenable."[49] Yet, it was progress, considering "health care [traditionally] was an area into which many governments did not wish to stray, for various reasons."[50]

While the EU revisited its health policy position in the Treaty of Amsterdam,[51] the relevant Article in this treaty, Article 152, suffered from some of the same limitations as Article 129.[52] Article 152 "was inserted at the last moment, with minimal consultation, and as yet another compromise, it is in places confusing and almost self-contradictory, in marked contrast to, for example, articles on consumer protection or the environment."[53] Despite the apparent drawbacks of Article 152, "it is stated that Community action shall be directed towards improving public health, although what is meant by public health remains unclear."[54]

These treaties created many uncertainties regarding the EU's health policy.[55] The result of this uncertainty is a lack of much needed initiative to support or interfere in the health care systems of the Member States when it may be appropriate, such as when EU enlargement and potential physician migration may threaten other Member States.[56]

2. Courts

The ECJ will resolve any questions or disputes EU legislation may create.[57] The ECJ has three main purposes:

> to judge in disputes brought by the Commission or the Member States against the Member States concerning questions about the legality of action and non-compliance; judicial review of the actions and the failure to act by the

47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.* Jacques Delors, European Commission President at the time the Member States signed the Treaty of Maastricht, articulated this view, stating health policy "was an 'inappropriate area' for the EU." *Id.*
51. McKee et al., *supra* note 11, at 11.
52. *Id.* at 12.
53. *Id.*
54. *Id.*
55. Martin McKee & Elias Mossialos, *Health Policy and European law: Closing the Gaps*, 120 J. ROYAL INST. OF PUB. HEALTH 16, 18 (2006).
56. *Id.*
57. *Id.*

> European institutions; and to act as a preliminary reference procedure, in other words as a system whereby national courts can refer questions on European law to the Court.[58]

The Court had a limited role until 1963, when it developed three doctrines possibly defining its scope and power.[59] First, after the "Court decided that individuals had the right to invoke European Community law[,] . . . the principle of 'direct effect'" developed through which the Court could hold Member States liable for failing to implement treaty provisions into their national laws.[60] Second, "the Court developed the doctrine of 'state liability' whereby the state can be held liable for infringements of Directives."[61] Third, the Court may operate under the "supremacy doctrine," which allows the Court to apply European law when a conflict exists between the laws of two Member States.[62] The last doctrine gives the Court the authority to act against states who have not complied with different EU mandates.[63] In the absence of a strong health policy in EU treaties, the ECJ has recently become the legal entity to shape it.[64]

The decisions by the Court in *Decker*[65] and *Kohll*[66] demonstrated the willingness of the Court to address health-related disputes and remedy some of the vagaries of the EU's health policy.[67] Both cases involved citizens of Luxembourg who received care outside of their country and in another Member State.[68] Mr. Decker, who obtained spectacles, and Mr. Kohll who received orthodontic treatment, both prevailed in their arguments asserting the Luxembourg health insurance plan was accountable to reimburse them for their expenditures "even though it had not authorised their treatment abroad."[69] In these rulings, the Court established two important principles: 1) "the mutual recognition of qualifications precludes health authorities from arguing that care provided in one country is of lower quality than in another;"[70] and, although less clear, 2) "some saw [these cases] as establishing an important precedent—that health care should be subject to European laws on the free movement of

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58. *Id.*
59. *Id.*
60. *Id.*
61. McKee & Mossialos, *supra* note 55, at 19 (citing Case C-6/90 and C-9/90, Francovich & Bonifaci v. Italian Republic, 1991 E.C.R. I-5357).
62. *Id.* (citing Case 6/64, Costa v. E.N.E.L., 1964 E.C.R. I-585).
63. *Id.*
64. Mossialos & McKee, *supra* note 29.
65. Case C-120/95, Decker v. Caisse de Maladie des Employes Prives, 1998 E.C.R I-01831.
66. Case C-158/96, Kohll v. Union des Caisses de Maladie, 1998 E.C.R I-01931.
67. Mossialos & McKee, *supra* note 29.
68. *Id.*
69. *Id.*
70. *Id.*

people and services."[71]

Another ECJ decision in 2001, *BSM Geraets-Smits v. Stichting Ziekensfonds VGZ* and *HTM Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, substantiated the movement of the EU toward more EU control of health policy in the Member States.[72] In these cases, two Dutch citizens sought treatment in other Member States.[73] The ECJ addressed these cases after the defendant health insurance fund refused to reimburse the plaintiffs on the ground their situations did not require treatment from abroad or from an institution with which it had not contracted.[74] The Court ruled "that member states had the right to organise their health care systems as they chose, although they must comply with relevant European law."[75] Furthermore, "for the first time, and in the face of forceful arguments to the contrary, the court held that medical care provided in hospitals was subject to European law on free movement of services, regardless of how it is paid for."[76] The Court went so far as to add "demanding prior authorisation was an obstacle to free movement of patients but that this could, in certain circumstances, be justified."[77] This decision, coupled with the 1998 decisions of the ECJ, showed the ECJ was willing to shape an EU health policy; when different EU treaties have reserved authority over these areas to the Member States themselves, these rulings afforded greater authority to the EU to regulate the health policies of its

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71. *Id.*

72. Case C-157/99, BSM Geraets-Smits v. Stichting Ziekensfonds VGZ and HTM Peerbooms v. Stichting CZ Groep Zorgverzekeringen, 2001 E.C.R I-05473.

73. *Id.*

74. *Id.*

75. Mossialos & McKee, *supra* note 29.

76. *Id.*

77. *Id.* The circumstances the court discussed were lengthy and can be summarized accordingly:

> The first circumstance is when it prevents the national healthcare system from being undermined. The court argued that this could apply if large numbers of patients were involved but, by implication, was not relevant where numbers are small.
>
> A second is where the treatment is considered to be ineffective. The court held that decisions on effectiveness must be based on what is "sufficiently tried and tested by international medical science." Preauthorisation could be refused when the treatment had been deemed ineffective according to explicit criteria. This presupposes that there is a common medical paradigm in Europe, a view that pays little attention to the evidence of national diversity in health beliefs and treatment patterns.
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> The third relates to the timeliness of treatment. The court confirmed that authorities could decline authorisation only if the patient could receive the same or equally effective treatment in their own country without undue delay; however, it did not define "undue delay." Surprisingly, although waiting lists have been cited in requests by British citizens seeking treatment abroad, so far none has mounted a legal challenge as a means of obtaining faster care elsewhere.

Id.

Member States.[78]

3. Legislation

Although EU treaties and ECJ decisions have helped shape EU health policy, the different Directives the EU has passed have facilitated the unrestrained flow of physicians through the different Member States.[79] The EU has the capacity to pass legislation governing the Member States; some of it effectively "takes priority over national legislation . . . ."[80] European legislation may take many forms including Regulations, Directives, Decisions, Recommendations, and Opinions.[81] "Regulations are specific measures that have immediate and direct force of law without adaptation to national circumstances, common in areas such as external trade."[82] The EU most commonly uses Directives as legislative mechanisms "setting out the goals to be achieved but leaving it to each Member State to determine how to achieve them."[83] Once the EU passes a Directive, the Member States must incorporate the Directive into their national laws within a given time period.[84] Decisions are also legally binding, but usually do not have a general effect, and Recommendations and Opinions have no legally binding effect whatsoever.[85]

The EU has used four different phases of Directives to affect the mutual recognition of qualifications for physicians: "transitional, sectoral, general and legal."[86] Under the Transitional Directives, European countries focused on "the recognition of professional experience rather than mutual recognition of diplomas."[87] Sectoral Directives "establish[ed] minimum periods for educational and training programmes and comprise lists of diplomas that meet those standards in the various Member States. A diploma listed in the directive is automatically recognized in another EU Member State."[88] The general directives apply to those who have already completed the necessary training, but do not have a diploma listed under a Sectoral Directive.[89] The general directives do not apply to those who "want to exercise their profession in another state but have not yet completed the required training in their state of

78. *Id.*

79. *See* Fitzhugh Mullan, *The Metrics of the Physician Brain Drain*, 353 NEW ENG. J. MED.1810, 1812 tbl. 2 (2005).

80. McKee et al., *supra* note 11, at 10.

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id. See also* Amsterdam Treaty, *supra* note 27, art. 249.

85. McKee et al., *supra* note 11, at 10.

86. Rita Baeten & Yves Jorens, *The Impact of EU Law and Policy*, *in* HUMAN RESOURCES FOR HEALTH IN EUROPE, 217 (Carl-Ardy Dubois, Martin McKee & Ellen Nolte eds., 2006).

87. *Id.*

88. *Id.*

89. *Id.* at 219.

origin."[90] The legal directives are those recent decisions coming out of the ECJ, such as those previously mentioned,[91] "which have moved from facilitat[ing] the freedom of establishment . . . to ensur[ing] the free movement of services."[92] The progression of these directives has laid a statutory framework to support the free movement of health professionals in the EU.

To loosen the barriers within the health services sector, in 1975, the EC passed two Sectoral Directives[93] pertaining specifically to doctors which are commonly known as the "Doctors' Directives."[94] These Directives entitled "any EU physician who has completed basic training in a member state and who holds a recognised qualification to be automatically registered in any other Member state."[95] In 1986, the EC passed another Directive dealing with specific training for general practitioners.[96] The EC combined all three of these Directives in 1993 in Council Directive 93/16/EEC (Directive 93/16), which it proposed, "to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications."[97]

The 1993 Directive applied to the nationals of all Member States[98] and provided:

> [e]ach Member State shall recognize the diplomas, certificates and other evidence of formal qualifications awarded to nationals of Member States by the other Member States in accordance with Article 23 and which are listed in Article 3, by giving such qualifications, as far as the right to take up and pursue the activities of a doctor is concerned, the same effect in its territory as those which the Member State itself awards.[99]

The majority of the Directive dealt with the manner in which the different Member States would translate their respective qualification systems,[100]

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90. *Id.* at 219-20.

91. *See infra* notes 65, 66, and 72.

92. Baeten & Jorens, *supra* note 86, at 217.

93. *See* Council Directive 75/363, 1975 O.J. (L 167)(EC); Council Directive 75/362, 1975 O.J. (L 167)(EC).

94. Nicholas, *supra* note 3, at 83.

95. Steven Simoens & Jeremy Hurst, *The Supply of Physician Services in OECD Countries* (OECD Health Working Papers No. 21, 2006), *available at* http://www.oecd.org/dataoecd/27/22/35987490.pdf.

96. Council Directive 86/457, 1986 O.J. (L 267)(EC).

97. Council Directive 93/16, 1993 O.J. (L 165)(EC).

98. *Id.* art. 2.

99. *Id.* Article 3 was deleted by Council Directive 2001/19 and replaced with a reference to "Annex A," which reorganized and relisted those qualifications a foreign physician must meet to practice in another Member State. Council Directive 2001/19, art. 14(1)-(2), 2001 O.J. (L 206)(EC).

100. *See generally* Council Directive 93/19.

concerning not only general medicine, but specialized medicine as well.[101] This Directive was the culmination of the various efforts of the EU to apply its principles of free movement of goods and services to physicians.

Most recently, the European Parliament consolidated the 1993 Directive and replaced it with Directive 2005/36 (Directive 2005/36).[102] The 2005 Directive consolidated the numerous Sectoral Directives applicable to various regulated professions in the EU, all of which established the mutual recognition of qualifications in each respective profession.[103] Similar to the 1993 Directive, the 2005 Directive stated:

> [e]ach Member State shall recognise evidence of formal qualifications as doctor giving access to the professional activities of doctor with basic training and specialised doctor. . . listed in Annex V, points 5.1.1, 5.1.2, . . . respectively, which satisfy the minimum training conditions referred to in Articles 24, 25, . . . respectively, and shall, for the purposes of access to and pursuit of the professional activities, give such evidence the same effect on its territory as the evidence of formal qualifications which it itself issues.[104]

Annex V lays out the different formal qualifications (diplomas) each host state should recognize from the physician's home state.[105] Articles 24 through 30 explain the specific minimal criteria general medicine and specialist physicians must meet.[106] The efforts of the EU Parliament to consolidate these Directives to establish a uniform health care principle, the mutual recognition of qualifications, throughout its various states indicates the EU Parliament is increasingly trying to improve the delivery of health care in the EU.

What is clear from the EU's approach to its health policy is that there is *no* clear policy or mandate to the Member States.[107] EU treaties have been reluctant to regulate the health systems of the Member States as a whole.[108] While the ECJ has more recently pushed for greater regulation from the EU, it can only act insomuch as the cases it receives allow it. EU legislation has

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101. Council Directive 93/16, art. 5.

102. Council Directive 2005/36, preamble, para. 9, 2005 O.J. (L 255)(EC). Directive 2005/36 is the latest Directive amending Directive 93/16, but it effectively replaces it; whereas, none of the previous amending Directives had this effect. For a full list of those Directives amending Directive 93/16, see Europa.eu, Medicine: Mutual Recognition of Qualifications, http://europa.eu/scadplus/leg/en/lvb/l23021.htm# AMENDINGACT (last visited Jun. 10, 2008).

103. Council Directive 2005/36, preamble, para. 9.

104. *Id.* art. 21.

105. *Id.* Annex V.

106. *Id.* arts. 24-30.

107. *See generally* Duncan, *supra* note 22; McKee & Mossialos, *supra* note 55; McKee et al., *supra* note 11.

108. McKee et al., *supra* note 11, at 10-11. *See also* McKee & Mossialos, *supra* note 55, at 18.

paved the way for health care professionals to move between the Member States; however, it has failed to go beyond that point and regulate against the potentially adverse effects these mandates may have on the health care systems of its Member States.

C. The Feared Effect

Although the EU has championed the free movement of its workers, including physicians, its mandates may pose serious threats to the health care workforces of some of its Member States.[109] The Directives would allow for what some have called "physician migration," where, under systems of mutual recognition and diplomas, physicians may move from one country and receive education or practice medicine in another country.[110] One scholar appropriately captured the problem, noting:

> the ongoing process of integration of EU countries and the removal of many barriers to professional mobility pose a direct challenge to the maintenance of an equitable workforce because of the real potential to deprive some regions and countries of key staff that can be attracted elsewhere by better paid jobs and enhanced working conditions.[111]

Physicians may choose to practice in other countries for various economic and professional reasons.[112] The economic incentives and the hope of a better lifestyle lure some physicians to practice in other countries where these goals can be realized.[113] Also, physicians may choose to move abroad because their home countries do not provide the high level of training or research opportunities they seek.[114] The prospect of unemployment in the home country of a physician may also drive him or her to seek employment in another country.[115] Furthermore, physicians may choose to return to practice abroad after returning home from their educational hiatus because another country has trained them to perform certain procedures the home country does not need or

109. Forcier et al., *supra* note 6.

110. *Id.*

111. Dubois et al., *supra* note 8, at 11.

112. Peter E. Bundred & Cheryl Levitt, *Medical Migration: Who Are the Real Losers?*, 356 THE LANCET 225, 245-46 (2000). In this article, one Ugandan doctor characterized the sober reality of this proposition in her comments indicating she "was seeking employment locally because she felt that the UK offered her children a better life." *Id.*

113. *Id. See also* James Buchan & Alan Maynard, *United Kingdom*, *in* THE HEALTH CARE WORKFORCE IN EUROPE: LEARNING FROM EXPERIENCE 139 (Bernd Rechel et al., eds., 2006) (noting " [b]y sharply raising the salaries of consultants and general practitioners, recruitment and retention are likely to be enhanced, with the United Kingdom becoming even more attractive to doctors from abroad").

114. Bundred & Levitt, *supra* note 112, at 246.

115. Nicholas, *supra* note 3, at 91-92.

because the work they find themselves doing is "unstimulating."[116]

Physician migration affects the home country and the host country in very different ways.[117] The effect of physician migration on host countries is usually more beneficial than the effect on the home country.[118] An increased supply of physicians in one country resulting from hosting foreign physicians may benefit its consumers, allowing greater access to physicians and potentially lower costs.[119] This is particularly important in countries which heavily rely on foreign physicians, such as the United Kingdom, to meet health services demands.[120] Furthermore, "[i]ncreased competition between physicians may raise the quality of health care provided in the host country."[121]

Despite the benefits physician migration may provide host countries, the home countries of the physicians pay the heaviest price.[122] Some have referred to the flight of physicians to foreign countries as a depletion of human capital which results in "brain drain."[123] The effect of brain drain includes "deterioration in the working conditions of remaining physicians. Moreover, it may affect access to and quality of care, and impair the ability of the health care system to achieve health objectives for its population."[124] Brain drain "may also influence the capacity of the home country to provide quality training to new physicians and the research capacity of medical schools."[125] Moreover, home countries will suffer economic losses where they pay to educate citizens who leave after graduation to work in another country.[126] The broader implications of brain drain include that it occurs generally in poor countries

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116. Bundred & Levitt, *supra* note 112, at 246.

117. *See* Mullan, *supra* note 79.

118. *See id.*

119. Nicholas, *supra* note 3, at 92.

120. Mullan, *supra* note 79, at 1816. In this article, the author highlighted the UK's reliance on foreign physicians, alluding to the United Kingdom's policy in a recent year, "to achiev[e] a rapid increase of 9500 physicians by a combination of new medical schools and increased recruitment abroad." *Id.* The driving
forces of this policy are evident when:

> between 1985 and 1994, the 27 countries that make up Organisation of Economic Co-operation and Development (OECD) increased the output from their medical schools by an average of 26%. (cite omitted). However, in the UK, USA, and Canada the increase was only 14%, 10%, and 18%, respectively, the shortfall being made up by physicians trained overseas. In the UK, many of the foreign doctors who now work in the National Health Service, initially came from higher level training in specialist subjects.

Bundred & Levitt, *supra* note 112, at 245.

121. Forcier et al., *supra* note 6.

122. Mullan, *supra* note 79, at 1816. The article articulates this effect clearly by stating, "[a]lthough there are undoubtedly benefits that accrue to source countries whose physicians move to high-income English-speaking nations, there can be little question that the emigration of these physicians is also a loss to the health systems of the source countries." *Id.*

123. Forcier et al., *supra* note 6; Mullan, *supra* note 79.

124. Forcier et al., *supra* note 6.

125. *Id.*

126. *Id.*

already facing physician shortages of their own.[127] The resulting "inadequacy and instability of the physician workforce in many lower-income countries are major impediments to disease-reduction initiatives sponsored by the Global Fund, the WHO, the World Bank, the U.S. government, and many others."[128]

As long as the EU fails to regulate the movement of its physicians, the physicians will most likely exercise their ability to move between the Member States at their discretion. The effect of physician migration will thus go untamed, potentially hampering the ability of developing countries of the EU to establish adequate health care delivery to their citizens, which could ultimately present a public health problem for the EU.[129] Regardless, it is still questioned whether the free movement of physicians in the EU threatens the health care systems of its Member States to the extent EU intervention and regulation is required.

II. ANALYSIS

Although there has been much discussion of the potential effect physician migration may have on developing EU countries, its actual effect remains unclear.[130] The second part of this Note will analyze the health care systems of two EU countries, England and Spain, and the manner in which these countries have implemented the EU Directives facilitating the free movement of physicians in and out of their countries. Ultimately, this portion of the Note will discuss the actual effect of the Directives on those countries and other EU countries, specifically those countries which have recently acceded to the EU.

A. The United Kingdom

1. The National Health Service

Whenever scholars discuss the topic of physician migration in the European context, the United Kingdom (UK) is a central focus of the debate because the UK continually suffers from physician shortages and has a great need for foreign physicians.[131] The NHS "covers everything from antenatal screening and routine treatments for coughs and colds to open heart surgery,

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127. *Id.*

128. Mullan, *supra* note 79, at 1816.

129. *Id.*

130. Katka Krosnar, *Could Joining EU Club Spell Disaster for the New Members?*, 328 BRIT. MED. J. 310 (2004), *available at* http://www.bmj.com/cgi/reprint/328/7435/310.pdf.

131. Zurn et al., *Imbalances in the Health Workforce* (WHO Briefing Paper, Mar. 2002), 1-55, 5, *available at* http://www.who.int/hrh/documents/en/imbalances_briefing.pdf. *See also* Bob Pond & Barbara McPake, *The Health Migration Crisis: The Role of Four Organisation for Economic Cooperation and Development Countries*, 367 THE LANCET 1448, 1449 (2006).

accident and emergency treatment and end-of-life care."[132] With an estimated budget of 90 billion pounds in 2007 and over a million employees, the NHS is one of the largest employers in the world.[133]

The Department of Health is the governmental entity responsible for the administration of services, which the NHS manages.[134] It controls the administration of these services through entities called Strategic Health Authorities (SHAs), of which there are now ten.[135] The SHAs are responsible for 152 Primary Care Trusts (PCTs) that oversee England's 29,000 general practitioners and 18,000 NHS dentists.[136] PCTs purchase health care services from local providers and also support local NHS organizations.[137] PCTs ensure local providers administer services efficiently, and PCTs are responsible for "mak[ing] sure that the organisations providing health and social care services are working effectively."[138] Most general practitioners, dentists, opticians, and other local providers contract directly with PCTs to provide services.[139] On the other hand, the NHS owns and runs its own hospitals and employs those physicians and nurses who work in there.[140]

Public sources provide the primary means of funding for the NHS.[141] In 2004, public sources accounted for 86% of the total funding for health care services.[142] With these funds, the UK spent $2,545 per capita on health care.[143] This amount was slightly lower than the average of $2,550 spent in the same year by other OECD[144] countries; health indicators in the UK showed the UK

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132. National Health Service, About the NHS, http://www.nhs.uk/aboutnhs/pages/about.aspx (last visited Jul. 8, 2008).

133. *Id*

134. *Id.*

135. *Id.*

136. National Health Service, NHS Structure, http://www.nhs.uk/aboutnhs/HowtheNHSworks/Pages/ NHSstructure.aspx (last visited Jul. 8, 2008).

137. National Health Service, NHS Authorities and Trusts, How the NHS Works, http://www.nhs.uk/ aboutnhs/howthenhsworks/authoritiesandtrusts/Pages/Authoritiesandtrusts.aspx (last visited Jul. 8, 2008). PCTs are the heart of the NHS and control 80% of its budget. *Id.*

138. National Health Service, *supra* note 132.

139. National Health Service, *supra* note 137.

140. *Id.*

141. Organisation of Economic Co-operation & Development, *Health Data 2006: How Does the United Kingdom Compare*, at 2, *available at* http://www.oecd.org/dataoecd/29/53/36959993.pdf [hereinafter OECD UK].

142. *Id.* Comparatively speaking, the OECD average level of public financing for a health care system in 2004 was 73% and the public funding of health care in the United States was 45%. *Id.*

143. *Id.* at 1.

144. Organisation for Economic Co-operation & Development, About OECD, at http://www.oecd.org/pages /0,3417,en_36734052_36734103_1_1_1_1_1,00.html (last visited Feb. 9, 2008).

> The OECD brings together the governments of countries committed to democracy and the market economy from around the world to:

was struggling to keep up with these countries as well.[145] In 2003, life expectancy was 79 years, just above the OECD average, but still lower than France, Italy, and Spain, among others.[146] Furthermore, although the UK's infant mortality rate has declined over the past decades and currently stands at 5.1 deaths per 1,000 citizens, its rate still lags behind most other European countries.[147] In light of these outcomes, "[t]here is evidence to suggest that higher densities of physicians tend to be associated with better health outcomes and responsiveness across countries . . . ."[148] Specifically, other academic work "has suggested that the number of physicians per capita is inversely associated with avoidable mortality. . . ."[149] Although the health care system of the UK may appear to have sound infrastructure and adequate capitalization, its shortage of physicians may greatly contribute to its deficient health care indicators.[150]

2. The UK's Implementation of EU Mandates

In the UK, the General Medical Council (GMC) governs and oversees the recognition of the professional qualifications of domestic and foreign physicians.[151] The Medical Act of 1858[152] established the GMC, which is

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> • Support sustainable economic growth
> • Boost employment
> • Raise living standards
> • Maintain financial stability
> • Assist other countries' economic development
> • Contribute to growth in world trade
> The OECD also shares expertise and exchanges views with more than 100 other countries and economies, from Brazil, China, and Russia to the least developed countries in Africa.

Id.

145. OECD UK, *supra* note 141, at 2-3. OECD countries include: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, United Kingdom, and the United States. Organisation of Economic Co-operation & Development, OECD Members and Partners, http://www.oecd.org/pages/0,3417,en_36734052_36761800_1_1_1_1_1,00.html (last visited Jul. 3, 2008).

146. OECD UK, *supra* note 141. In 2005, France posted a life expectancy of 80.3 years; Italy of 80.4 years; and Spain of 80.7 years. Organisation of Economic Co-operation & Development, *Health Data 2007: Frequently Requested Data*, http://www.oecd.org/dataoecd/46/36/38979632.xls (last visited Jan. 19, 2007)[hereinafter OECD Data].

147. OECD Data, *supra* note 146. In 2005, France had an infant mortality rate of 3.6 infant deaths per 1,000 births; Germany, 3.9 infant deaths per 1,000 births; Italy, 4.7 infant deaths per 1,000 births; and Sweden, 2.4 infant deaths per 1,000 births. *Id.*

148. Simoens & Hurst, *supra* note 95, at 15. This paper also notes "the magnitudes of the effects cannot be estimated with any degree of reliability from international comparisons." *Id.*

149. *Id.*

150. *Id.* at Fig. 4.

151. General Medical Council, *The Role of the GMC*, http://www.gmc-uk.org/about/role/index.asp (last visited Jun. 10, 2008).

composed of thirty-five members.[153] Its official purpose is to "protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine."[154] The Medical Act of 1983 most recently validated the existence and role of the GMC.[155] The UK has used the 1983 Act and its amendments as legislative vehicles to implement the major provisions of Directives 93/16, and now Directive 2005/36.[156]

In Section 3, the Act readily implements the provisions of Directive 2005/36, acknowledging:

> subject to the provisions of this Act any person whose fitness to practise is not impaired and who—
>
> (a) holds one or more primary United Kingdom qualifications and has satisfactorily completed an acceptable programme for provisionally registered doctors; or
>
> (b) being a national of any relevant European State, holds one or more primary European qualifications,

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152. Medical Act, 1858, 21 & 22 Vict., c. 90 (Eng.).

153. General Medical Council, *supra* note 151. The GMC is composed of: 19 doctors who registered doctors elect; 14 members of the public who the NHS Appointments Commission chooses; and 2 members that the universities and medical royal colleges elect. *Id.*

154. *Id.*

155. Medical Act, 1983, c. 54 (Eng.). The role of the GMC was specifically validated in Part I where it states "[t]here shall continue to be a body corporate known as the General Medical Council . . . having the functions assigned to them by this Act." Medical Act, ch. 54 § 1. One of these functions is immediately stated afterwards as registering and keeping a list of foreign practitioners. *Id.* § 2.

156. *See generally* Medical Act, c. 54. The UK has subsequently amended the Medical Act, which in 1983 could not have possibly reflected Directive 93/16, which the EU issued in 1993. The Acts that amended the Medical Act of 1983 are as follows:

> the Professional Performance Act 1995; the European Primary Medical Qualifications Regulations 1996; the NHS (Primary Care) Act 1997; the Medical Act (Amendment) Order 2000; the Medical Act 1983 (Provisional Registration) Regulations 2000; the Medical Act 1983 (Amendment) Order 2002; and the National Health Service Reform and Health Care Professionals Act 2002; The European Qualifications (Health Care professions) Regulations 2003 [and] the European Qualifications (Health & Social Care Professions and Accession of new Member States) Regulations 2004.

General Medical Council, Medical Act of 1983, http://www.gmc-uk.org/about/legislation/medical_act.asp (last visited Jan. 26, 2008). Most recently, the UK's Department of Health has issued regulations to amend the Medical Act and implement the provisions of Directive 2005/36. The European Qualifications (Health and Social Care Professions) Regulations, 2007, S.I. 2007/3101 (UK) [*hereinafter* Regulations]. However, the amendments from this regulation largely replace the groundwork laid by Directive 93/16. *E.g.* Regulations, Part 2, 5(c) (noting one of the places where the amendments are specifically replacing provisions set forth by Directive 93/16).

> is entitled to be registered under this section as a fully registered medical practitioner.[157]

The language is greatly similar to the purposes set forth for Directive 2005/36 itself, which state each Member State in the EU should recognize the qualifications of a physician who holds "specific professional qualifications" from another Member State.[158]

Section 17 clarifies these specific professional qualifications, defining what primary European qualifications mean for purposes of Section 3(b).[159] A physician satisfies the standard of a primary qualification as long as he/she holds the credentials from his/her home state listed in Annex 5.1.1 of Directive 2005/36 and meets any other applicable criteria in subsection(a).[160] Section 17 also requires the UK Registrar be satisfied the physician has met the general standards set forth in Article 24[161] of Directive 2005/36 and a competent authority from the physician's home state certify the physician "has effectively and lawfully been engaged in medical practice in that State for at least three

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157. Medical Act, c. 54 § 3.

158. Council Directive 2005/36, art. 1.

159. Medical Act, c.54 §17(1).

160. *Id.* § 17(1)(a).

161. Article 24 provides fundamental standards a physician from a relevant European state must meet to practice in another Member State:

> 1. Admission to basic medical training shall be contingentupon possession of a diploma or certificate providing access, for the studies in question, to universities.
>
> 2. Basic medical training shall comprise a total of at least sixyears of study or 5 500 hours of theoretical and practical training provided by, or under the supervision of, a university.
> For persons who began their studies before 1 January 1972, the course of training referred to in the first subparagraph may comprise six months of full-time practical training at university level under the supervision of the competent authorities.
> 3. Basic medical training shall provide an assurance that the person in question has acquired the following knowledge and skills:
> (a) adequate knowledge of the sciences on which medicine is based and a good understanding of the scientific methods including the principles of measuring biological functions, the evaluation of scientifically established facts and the analysis of data;
> (b) sufficient understanding of the structure, functions and behaviour of healthy and sick persons, as well as relations between the state of health and physical and social
> surroundings of the human being;
> (c) adequate knowledge of clinical disciplines and practices, providing him with a coherent picture of mental and physical diseases, of medicine from the points of view of
> prophylaxis, diagnosis and therapy and of human reproduction;
> (d) suitable clinical experience in hospitals under appropriate
> supervision.

Council Directive 2005/36, art. 24. *Cf.* Council Directive 93/16, art. 23.

consecutive years during the five years preceding the date of the certificate."[162]

Finally, Section 15A of the Act allows the GMC to provisionally register foreign physicians so foreign physicians may eventually achieve primary European qualification.[163] Under this Section, the GMC gives those who it has determined have adequate training[164] or level of education, meaning a medical degree meeting the standards set forth in Directive 2005/36,[165] the opportunity to attain the appropriate amount of clinical experience likely needed to meet the standard of primary European qualification the Act requires.[166] The Medical Act demonstrates how an EU country may implement a legislative scheme that an EU directive would propose. In this case, it allows for the free movement of physicians from other countries in the EU to potentially practice in the UK through the GMC's mutual recognition of their qualifications.

The Directives encouraging the mutual recognition of physician qualifications may not have posed any apparent problems when the EU initially implemented them in 1975; however, when ten new countries were set to enter the EU in 2004, and subject themselves to the EU laws allowing for the free movement of physicians, the UK became concerned with a potentially great influx of foreign physicians.[167] Nevertheless, an influx of physicians would invariably help the UK relieve its physician shortages. At the same time, it could end up costing other countries valuable medical human resources.[168]

3. *The Effect of Physician Movement on the United Kingdom*

The UK suffers from a shortage of physicians.[169] However, EU laws allowing for the free movement of physicians, which the UK has adopted through the Medical Act of 1983 that implements the provisions of Directives 93/16 and 2005/36, allow the UK to draw from the physician supplies of other countries. Statistics are particularly revealing of physician shortages in the UK.[170] As mentioned above, the UK has 2.3 practicing physicians per 1000 persons, which, although it is up from 1998 when it only supplied 1.9 physicians per 1000 persons, still lags behind the OECD average of 3.0 physicians per 1000 persons.[171] The shortage became apparent "[where]

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162. *Id.* § 17(2)(a)-(b).

163. Medical Act, c. 54 § 15A.

164. *Id.* § 15A(2).

165. *Id.* § 15A(5).

166. *Id.*

167. Rhona MacDonald, *What Will Happen in the United Kingdom When the 10 Accession States Join the European Union?*, 328 BRIT. MED. J. 89, 89 (2004), *available at* http://careerfocus.bmj.com/cgi/ reprint/328/7438/89.

168. Simoens & Hurst, *supra* note 95, at 50.

169. Buchan & Maynard, *supra* note 113, at 130 (indicating "[s]hortages of skilled staff have been highlighted as one of the main obstacles to achieving NHS targets. A report issued in 2002 stressed that 'the UK does not have enough doctors and nurses'").

170. *See* OECD UK, *supra* note 141.

171. *Id.*

physician shortages [could] be observed in three-month vacancy rates of 4.7% of all specialist physicians posts and 3.3% of all primary care physician posts in England in the year to March 2003."[172]

In response to this problem, the UK has engaged in various recruitment programs to attract foreign doctors to the UK.[173] EU laws make this particularly effortless by allowing other doctors from EU Member States instant opportunities for the UK to recognize their qualifications.[174] The NHS has used these laws to its advantage, professing "[t]o further boost NHS staff numbers in the short term, the Department of Health will work with the leaders of the professions and with other government departments to recruit additional suitably qualified staff from abroad where this is feasible, meets service priorities and complies with NHS quality standards."[175] The NHS has indicated, "[t]here will be targeted, nationally co-ordinated campaigns using short term contracts to boost the number of medical consultants and the overall number of doctors in the next three years."[176] These laws make it easier for the

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172. Simoens & Hurst, *supra* note 95, at 20.

173. *Id.* at 36. *See also* Mullan, *supra* note 79 (in the last decade, the United Kingdom has stated it would try to increase its physician supply by 9,500 doctors through recruitment and new medical schools). *See also* Pond & McPake, *supra* note 131, at 1449.

174. *See* Council Directive 2005/36, art. 21.

175. NATIONAL HEALTH SERVICE, THE NHS PLAN: A PLAN FOR INVESTMENT; A PLAN FOR REFORM, 1-144, 55, *available at* http://www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf. *See also* Buchan & Maynard, *supra* note 113, at 131, 136-37. The policies the UK has sought to increase its physician supplies are as follows:

> 1. Entry to medical schools has been increased by 30% by creating new medical schools and increasing entries to existing schools.
> 2. Changes in skill mix. Nurses are being trained to take over doctors' roles and a new grade of "consultant nurse" is being developed in English hospitals. Outside hospitals, nurses are being trained to dispense pharmaceuticals. While such skill mix changes may compensate for shortages of doctors, they might increase nurse shortages.
> 3. Incentive systems to enhance recruitment and retention have been put in place.
> 4. International recruitment. Considerable efforts have been put into recruiting more doctors from overseas. The United Kingdom has traditionally recruited doctors from the Indian subcontinent and the Middle East and over 25% of the existing doctor stock has been trained overseas. The new recruitment drive has focused on countries with a surplus, such as Spain, but despite attempts to avoid recruitment from developing countries, it has also attracted many doctors from countries such as South Africa. A Code of Practice on international recruitment has now been enacted, although the private sector is not bound by it.
>
> These policies have facilitated an increase in the number of physicians. However, their effectiveness has been reduced by other developments. The EU Working Time Directive and NHS reforms creating a "consultant-led service" have reduced the number of hours worked, making supply deficiencies more evident. In addition, scandals related to medical practice, which have had wide circulation in the national media, appear to have encouraged much greater caution by practitioners, leading to slower processes of care.

Id.

176. NATIONAL HEALTH SERVICE, *supra* note 175, at 55. In light of the recruitment efforts of the NHS, it has also adopted an ethical code in its recruiting, pledging to abstain from

UK to promote employment in the NHS to other countries to sustain the proposed staff expansion growth of the NHS.[177] While these efforts may relieve the UK of its physician shortages, these efforts may come at the expense of exploiting the physician supplies of other countries and, ultimately, their public health predicaments.[178]

Although the UK may draw physicians from other EU countries, statistics show the UK does not necessarily draw a high percentage of physicians from these countries.[179] In 2001, 37.3% of the UK's physician workforce consisted of foreign physicians.[180] However, upon close examination, one would find the majority of the physicians who make up this 37.3% of foreign physicians in the UK are not from EU countries: 18.3% are from India; 15.2% are from Ireland; 7% are from South Africa; and 12.3% are from other parts of Africa.[181] In comparison, 4.0% of the physicians composing the 37% of foreign physicians in the UK are from Germany, 2.6% are from Spain, and 1.6% are from Poland.[182] Despite the efforts by the UK to remedy its shortages through relying on a low percentage of physicians trained in other EU countries, this percentage still represented 5,212 doctors from other EU countries - 5,212 doctors some underdeveloped countries of the EU probably valued very highly.[183]

EU laws facilitate the free movement of physicians between EU countries; the UK greatly benefits as a result. The UK has implemented the fundamental principles of Directive 2005/36 into its laws to ensure the recognition of the qualifications of EU physicians as long as the EU physicians meet certain requirements ultimately set out in the Directive.[184] As a result, the UK may take advantage of other physician pools in EU countries to relieve its shortages. While it does not primarily target EU physicians in its recruitment efforts it still recruits physicians from the EU, and it recruits them from less developed countries.[185] Across the English Channel, Spain faces an entirely different situation than the problem of physician shortages confronting the UK.

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recruiting from countries suffering from physician shortages. Pond & McPake, *supra* note 131, at 1453.

177. NATIONAL HEALTH SERVICE, *supra* note 175, at 55.

178. Pond & McPake, *supra* note 131, at 1453 (noting "[t]he small amount of analysis up to now comparing the volume of health worker flows suggests that the UK benefits more than other high-income countries from health worker emigration from the poorest countries").

179. Buchan, *supra* note 10, at 49.

180. Simoens & Hurst, *supra* note 95, at 33.

181. *Id.* at 34 tbl. 4.

182. *Id.*

183. NHS Hospital & Community Health Services, *Medical and Dentist Workforce Census*, at 13 tbl. 4, *available at* http://www.ic.nhs.uk/webfiles/publications/nhsstaff/Med%20and%20Den%20bulletin%201995%20to%202005.pdf (last visited Jul. 3, 2008).

184. *See* Medical Act, c. 54 § 17 (implementing the criteria of Council Directive 2005/36, arts. 21, 24).

185. Simoens & Hurst, *supra* note 95, at 34 tbl. 4.

B. Spain

1. Sistema Nacional de Salud

The health care problems of Spain are completely opposite of those in the UK; Spain suffers from physician surpluses, and it is very difficult for domestic and foreign physicians to practice medicine in Spain.[186] Furthermore, it does not appear Spain has implemented Directive 2005/36; therefore, the system of recognizing the qualifications of physicians in Spain abides by the standards set forth in Directive 93/16.[187] Although the EU's system may not relieve Spain's surpluses, its participation in the EU allows the doctors trained in Spain to move abroad, thereby relieving Spain from its physician surplus.

The health care system in Spain is called el Sistema Nacional de Salud (SNS), or in English, the "National Health System."[188] The Ley General de Sanidad de 1986 ("National Health Act of 1986" (NHA)) established the SNS as it fundamentally exists today. The NHA established the SNS hoping the SNS would achieve "universal coverage . . . and foster decentralization."[189] In Spain, the governmental entity that oversees health related matters is the Ministerio de Sanidad y Consumo (Health and Consumption Ministry), under which its central organ, INSALUD,[190] oversees the SNS.[191] The Spanish health care system depends not only the function of INSALUD, but also on the function of the various Comunidades Autonomas (Autonomous Communities) primarily managing the local delivery of health care.[192] Ideally, these Autonomous Communities would develop their own regional health plans and

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186. Organisation for Economic Co-operation & Development, *OECD Health Data: How Does Spain Compare?*, at 2, *at* http://www.oecd.org/dataoecd/27/6/36972440.pdf (last visited Jun. 10, 2008) [hereinafter OECD Spain]; Elaine Duncan, *Working in Spain*, 316 BRIT. MED. J. 7145, 7145 (1998), *available at* http://www.bmj.com/cgi/content/full/316/7145/S2-7145. *But see* Beatriz González López-Valcárcel & Carmen Delia Dávila Quintana, *Spain*, *in* THE HEALTH CARE WORKFORCE IN EUROPE: LEARNING FROM EXPERIENCE 116 (Bernd Rechel et al. eds., 2006) (stating "[t]here is thus some contention about whether there are too many or too few doctors in Spain (citation omitted). While the emergence of unemployment since the 1980s in the medical profession points to an oversupply of physicians, Spain remains below the European average in terms of employment in the *health sector*"(emphasis added)).

187. Ministerio de Educacion y Ciencia, Estancias Formativas de Ciudadanos Extranjeros En Centros Espanoles Acreditados para la Docencia, http://www.msc.es/profesionales/formacion/estancias Formativas.htm (last visited Mar. 15, 2008).

188. MINISTERIO DE SANIDAD Y CONSUMO, SISTEMA NACIONAL DE SALUD, 1, *available at* http://www.msc.es /organizacion/sns/docs/LIBRO-BAJA.pdf.

189. Eunice Rodriguez et al., *The Spanish Health Care System: Lessons for Newly Industrialized Countries*, 14 HEALTH POL'Y & PLAN. 164, 166 (1999), *available at* http://www.ub.es/epp/salud/health.pdf# search=%22spanish%20care %20system%22.

190. INSALUD is an abbreviation for Insituto Nacional de Salud, which in English, means the "National Institute of Health."

191. MINISTERIO DE SANIDAD Y CONSUMO, *supra* note 188, at 17.

192. Rodriguez et al., *supra* note 189, at 167-68.

manage their administration to local Spaniards.[193] In actuality, only seven of the seventeen Autonomous Communities had accomplished this level of administration as of 1999. At this time, INSALUD still managed the regional administration of health care through the other ten Autonomous Communities.[194]

At the local level, health care providers deliver their services through two main centers.[195] The first is Atencion Primaria (Primary Care), where health care providers locally administer services in Centros de Salud (Health Centers).[196] Health Center providers seek to offer Spanish citizens a basic level of care and aim to situate themselves fifteen minutes from each Spanish citizen's residence.[197] Health Centers employ family physicians, pediatricians, nurses, and spaces for social workers and physical therapists.[198] The second set of centers through which health care providers deliver services are Centros de Especialdades y Hospitales (Specialist and Hospital Centers), where physicians render specialty outpatient and inpatient care.[199]

The SNS funds health care services through a mix of two sources: taxes and each Autonomous Community's budget.[200] Generally, taxes constitute 90% of the funding and social security supplies the remaining 10%.[201] SNS primarily pays Spanish physicians in the form of salaries the government formulates by taking into account the number of years SNS has employed a physician and if a physician has continually served in a full-time capacity.[202]

Whether Spain finds its health care desirable or not, the SNS is imploded with physicians.[203] In the early 1990's, the amount of practicing physicians doubled; consequently, it provided 4.8 physicians per 1,000 inhabitants, more than twice the number of physicians per 1,000 inhabitants in the UK in the early 1990's [204] Although these surpluses may have benefited the SNS, great unemployment existed among doctors in Spain in the late 1980's, exposing the beginnings of continuing physician surpluses.[205]

Despite high levels of physician unemployment, the SNS has performed well compared to other OECD countries.[206] It spent a total of 8.1% of its GDP on health care, which is slightly below the OECD average of 8.9%.[207] It also

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193. *Id.*
194. *Id.*
195. *See* MINISTERIO DE SANIDAD Y CONSUMO, *supra* note 188, at 31-32.
196. *Id.* at 31-32.
197. *Id.* at 32.
198. *Id.*
199. *Id.*
200. *Id.* at 27.
201. Rodriguez et al., *supra* note 189, at 167.
202. *Id.* at 169.
203. *See id.*
204. *Id.*
205. *Id.* (noting physician unemployment levels of 20%).
206. *See* OECD Spain, *supra* note 186, at 2.
207. *Id.* at 1.

spent less per capita for health care than the OECD average, with expenditures in 2004 of $2,100, compared to the average OECD country expenditure of $2,550.[208] Despite indications of low spending on health care in Spain, it has steadily increased its health expenditures "by 5.6% per year on average" and boasts "more physicians per capita than . . . most other OECD countries."[209]

Spain's health indicators also demonstrate its apparent success: "In 2004, life expectancy at birth in Spain stood at 80.5 years, more than two years higher than the OECD average (78.3 years). Only Japan, Switzerland, Sweden and Australia registered a higher life expectancy than Spain in 2004."[210] Also, the infant mortality rate in Spain was significantly less than the OECD average of 3.5 deaths per 1,000 live births in 2004 and an average of 5.7 deaths per 1000 births on average across OECD countries.[211] Thus, the SNS spends less than the average OECD country on its health care, but Spain's indicators show its citizens do not suffer as a result.

2. *Spain's Implementation of EU Law*

While Spain does not appear to have implemented Directive 2005/36, it still heavily bases its system of mutual recognition of qualifications in the predecessor of Directive 2005/36, Directive 93/16.[212] The entity that recognizes, coordinates, and is in charge of the recognition of qualifications of foreign physicians is the Ministerio de Educacion y Ciencia (Ministry of Science and Education)(MECD).[213] Within the MECD, the Subdireccion General de Titulos, Convalidaciones, y Homologaciones is recognizes degrees from physicians from other EU nations in accordance with EU directives, such as Directive 93/16.[214] To practice in Spain, a foreign physician qualified in the EU must submit official documents through competent authorities in accordance with the jurisdictional policies of the foreign physician's home country.[215] However, one need not convert these documents to Spanish credentials or legalize them if these documents are sent from Member States of

208. *Id.* at 2.

209. *Id.* at 2.

210. *Id.* at 2.

211. OECD Spain, *supra* note 186, at 2.

212. Ministerio de Educacion y Ciencia, *supra* note 187 (noting licensed practitioners of Member States may practice in Spain if they have met those basic requirements set forth in Directive 93/16 and those Directives which subsequently amended it and were also transposed into law).

213. Ministerio de Educacion y Ciencia, Reconocimiento de Titulos Regulados por Directivas de la Union Europea a Efectos Profesionales, *at* http://www.mec.es/mecd/jsp/plantilla.jsp?id=81&area=titulos (last visited Jun. 10, 2008) [hereinafter Titles].

214. Ministerio de Educacion, Cultura y Deporte, La Subdirrecion General de Titulos, Convalidaciones y Homologaciones, http://www.mec.es/mecd/jsp/plantilla.jsp?id=99&area=titulos (last visited Jun. 10, 2008).

215. Titles, *supra* note 213.

the EU.[216] To satisfy these basic requirements, it is most likely a physician must present a certified copy of his/her academic and professional title, certified documents of nationality, and the official Spanish translation of his/her academic and professional title to the Subdireccion General de Titulos, Convalidaciones, y Homologaciones.[217]

Spain has implemented these requirements reflecting the provisions of Directive 93/16 through regulations named Real Decretos.[218] Real Decreto 1691/1989 instituted the Sectoral Directives preceding Directive 93/16,[219] and Real Decreto 2072/1995 amended Real Decreto 1691/1989 to implement the provisions of Directive 93/16, which still govern Spain's system of mutual recognition of qualifications for physicians.[220]

The system of mutual recognition of qualifications in Spain is based on the principle of mutual trust; professionals who are completely qualified to exercise a profession in their home state are deemed qualified to be recognized to practice that profession in Spain.[221] Such a policy reflects Directive 93/16 set out in Article 2 propogating this mutual trust.[222] However, some have observed Spain's system is lacking, indicating:

> there will come a point when you become extremely disoriented by the whole process. Senior males will suffer most, whereas women will more quickly recognize that 'glass ceiling' feeling, when nobody blatantly turns around and says 'forget it' but a distinct lack or progress is being made. Much has been written about EC directive 93/16/EEC and if David MacLachlan is right this seems to run smoothly in Germany.

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216. *Id.*

217. Ministro de Educacion y Ciencia, Documentacion Basica para el Reconocimiento, http://www.mec.es/ mecd/jsp/plantilla.jsp?id=86&area=titulos (last visited Jun. 10, 2008) (see bullet points under "Para las profesiones reguladas por Directivas Sectoriales").

218. Real Decreto 1691/1989, Por El que se Regulan el Reconocimiento de Diplomas, Cerfificados y Otros Titulos de Medico y de Medical Especialista de Estados Miembros de la Comunidad Economica Europea, El Ejercicio Efective del Derecho de Establecimiento y la Libre (R.D. 1989, 1691)..

219. *Id.*

220. Real Decreto 20072/1995, Por el que Se Modifica y Amplia el Real Decreto 1691/1989, de 29 de Diciembre, por el que Se Regula el Reconocimiento de Diplomas, Certificados y Otros Titulos de Medico y Medico Especialista de los Estados Miembros de la Union Europea, el Ejercicio Efectivo del Derecho de Establecimiento y la Libre Prestacion de Servicios (R.D. 1995, 2072). It should also be noted subsequent Directives were issued amending the requirements set forth in Directive 93/16 before Directive 2005/36, namely in Directives 2001/19, 98/63 and 99/46. However, these Directives did not modify the basic principles of Directive 93/16; rather, these Directives added specific requirements for specialist physicians and effected other minor changes. *See* Council Directive 2001/19; Council Directive 99/46, 1999 O.J. (L 139)(EC); Council Directive 98/63, 1998 O.J. (L 253)(EC). *See also* Ministerio de Educacion y Ciencia, *supra* note 187 (Spain's website acknowledging these amending Directives, which it has transposed into law).

221. *Id.*

222. *See* Council Directive 93/16, art. 2.

> However, Spain is not Germany, and the less assiduous, "So what are you going to do about it?" attitude to the application of EU norms, combined with a massive historical problem of medical unemployment, means that foreigners must expect obstacles.[223]

Despite the tedious process foreign physicians must endure for Spain to recognize their qualifications, Spain greatly benefits from EU laws allowing for the mutual recognition of qualifications because it allows the surpluses of physicians it trains to move to other EU countries and practice with relative ease.

3. *The Effect of EU laws on Physician Movement in Spain*

Spain's relationship with the UK may highlight the manner in which Spain benefits from EU laws allowing for the mutual recognition of physician qualifications. In 2000, a representative from the NHS visited Spain as part of the NHS' recruiting process to, in this instance, recruit more nurses.[224] However, "[t]he agreement also opened the door to recruit Spanish doctors . . . Spain is a fertile area for the recruitment of doctors because it has a surplus [of physicians]."[225] This is particularly beneficial to Spain which, at the time of these agreements, "showed that 22% of Spanish doctors were either unemployed or . . . without job security because the country had more doctors than it needed." Spanish physicians encourage the open recruiting in which the UK engages.[226] One physician noted he "welcomed the NHS move to recruit Spanish doctors, thinking that this might actually [be] . . . a solution for those doctors who were currently unemployed or working in insecure conditions."[227]

EU laws help solve the problems of physician supply faced by both the UK and Spain. In the UK, EU laws permit it to actively recruit abroad because laws allowing for the mutual recognition of qualifications make the transition of a foreign physician less problematic.[228] EU laws allowing for the free

223. Duncan, *supra* note 186.

224. *See* Xavier Bosch, *Milburn Visits Spain for Doctors and Ideas*, 323 BRIT. MED. J. 7322 (2001), *available at* http://www.bmj.com/cgi/content/full/323/7322/1150/a. The article notes that since both countries signed the agreement they made during this visit, the NHS has recruited 400 nurses from Spain. *Id.*

225. *Id. See also* Lopez-Valcarcel & Davila Quintana, *supra* note 186, at 118 (indicating the migratory flow has changed and Spanish specialists are now emigrating to nearby countries such as Portugal. In 2000, an agreement facilitating employment was signed between Spain and the United Kingdom. In the United Kingdom, salaries are more than double those in Spain, but the exact extent of migration from Spain is unknown).

226. Bosch, *supra* note 221.

227. *Id.*

228. The levels of difficulty a physician may encounter in having another country recognize his/her qualifications will also depend heavily on the level of the physician's training in his/her home state. The process may be complicated if they have to pursue more training or have to

movement of physicians among EU countries permit Spanish doctors, who are not in high demand in Spain, to move abroad and find employment in countries, such as the UK, where their services are needed.[229] In the UK, Spanish doctors can "expect 'either to get a permanent job . . . or to come back to Spain with a chance of getting a non-precarious post."[230]

C. *The Effect of EU Law on the Underdeveloped Countries of the EU*

Despite the advantages EU laws grant countries such as the UK and Spain, some EU countries would argue these laws were not advantageous to the maintenance of their physician supplies.[231] This attitude recently surfaced while the EU anticipated the addition of ten new countries to its structure in 2004.[232] Many deemed this occurrence as "one of the most significant events in the economic and political life of the European continent."[233] The enlargement added "almost 75 million persons to a community already comprising 380 millions (an increase of 19.5%)."[234] Despite the significance of the event, and its potential positive implications, it provoked concerns that, given the EU's laws allowing for the free movement workers, workers from the acceding countries would emigrate "*en masse*."[235] It was believed such migration would "create pressure in the already dysfunctional markets and would potentially cause further unemployment and lower wages, among other harmful results."[236]

The health situations of the acceding countries also varied substantially from those of the previous fifteen Member States, which created further apprehension.[237] All of the "candidate countries of CEE [Central and Eastern Europe] . . . ha[d] levels of life expectancy that lag[ged] behind those in western Europe, although they at last were improving."[238] Furthermore, these countries suffered from deteriorating birth rates which, combined with the increasing aging of their populations, posed "important consequences [for] the

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take an additional test. Regardless of these inconveniences, Directive 93/16/EEC and the adoption of the measure by each country at least give each physician notice of what the physician will have to do to have a country recognize his/her qualifications.

229. *See* Duncan, *supra* note 22.

230. Bosch, *supra* note 224.

231. Ozren Polasek & Kolcic Ivana, *Croatia's Brain Drain*, 331 BRIT. MED. J. 1204, 1204 (2005), *available at* http://www. bmj.com/cgi/content/full/331/7526/1204.

232. *Id. See also* Chammartin & Cantu-Bazaldua, *supra* note 7, at 1.

233. Chammartin & Cantu-Bazaldua, *supra* note 7, at iii.

234. *Id.* at 1.

235. *Id.*

236. *Id.*

237. Martin McKee et al., *Health Status and Trends in Candidate Countries*, *in* HEALTH POLICY AND EUROPEAN UNION ENLARGEMENT 24, (Martin McKee et al. eds., 2004).

238. *Id.* Particularly, in 2001, the EU life expectancy average for males was about 75 years while the Czech Republic rate's measured about 72 years, Slovenia's rate about 71 years, Poland's rate about 70 years, Hungary's rate about 68 years, Romania's rate about 67 years, Lithuania's rate about 66 years, Estonia's rate about 65 years, and Latvia's rate about 64 years. *Id.* at 25.

future."[239] One study found "in 1988, about 25% of the mortality gap between east and west Europe between birth and age 75 could have been explained by medical care."[240]

While many underdeveloped nations of the EU's health care indicators were lacking, many of their youngest and most well educated population desired to move abroad.[241] "The potential youth drain is combined with a potential 'brain drain.' The sending countries are in danger of losing between 3% and 5% of people who have third-level education, and more than 10% of their students."[242] Of these, 2-3% of graduate students have a firm intent to move abroad after graduation.[243] These youngest and brightest students include physicians.[244]

One of these countries, Lithuania, indicated a third of its doctors would go abroad to other EU states when it joined the EU in 2004.[245] Speaking on a broader scale, Lithuania's health ministry, through is own research, found "61% of doctors in training and 27% of practicing doctors said they wanted to work abroad once the Baltic . . . join[ed] the European Union [and] . . . of those, 15% of doctors in training and 5% of practicing doctors *firmly* intend[ed] not to return."[246]

In Croatia,[247] 204 medical students in their last year at the University of Zagreb's Medical School were surveyed,[248] and the survey found "[e]ighty four students were considering immigrating, mostly to the EU (57 respondents), especially [those from] Slovenia."[249] These results revealed a 10% increase from the previous year of new graduates who would emigrate abroad.[250]

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239. *Id.* at 24.

240. *Id.* at 37. Other factors also indicate the struggling nature of the majority of the health systems of the acceding countries; the acceding countries have high rates of death attributable to cardiovascular disease and alcohol and more than 20 % of their women suffering from some long-term chronic illness, with a greater number of males suffering from the same category of ailment. *Id.* at 28-29.

241. European Foundation for the Improvement of Living and Working Conditions, Migration Trends in an Enlarged Europe, at 4 (2004), http://www.eurofound.europa.eu/pubdocs/2003/109/en/1/ef03109en.pdf [hereinafter Foundation].

242. *Id.* at 66.

243. *Id.*

244. Polasek & Ivana, *supra* note 231, at 310.

245. Krosnar, *supra* note 130.

246. *Id.* (emphasis added).

247. Croatia is currently a candidate country for the EU; nonetheless, its predicament is relevant to the discussion as many of its neighbors belong to the EU. Europa.eu, Candidate Countries, http://europa.eu/ abc/european_countries/candidate_countries/index_en.htm (last visited Jul. 4, 2008).

248. The survey yielded a response of 85% and ran its data through a regression analysis to achieve its numbers. Polasek & Ivana, *supra* note 231.

249. *Id.*

250. *Id.* In the previous year, 31% of those graduating said they would seek to practice abroad. *Id.* Of those graduating physicians in this survey, 41% said they would move abroad. *Id.*

Among those who indicated they were the most likely to leave were those at the top of their class; Croatia's best and brightest.[251] Thus, EU laws allowing physicians from Member States the ability to move freely and practice in other Member States could potentially debilitate Croatia's health care system, which already faces "[a] serious shortage of doctors [and] . . . faces substantial problems in healthcare provision."[252]

The problem of physician flight does not elude Poland either.[253] In 2001, Poland experienced its own shortage of physicians.[254] Regardless of this shortage, other countries experiencing shortages, including EU Member States, targeted Poland's physician workforce: " . . . there have been significant increases in offers of work from abroad . . . [a]dvertisements have been placed in local newspapers, web-services for health professionals, career opportunity sites and distributed by professional bodies of nurse and physicians. In a few cases even the Government was involved."[255] Despite the potential benefits the accession by Poland to the EU may afford both Poland and the EU, "[the] risk of brain drain could be the most important disadvantage of enlargement for the Polish health care system."[256] Furthermore, like Lithuania, the group mostly likely to migrate "would be the youngest and best qualified nurses and doctors."[257] Recent moves made by physicians to take advantage of opportunities to migrate to other countries with which Poland has existing agreements highlight the negative implications of Poland's accession, and the effective threat current EU laws allowing for the mutual recognition of qualifications may pose to its health care system.[258] Thus, EU laws allowing for the mutual recognition of qualifications, and facilitating physician migration, stand to adversely affect Poland.[259]

An independent commission, The Permanent Working Group of European Junior Doctors, confirmed the desires of soon-to-graduate physicians from those countries who entered the EU in 2004 to move to other EU states to practice once the physicians entered the EU.[260] It explained it "[e]xpected migration rates from most of these countries [except in the more wealthy ones, particularly Slovenia and Malta] to rise significantly once they join[ed] the European Union. Doctors, particularly junior doctors, will move not only for

251. *Id.* In regard to Croatia's physician shortages, this article indicated "according to a new legislative scheme, a shortfall of 398 consultants in internal medicine and 340 consultants in surgery is predicted by 2007." *Id.*

252. *Id.*

253. *See generally* Monika Zajac, *Free Movement of Health Professionals: The Polish Experience*, *in* HEALTH POLICY AND EUROPEAN UNION ENLARGEMENT 109-29 (Martin McKee et al. eds., 2004).

254. *Id.* at 109-10.

255. *Id.* at 118-19.

256. *Id.* at 121.

257. *Id.*

258. *Id.*

259. Zajac, *supra* note 253, at 119.

260. Krosnar, *supra* note 130, at 310.

much higher pay but also better training opportunities and working conditions."[261] The President of the organization also noted the physicians from these states mostly wanted to emigrate to the UK.[262] Therefore, while EU laws allowing the free movement of physicians benefit some of the most developed nations in the EU, such as Spain and the UK, EU laws allowing the free movement of physicians are depriving many of its developing nations of valuable health care resources—their personnel—which ultimately decreases the level of health care the citizens of those countries may receive.[263]

III. COUNTERARGUMENTS

Although some countries may bear the burden of EU laws allowing their physicians to move abroad to practice medicine, the effect any physician migration may have on these states—mostly new Member States—may be insignificant; further, the various benefits laws allowing for the free movement of physicians bring may outweigh their costs.[264] One of the foremost arguments to fears of physician flight and brain drain has been that as the newer Member States transition into the EU community, regardless of EU laws such as Directives 96/13 and 2005/36, immigration levels will be modest.[265] A group of EU research institutes confirmed the level of immigration's "overall impact on the European labour market should be limited."[266] Other reports have noted migration will not initially overwhelm the Member States, but it will occur gradually over time.[267] And, even as immigration occurs over time, the European Foundation for the Improvement of Living and Working Conditions concluded a maximum of only 4.5 percent of the population in the new Member States may emigrate in the next five years.[268]

Past EU enlargement also helps to prove the expectation of large-scale emigration and its consequences is unfounded.[269] One group of authors noted similar fears of migration accompanied these expansions,[270] but "the feared

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261. *Id.*

262. *Id.*

263. *See generally* The Commonwealth, Commonwealth Code of Practice for the International Recruitment of Health Workers, 3-6, http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7 B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf (last visited Jul. 4, 2008) [hereinafter Code]. *See also* Mullan, *supra* note 79.

264. Chammarin & Cantu-Bazaldua, *supra* note 7, at iii.

265. Zajac, *supra* note 253, at 123.

266. *Id.* at 118.

267. Foundation, *supra* note 241, at 2.

268. *Id.* at 65.

269. Chammartin & Cantu-Bazaldua, *supra* note 7, at 9.

270. *Id.* "The EU had passed through four enlargements before the recent expansion of May 2004.
They occurred in 1973 (Denmark, Ireland and United Kingdom), 1981 (Greece though full labour mobility until 1986), 1986 (Portugal and Spain though full labour mobility until 1992) and 1995 (Austria, Finland and Sweden)." *Id.*

migration flow from these countries never materialized."[271] To the contrary, this group of authors argued EU enlargement deters the citizens of new Member States from immigrating:

> the EU experience has confirmed that countries with below-average GDP and a negative migration balance actually diminish and even invert their level of migration after their integration in the economic community. This happens because the new members benefit from big flows of investment from the richer members and from higher international trade, which generate growth and employment. The positive economic performance and the ensuing improvement in living standards attract migrants back to their home countries. In fact, the higher the level of integration of the economies, the lower the level of migration pressures. For this reason, it has been argued that the close level of integration of their members has actually deterred intra-EU migration flows.[272]

Furthermore, "labour mobility has ranked as the least used freedom in the Union."[273] Among the majority of existing Member States, "the level of intra-EU mobility has remained modest, never surpassing 50% of the total foreign population," and for six of the Member States, it has never risen above 25%.[274]

Not only does EU experience with past EU enlargement downplay its potential adverse consequences, but other natural barriers may constrain foreign physicians from emigrating to other Member States.[275] There are language barriers; although foreign physicians may desire to practice abroad, the inability of foreign physicians to speak the language of the country in which they may desire to practice greatly limits those desires.[276] Furthermore, foreign physicians may have to bear costs, including language differences, in adapting not only to a foreign culture, but to a foreign medical culture.[277] The "strong social and cultural ties" of a foreign physician with his/her country may initially discourage him or her from migrating as well.[278] Moreover, the prospect of receiving a reduced wage or receiving a position for which the physician is overqualified may also deter a foreign physician from migrating.[279] Lastly,

271. *Id. See also* Zajac, *supra* note 253, at 118 (noting "[v]ery modest migration flows were recorded after the Spanish and Portuguese accessions").

272. *Id.*

273. *Id.*

274. *Id.*

275. Zajac, *supra* note 253, at 123.

276. *Id.*; Chammartin & Cantu-Bazaldua, *supra* note 7, at 12.

277. Zajac, *supra* note 253, at 123.

278. Chammartin & Cantu-Bazaldua, *supra* note 7, at 12.

279. Zajac, *supra* note 253, at 123.

some populations are more risk averse; thus, some populations may "wait and see" before making any moves to emigrate, stagnating any initial mass migration in the face of EU enlargement.[280]

Another argument, particularly against those who persist some EU countries heavily rely on foreign physicians, is that a majority of those foreign physicians are not citizens of the new Member States.[281] The WHO reported while

> about one in three of the 71,000 hospital medical staff working in the NHS . . . had obtained their primary medical qualification in another country[in 2002,] . . . [t]he main sources of recruits were not from within the EU but from [non-EU] countries, such as South Africa and India.[282]

Also, proposals for regional solutions may not be necessary as some countries have already implemented their own codes for ethical recruiting.[283] Recognizing the foreign recruiting practices of the UK may adversely affect those countries with lower physician supplies, it "issued a Code of International Recruitment . . . which requires that NHS employers do not recruit actively from developing countries, unless there is a bilateral agreement."[284]

Additionally, the free movement of physicians, which EU laws afford, may potentially benefit the old and new EU Member States.[285] Countries that stand to lose their physicians may improve their health care systems and potentially offer greater benefits and incentives to keep their physicians.[286] Migration, coupled with the mutual recognition of qualifications, would also allow physicians from less developed countries in the EU to develop an expertise abroad, then return to contribute that newfound ability to the health care systems of their home country.[287]

Moreover, EU laws allowing for the mutual recognition of qualifications would benefit the EU as a whole. Mutual recognition of qualifications would allow countries suffering from physician surpluses and high unemployment to aid other EU countries suffering from labor and physician shortages.[288] Poland suffers from the same unemployment problem as Spain, with levels as high as 16.1 percent in 2000.[289] However, Poland is not alone, as the new Member

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280. *Id.*

281. Buchan, *supra* note 10, at 48-49. *See also* Pond & McPake, *supra* note 131, at 1449-50 (noting the UK primarily relied on physicians from sub-Saharan Africa for newly registered physicians in 2003).

282. Buchan, *supra* note 10, at 53.

283. *Id.* at 54.

284. *Id.*

285. Chammartin & Cantu-Bazaldua, *supra* note 7, at iii.

286. Zajac, *supra* note 253, at 120.

287. *Id.*

288. Buchan, *supra* note 10, at 41.

289. Zajac, *supra* note 253, at 122.

States post higher unemployment levels than the average unemployment rates of those Member States existing before accession.[290] EU laws allowing for the recognition of the qualifications of physicians in other EU countries would permit unemployed physicians to seek employment in other EU Member States starving for medical human capital.[291]

The chief of the International Migration Programme summarized the net benefits of migration and the benefits thereof as follows:

> [t]he accession of the new members will improve their situation enormously and give a new stimulus to stagnant markets in Western Europe. Some migration will undeniably appear, particularly in the neighbouring countries in the EU-15 in the short-term. However in the long run, anticipated intra-EU migration will probably continue at limited levels, even after the restrictions are lifted.[292]

Thus, arguments exist asserting critics of physician movement are greatly overstating feared migration levels and EU laws allowing for the mutual recognition of physician qualifications, and the migration they encourage, actually benefit the health care systems of the EU Member States and the EU as a whole.[293]

IV. SOLUTIONS

Whether EU laws are the cause of physician supply disparities in different countries or whether apparent large amounts of migration will actually occur is unclear. However, the looming concern of their effect, particularly on the recently acceded EU countries, has generated different approaches to remedying the problem.[294] One of the foremost proposals is the International Code of Practice for the International Recruitment of Health Workers (Code).[295]

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290. Chammartin & Cantu-Bazaldua, *supra* note 7, at 5.

291. Buchan, *supra* note 10, at 41.

292. Chammartin & Cantu-Bazaldua, *supra* note 7, at iv.

293. *Id.*

294. *See generally* Buchan, *supra* note 10, at 56-60.

295. Code, *supra* note 263, at 3-6. Further,

> [t]he Commonwealth is an association of 53 independent states consulting and co-operating in the common interests of their peoples and in the promotion of international understanding and world peace. The Commonwealth's 1.8 billion citizens, about 30 per cent of the world's population, are drawn from the broadest range of faiths, races, cultures and traditions. The association does not have a written constitution, but it does have a series of agreements setting out its beliefs and objectives. These Declarations or Statements were issued at various Commonwealth Heads of Government Meetings. The first, fundamental statement of core beliefs is the Declaration of Commonwealth Principles which was issued at the 1971 summit in Singapore. Among other things, it stresses the need to foster international peace and security; democracy; liberty of the

Although the Commonwealth does not include many EU countries, but more African countries, it has sought to address the potential problems the free movement of physicians may cause, noting that "[m]any Commonwealth countries, both developed and developing, are experiencing shortages of skilled health workers."[296] The Code illuminates the dichotomy explained above indicating some countries have engaged in aggressive recruiting programs to fulfill their need for health workers; while "this is helping some recipient countries to overcome their staff and skills shortages, it deprives source countries of knowledge, skills, and expertise for which large amounts of resources have been expended."[297] The purpose of the Code is to "provide[] guidelines for the international recruitment of health workers in a manner that takes into account the potential impact of such recruitment on services in the source country."[298] The Code also seeks "to discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages . . . [and to] safeguard the rights of recruits, and conditions relating to their profession in recruiting countries."[299]

The Code focuses on principles of transparency, fairness, mutuality of benefits, compensation, selection procedures, registration, and workforce planning to achieve its objectives.[300] Regarding transparency, the Code explains transparency should exist in "any activities to recruit health care workers from one country to another," which may involve home and host states forming agreements between the two.[301] Moreover, recruiters should be honest in their recruiting efforts "about the type of skills, expertise, the number of recruits, and grades being sought."[302]

To ensure fairness in the recruiting process, recruiting countries should not seek to recruit those individuals who have obligations to their home countries.[303] In many cases, home states providing the funding for the training of a physician require him or her to stay and practice for a designated amount of time; other countries should be respectful of these agreements.[304] One author argued host countries should honor contracts physicians have with their home

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> individual and equal rights for all; the importance of eradicating poverty, ignorance and disease; and it opposes all forms of racial discrimination.

The Commonwealth, *About Us*, http://www.thecommonwealth.org/Internal/20596/about_us/ (last visited Jun. 10, 2008).

296. Code, *supra* note 263, at 3. The United Kingdom would fall into this category as mentioned many times throughout this Note and, consequently, is a member of the Commonwealth. The Commonwealth, *Members*, http://www.thecommonwealth.org/Internal/142227/members/ (last visited Jun. 10, 2008).

297. Code, *supra* note 263, at 3.

298. *Id.* at 4.

299. *Id.*

300. *Id.* at 4-6.

301. *Id.* at 4.

302. *Id.*

303. Code, *supra* note 263, at 4.

304. Tikki Pang, *Brain Drain and Health Professionals*, 324 BRIT. MED. J. 499 (2002), *available at* http://www.bmj.com/cgi/content/full/324/7336/499.

state and should not be allowed to advertise "'in developing countries unless that country has specifically invited the [host country] to undertake a recruitment programme'—that recruitment 'should only be undertaken as part of an inter-governmental cooperation agreement... encouraging the exchange of healthcare personnel, healthcare information, and guidelines.'"[305]

Recruiters should also "provide full and accurate information to potential recruits concerning: [1] the nature and requirements of the job that recruits are expected to perform; [2] countries to which they are being recruited; [3] administrative and contractual requirements; and [4] their rights."[306] Recruits should also have access to all information about the selection process; recruiters should assure recruits they will have the same opportunities and safeguards as other physicians practicing in the host state.[307]

The Code also desires that both countries, the home and host country, benefit through the recruitment process. Where the migration of physicians greatly affects a home country, the host country should find ways to assist the home country.[308] Host countries may wish to compensate home countries "through the transfer of technology, skills and technical and financial assistance to the country concerned."[309] Alternately, host countries could provide "training programmes to enable those who return to do so with enriched value" and could "arrange[] to facilitate the return of recruitees."[310]

Host countries should also ensure recruits understand their recruiting contracts and are willing to abide by them.[311] Additionally, host countries should inform potential recruits of the licensing requirements of the host country and take steps to ensure recruits have fully complied with all necessary educational training requirements or ensure the training deficiencies of the recruits are clearly conveyed to them.[312]

Lastly, the Code encourages Commonwealth countries to reform domestic and training programs so Commonwealth countries will have to do less recruiting abroad.[313] Those countries with physician shortages could accomplish this by allowing more students to attend medical school,[314] or as

305. Vikram Patel, *Recruiting Doctors from Poor Countries: The Great Brain Robbery?*, 327 BRIT. J. 926 (2003), *available at* http://www.bmj.com/cgi/content/full/327/7420/926.

306. Code, *supra* note 263, at 4.

307. *Id.* at 5.

308. *Id.*

309. *Id.*

310. *Id.*

311. *Id.* at 5-6.

312. Code, *supra* note 263, at 6.

313. *Id.*

314. Krosnar, *supra* note 130. The United Kingdom implemented this policy in 1998 and "by 2002, the annual number of acceptances to medical school had increased by a third, four new medical schools were opened in 2002, and in 2003, medical school acceptance was 50% higher than in 1997." Pond & McPake, *supra* note 131, at 1449. Other countries have also initiated internal reforms around this principle. Germany is an example of a state which has failed to successfully limit those numbers of medical students who enter medical school, which

two scholars proposed, to encourage more women to move into the physician workforce.[315] Regardless of the method, countries suffering from physician shortages could help remedy these shortages without infringing on the physician supplies of other countries who cannot afford to lose their physicians.

The Code provides a good working framework encompassing many viable solutions.[316] However, although many countries adopted it at the Pre-WHA[317] Meeting of Commonwealth Health Ministers in 2003 in Geneva,[318] it holds no binding effect on nations who have not signed it, such as the UK.[319] Furthermore, its text exposes its own inherent weaknesses. It notes it "is not a legal document" and that "it is hoped that governments will subscribe to it."[320] Additionally, it explains it is not meant to "hinder" the ability of individuals to make their own career choices; it is a legal framework which Commonwealth governments may use to supplement their own policies and laws with depending on their particular situations.[321] Failures by the UK, Australia, and Canada, all developed countries who experience shortages, to adopt the Code, reveal its greatest weakness.[322] Thus, the language of the Code exposes the reality that the adoption of its solutions is at the mercy and discretion of the Commonwealth states who may freely choose to enforce it or not.[323]

Other scholars have focused on what home countries, which face the efforts of other countries recruiting their physicians, may do to keep their physicians.[324] To retain their trained physicians, home countries could delay

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has led to an oversupply of physicians. France, on the other hand, has been successful, under a centralized system, in limiting the amount of health care staff entering the workforce; but, this has led to a feared shortage of health care workers, including doctors. Dubois et al., *supra* note 8, at 5.

315. Simoens & Hurst, *supra* note 95, at 20-21. The authors of this article explain many countries will experience shortages and women may be an alternative source of human capital to fill that void as health care demands increase. *Id.* However, they are skeptical of this alternative, indicating "increasing female participation in the physician workforce can have important consequences for the supply of physicians, given that female physicians tend to differ from their male colleagues in how they participate in the workforce." *Id.* at 21. Women tend to prefer primary care, but "are less likely to work in rural areas, are more likely to leave the practice of medicine or practice at low activity levels during child-bearing age, tend to work fewer hours and are more likely to retire early." *Id.* *See also* Pond & McPake, *supra* note 131, at 1449.

316. *See* Buchan, *supra* note 10, at 58.

317. World Health Organization, *56th World Health Assembly*, http://www.who.int/mediacentre/news/ notes/2003/npwha/en/index.html (last visited Jul. 4, 2008). WHA stands for World Health Assembly, which is the annual meeting of the 192 states who are members of the World Health Organization. *Id.* This meeting takes place each year in Geneva, Switzerland. *Id.*

318. Code, *supra* note 263, at 6.

319. *See* Buchan, *supra* note 10, at 58.

320. Code, *supra* note 263, at 5.

321. *Id.* at 3.

322. Buchan, *supra* note 10, at 58.

323. *See id.*

324. *See* Pang, *supra* note 304; Zurn et al, *supra* note 131, at 6; Krosnar, *supra* note 130.

the departure of their physicians through compulsory service.[325] Home countries could also raise salaries for physicians who work in public health sectors.[326] Home countries may consider allowing their publicly paid physicians to supplement their public practices with private practices to pursue an additional specialty or interest for which the public health system may not provide an opportunity.[327] Additionally, home countries could provide better pensions, child care, educational opportunities, and better educational environments in which the children of physicians would have greater opportunities.[328] Other efforts home countries could make to improve the retention of the physicians they train include improving medical infrastructure[329] and making more bilateral agreements with countries seeking to recruit their physicians.[330] The latter may mandate that host countries train recruits from the home country primarily in methods of care that would benefit the home country.[331] Lastly, home countries may require recruiting countries to reimburse home countries for costs of training provided to a physician who seeks to migrate.[332]

All of these solutions may work toward allowing home countries to salvage their physician resources. Particularly where sovereign nations may bargain with recruiting countries to provide some mutual benefit, sovereign nations should do so because regional non-binding agreements, such as the Code, provide no binding effect to protect countries that can ill-afford to lose their physicians.

This Note proposes the EU take initial legislative action to implement some of the suggestions the Code mentions. The Code could serve as a basis over which the Member States could negotiate different provisions potentially regulating some aspects of the free movement of physicians in the EU. Currently, proposals to regulate physician movement, such as the Code, hold non-binding effect and rely on ethical constraint. The EU, however, has power to pass binding resolutions. As previously explained, the EU has shown a greater interest in addressing health care issues than in past decades and where it has allowed the free movement of physicians through Directive 96/13, and now Directive 2005/36, it should allow itself to place regulations on the negative effects this free movement may potentially cause.

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325. Pang, *supra* note 304.

326. *Id.*; Krosnar, *supra* note 130.

327. Pang, *supra* note 304.

328. *Id.*; Zurn et al., *supra* note 131, at 19.

329. Pang, *supra* note 304; Krosnar, *supra* note 130. According to these articles, infrastructure improvements would include better medical facilities with better technologies. Pang, *supra* note 304; Krosnar, *supra* note 130. It would also include more efficient management of health care, such as streamlining hospital care by shutting down unused hospitals, selling them, and contributing the proceeds back to the health care budget. Krosnar, *supra* note 130.

330. Pang, *supra* note 304.

331. *Id.*

332. *Id.*; Krosnar, *supra* note 130.

Ideally, the EU could solve the potential problem this Note identifies through issuing a Directive or set of Directives considering some of the solutions the Code and other academics have proposed. It could start gradually by requiring its Member States to respect the agreements other Member States make with the physicians they train. Then, it could implement greater measures requiring countries such as the UK to pay the training costs of the physicians it recruits. Another effective means by which the EU could gradually regulate physician migration would be through enacting temporary restrictions on the number of foreign physicians EU members may recruit, depending on the numbers of each home country's respective physician supply.[333]

If the EU chose to take legislative action, the ECJ could also provide support. This is likely given its recent indications that it would allow the EU to provide more regulation of health care than the Members States currently provide.[334] It could uphold any regulations the EU implements to stymie adverse effects of physician flow in the EU. Alternatively, it could affirm a home country's implementation of one of the aforementioned policies to protect its physician supplies. Lastly, the EU could propose language in future treaties amongst EU countries that would promote policies helping resolve potential problems of disparate physician supplies among EU countries.

Following its gradual intervention to regulate the potentially adverse outcomes of EU law allowing for the free movement of physicians, this Note proposes the EU legislatively requires its countries to implement a system of data collection allowing researchers to monitor the level of actual migration and physician depletion in EU countries as well as to investigate which gradual interventions work to balance the physician working force in the EU.[335] Scholars have suggested researchers and/or countries engage in more "data analysis" to fulfill a "need for a more detailed assessment of the actual impact of health workers moving to other countries compared to that caused by health workers leaving the health sector in-country."[336] This would allow the EU to determine whether health workers are migrating in a considerable manner and in what way this affects EU countries.

These are all legal mechanisms and institutions the EU could utilize to ensure the effect of EU laws on physician migration, especially with the recent accession of new Member States, will not produce adverse outcomes in any of the Member States. Where the EU sought initially that every EU country benefit through the mutual recognition of qualifications and the free movement of physicians, it should also seek that every country benefit through protective measures limiting the adverse effects of its former proposals. A gradual method of intervention would address the arguments of those who are skeptical of EU laws allowing for physician movement without immediately jeopardizing

333. Chammartin & Cantu-Bazaldua, *supra* note 7, at 7-8.

334. Mossialos & McKee, *supra* note 29.

335. Buchan, *supra* note 10, at 54.

336. *Id.* at 56.

the apparent benefits of these laws.[337] The EU needs this type of balance where, regardless of the counterarguments, the underdeveloped nations of the EU face health care problems and cannot afford to hope their physicians will not leave them and their health care systems impaired.[338]

V. CONCLUSION

The EU has made great strides in recent decades and has emerged as a formidable player in an international economy.[339] Its emphasis on the free movement of goods and services within the EU has allowed for its economic successes and it promoted such activity in the health care sector primarily through Directive 93/16 and now Directive 2005/36.[340] The latter Directive now sets standards for the mutual recognition of physician qualifications in EU countries.[341] This ultimately allows physicians to seek employment with relative clarity and ease in the different EU Member States.[342] However, the free movement of physicians may adversely affect those countries with low physician supplies from which larger countries with shortages recruit.[343] The UK is a country that has implemented the Directive and seeks physicians from other countries to satisfy its perpetual shortages. Its intercourse with Spain, which experiences physician surpluses, demonstrates the EU laws allowing for the free movement of physicians may be highly beneficial to the Member States of the EU. In light of these conflicting views, the EU must decide whether the problem exists to the extent the EU should intervene to resolve it.[344] Regardless of whether the EU decides to address the issue, it would ideally be the best equipped to do so as it can pass binding policies its Member States are compelled to recognize. The hope is that the EU chooses to do so to promote better health outcomes in its developed states as well as its more fledgling states, who are trying to survive in a global economy.

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337. Buchan, *supra* note 10, at 41.
338. McKee et al., *supra* note 234, at 32.
339. RANDALL, *supra* note 1, at 3.
340. Council Directive 93/16, art. 2.
341. *Id.*
342. Nicholas, *supra* note 3, at 83.
343. Polasek & Kolcic, *supra* note 231; Chammartin & Cantu-Bazaldua, *supra* note 7, at 1.
344. Buchan, *supra* note 10, at 59.