Introduction
In an increasingly interconnected global community, severe disasters or disease outbreaks in one country or region may rapidly impact global health security. As seen during the responses to the earthquakes in Haiti and Japan, Typhoon Haiyan in the Philippines, and the current Ebola outbreak in West Africa, local response capacities can be rapidly overwhelmed and international assistance may be necessary to support the affected region to respond and recover and to protect other countries from the spread of disease. For example, President Obama stated on September 16, 2014, that “if the [Ebola] outbreak is not stopped now, we could be looking at hundreds of thousands of people infected, with profound political and economic and security implications for all of us.... [T]his...is not just a threat to regional security — it’s a potential threat to global security if these countries break down.... And that’s why...I directed my team to make this a national security priority.”

The 2014 Ebola outbreak is an example of why the timely international deployment of public health subject matter experts and medical personnel to the affected area is critical to both local and global health security. While response personnel from non-governmental organizations are an undoubted resource and usually the first to be mobilized, government personnel from other countries may play a critical role in providing specialized expertise or supplementing insufficient or exhausted resources. However, when government personnel, usually organized and prepared to address the need of their own countries, are called to deploy across international borders, both donor and recipient countries must be prepared to handle a unique set of legal, regulatory, logistical, and funding issues. Here, we describe some of the key legal issues that impact the international deployment of personnel based on analysis of potential international emergencies as well as lessons learned from a few international deployments of U.S. Department of Health and Human Services (HHS) personnel. Finally, we summarize regional and multilateral efforts that can help identify and implement common solutions to those challenges.

Legal Challenges
No country is immune to public health emergencies resulting from natural disasters, disease outbreaks with pandemic potential, or man-made or accidental release of chemical, biological, and radiological/nuclear threat agents. Countries should have public health and medical personnel ready to respond. This should include plans for potential donor and recipient countries to deploy and receive government public health and medical personnel across borders in a timely manner. Donor countries should have legal authorities to deploy specific personnel teams and necessary legal protections for those personnel, while recipient countries must be able to receive those personnel into their existing legal and health care sys-
tems. The following sections describe some of the critical legal issues that must be addressed in anticipation of a deployment.

**Licensing**

Medical or professional licenses give personnel the right to practice in a specific jurisdiction. Generally, government authorities or approved professional associations are responsible for issuing licenses, and obtaining them requires completion of a minimum course of study, examination by a professional body, and a background investigation. In the United States, the licensing of public health and medical personnel is regulated by states and territories, and the federal government does not have the ability to alter or waive these requirements. Further, most licenses are not portable or transferrable between the United States and foreign jurisdictions. Without a license to practice in a foreign country, recognition of their license, or a waiver, regulated public health and medical personnel acting on behalf of the U.S. Government can be vulnerable to legal or professional violations in either the country in which they are deployed or in the United States. Before government personnel are deployed outside of the United States, it is critical that recipient countries or professional societies recognize their licenses, provide provisional licenses, or officially waive the licensure requirements.

Conversely, foreign health care personnel providing emergency aid in the United States will need licensing recognition or a waiver from a U.S. State or territory. Thus, countries could facilitate the process to waive or recognize foreign licenses during an emergency by pre-drafting government waivers, or pre-registering potential response personnel in national or international systems to facilitate license verification/recognition. They may also consider establishing procedures for temporary emergency licensure, which would allow public health and medical personnel to practice on a short-term basis.

**Tort Liability Protections**

Public health and medical personnel providing care in a foreign country may face claims for malpractice or negligence brought by patients. Liability protections are particularly important in the context of catastrophic disasters because those situations may require care in high-risk environments and under unusual standards of care. Liability protections in their home jurisdiction may not protect against claims abroad. In the United States, the Federal Tort Claims Act (FTCA) is an important source of liability protections, shielding federal employees from certain tort claims when they are acting within the scope of their official duties. However, the FTCA generally does not apply to official duties outside the United States or to foreign health care workers who provide assistance within the United States.

There are several options for nations to address or mitigate tort liability. First, governments might purchase insurance for personnel to cover financial losses of potential claims. Second, governments might indemnify, or take financial responsibility for, responders during their deployment. Similarly, governments at all levels could provide immunity agreeing to hold foreign personnel harmless for certain actions, meaning that residents in the receiving jurisdiction would simply be unable to make claims against foreign responders as long as the responders acted within their specified duties and abilities.

**Workers’ Compensation**

Workers’ compensation protections are designed to protect responders in the event that they suffer injury, illness, or death while performing their duties. Protections provided to responders in their day-to-day domestic capacity may be inadequate to protect them against injuries that arise in foreign countries. Options for addressing workers’ compensation coverage include: (1) purchasing medical evacuation insurance or other types of additional insurance prior to deployment, or (2) reaching an agreement that either the donor or recipient government will cover the losses related to injuries that responders may suffer while deployed.

**International Collaboration to Address the Challenges of International Deployment of Public Health and Medical Personnel**

Solving these complex challenges requires international dialogue and collaboration. The following are some examples of initiatives that HHS has leveraged to analyze challenges and find common solutions.

**World Health Organization (WHO) and International Health Regulations (2005) [IHR (2005)]**

The U.S. Government is signatory to the IHR (2005), a legally binding global health security framework that promotes the importance of mutual assistance in the wake of public health emergencies of international concern. Article 44 of the IHR (2005) calls on signatories to undertake to collaborate with each other, to the extent possible on activities including: the detection and assessment of, and response to, events; the provision or facilitation of technical cooperation and logistical support; the mobilization of financial resources to facilitate implementation of their obliga-
tions; and the formulation of proposed laws and other legal and administrative provisions for the implementation of these regulations. In this regard, in 2013, the WHO published Foreign Medical Team (FMT) guidelines to provide a classification structure, minimum standards, and a registration form for teams that seek to provide surgical or trauma care in the aftermath of sudden onset disasters in other countries. In 2010, the Global Health Cluster (GHC) resolved to explore the creation of an international register of FMTs to allow crisis-affected countries to more rapidly identify and approve FMTs from the register. This should contribute to a better matching of supply and demand, alignment with national coordination mechanisms, and improved adherence to predefined legal and regulatory standards. HHS is working with the Pan-American Health Organization to learn more about these tools and their application in the Americas.

Global Health Security Agenda (GHSA)

In 2014, the United States, along with more than 40 nations, launched GHSA to accelerate progress toward a world safe and secure from infectious disease threats and promote global health security as an international security priority. Recognizing the importance of cross-border deployment of personnel, GHSA calls on nations, international organizations, and public and private stakeholders, “to have the necessary legal and regulatory processes and logistical plans to allow for the rapid cross-border deployment and receipt of public health and medical personnel during emergencies.” As such, HHS has started to work with partner nations to develop a strategy for a global dialogue about this issue and to identify common solutions.

Beyond the Border (BTB) Initiative

BTB is a bilateral endeavor launched by President Obama and Canadian Prime Minister Harper in February 2011. BTB articulates a shared approach to cross-border security for both countries to work together to address threats within, at, and away from their borders. The BTB Health Security Chapter focuses on enhancing collective preparedness and response capacity for health security threats, including supporting the ability to share public health and medical personnel. HHS is working closely with the Public Health Agency of Canada to propose a series of options to allow both countries to share medical personnel taking into account the legal systems and capacities of the two federal, state, and/or provincial systems. Work is in progress to create a toolkit that includes provisions from cross-border U.S./Canadian emergency management agreements formed between U.S. states and Canadian provinces/territories. These agreements deem foreign responders to be licensed and to act as agents of the requesting jurisdiction for liability purposes. While these agreements do not directly govern federal personnel, they are important tools for cross-border deployments between the United States and Canada.

Conclusion

Legal and regulatory systems throughout the world must be adapted to support the dynamic public health emergency preparedness and response capaci-
ties that global health security now demands. Legal issues around international deployment of personnel between governments during an emergency are critical but not the only challenges to mobilize assets to augment local response capacity. Customs clearance for equipment and medicines, national incident command system considerations, training on the principles and practice of the United Nations Cluster System, and the ability to obtain funding rapidly, among other issues, are still major gaps. Countries’ ministries of health have a key role in identifying gaps and in addressing barriers in their own systems. They should promote national collaboration with their agencies for international development and the military, and internationally with government and non-government organizations, to develop further capacities to provide and receive international assistance to rapidly respond to public health emergencies.

Disclaimer
The findings and conclusions in this report are those of the author(s) and do not necessarily represent the views of the Department of Health and Human Services or its components, neither of those entities mentioned in the document.

References
2. 28 U.S.C. 2671 et seq.
8. See BTB Homepage, supra note 7.