INTERNATIONAL AFFAIRS

POACHING FOREIGN DOCTORS

Do our development and immigration policies amount to foreign aid in reverse?

by Larry Krotz
illustration by Catherine Lauigan

In the mid-1990s, I had a job making a film for the Manitoba agency charged with finding doctors and nurses to staff the province's more remote health clinics. On behalf of the J.A. Hildes Northern Medical Unit, off I went with cameras and crew to make such obscure places as Norway House and Churchill look as appealing as possible—emphasizing their well-equipped clinics, comfy living quarters, hunting and fishing just outside the back door. The film was destined for faraway places like South Africa, and when physicians there saw it we wanted them to eagerly pull up stakes and come to Canada's North.

It worked—Manitoba scored its share of South African medical professionals—and I felt more than a little guilty. What business did we have enticing skilled professionals away from countries that had spent millions of scarce dollars training them and desperately needed their services, simply to fill our own needs, however pressing they might be?

Over a decade later, one could have hoped that poaching of the talented human resources of the perennially more desperate South and East by the powerful countries of the North and West would have been called off. It hasn't. In a now-celebrated case, last fall newspaper reports alerted us that Shoppers Drug Mart had sent recruiters to AIDS-stricken South Africa to interview young pharmacists, and lure them to Canada with promises of $100,000 salaries. "We have a long history of helping pharmacists from other countries start new careers in Canada," a Shoppers spokesperson said. Not everyone was content to let it pass. In January, an editorial in the *Canadian Medical Association Journal* blasted Shoppers, pronouncing such ventures "not just gauche [but] unethical. It amounts to a Canadian corporation taking advantage of South African taxpayers and [an] impoverished higher education system—truly foreign aid in reverse."

A fight was on, I thought. But sober realities quickly intruded to overwhelm the debate. Finger pointing about outright poaching aside, even the CMA would have to acknowledge that our economy and the provision of public services depend mightily on more subtle forms of this phenomenon. Professor Ronald Labonté has watched the situation develop for a number of years—with no small amount of dismay. As the Canada Research Chair in Globalization and Health Equity at the University of Ottawa, and until recently adjunct professor in the Department of Community Health and Epidemiology at the University of Saskatchewan, he observes that active recruiting efforts are not even necessary: "All you have to do is post your needs on your website and let word of mouth take care of the rest."

Unfettered globalization, with its free flow of capital and investment, is increasingly being followed by the free movement of people with professional skills, and Canada and other wealthy countries have become landing spots for many of the best and brightest from the developing world. By doing little to discourage this and much to promote it—everything from word of mouth campaigns to targeted immigration approaches that identify skilled professionals—almost everybody in government and industry working on Canada's skills shortage is complicit. Arguably, Shoppers Drug Mart was simply doing overtly what most governments from the North and West both allow and encourage more covertly every day.

While few would want to forbid people from moving to a better life, the fact remains that as we benefit, the other half of the world pays a hefty price. Clearly evident in engineering, agricultural technology, business, education—any number of fields, really—the effects of this out-migration are most dramatic in health care, and the place hardest hit is Africa. Across the continent, there are thirteen doctors for every 100,000 people, though for some countries, such as Ethiopia, that number is just two. (I have visited clinics in African countries that have not seen a doctor in years, and some only have a single nurse attempting to hold things together.) Meanwhile, in the US the ratio of doctors to citizens is 256 to 100,000; in Canada, it is 214 to 100,000.

According to the United Nations Conference on Trade and Development,

65 percent of newly qualified doctors in Bangladesh seek jobs abroad. As in Ethiopia, Bangladesh's locally trained medical personnel depart for the greener pastures of the North and West. In particular, the health care systems of Canada, the UK, the US, and Australia have become heavily dependent on immigrant health care professionals. The Organisation for Economic Co-operation and Development (OECD) reports that 22 percent of practising doctors in Canada were trained elsewhere; in the UK, it is 33 percent. The US and Australia fall somewhere in between.

Such reports indicate that policy-makers and institutions have been aware of the issue for years. In 1999, the World Bank's *World Development Report* declared that the brain drain from the Third World to the First would be "one of the major forces shaping the landscape of the 21st century." But nearly a decade into this new century, all we've really done about "foreign aid in reverse" is take advantage of it.

Dr. Amir Attaran, the Canada Research Chair in Law, Population Health, and Global Development Policy at the University of Ottawa and co-author of the CMAJ editorial, says that Shoppers Drug Mart–type recruiting would be much less likely today in Britain. In 2004, the British House of Commons International Development Committee issued a statement arguing that the migration of vast numbers of skilled workers contradicted the goals of the West's development programs: "[It is] unfair, inefficient and incoherent for developed countries to provide aid to help developing countries to make progress towards the Millennium Development Goals on health and education, whilst helping themselves to the nurses, doctors, and teachers who have been trained in, and at the expense of, developing countries," stated the parliamentarians. This is not to suggest that Britain has not, over the years, recruited from needy countries, as the OECD statistics reveal. Indeed, Manchester reputedly has more Malawian doctors than Malawi, and hospitals across Britain are heavily dependent on Zimbabwean and Zambian nurses. Nonetheless, also in 2004, the National Health Service decided as a matter of policy to cease active offshore recruitment from developing countries. "It didn't require a law," says Attaran, "just a change in behaviour. And after the NHS lead, the public culture changed." "Boots [the British drugstore chain] would not do what Shoppers has done," he continues—"go to a struggling country that has one of the world's highest incidences of HIV/AIDS, and lure their pharmacists away."

While chastising Shoppers, Attaran reserves equal scorn for Canadians as a whole. "Does anyone give them [Shoppers] a hard time about it? Not in this backward country," he fumes. His point is that few ask what happens to the sending countries when they export their talent to Canada, and fewer still ask policy-makers to admit that domestic laws and practices amount to a jumble of contradictions and hypocrisy. Canada boasts about its refugee settlement programs—as the US does about opening its arms to "the huddled masses" of the world—but in the main, it is no longer the poor, unskilled, and uneducated who emigrate. While stories of overqualified immigrants driving cabs in Canadian cities are legend, it is our ability to put foreign-trained skill to use that we consider our real genius, and that is where the majority of our efforts get directed.

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Forty-nine percent of Canada's Ph.D.s were born elsewhere, and the rules and regulations outlined in our immigration statutes—particularly the points system—tilt strongly toward enticing more foreign nationals with money, skills, and education. According to the minister for citizenship and immigration, Diane Finley, this is precisely what Canada must do—it's a global competition, after all—and the Harper government's March budget implementation bill included a provision giving the minister discretion in hand-picking certain immigrant applicants from the large backlog and accelerating their passage into Canada. Identify the need, and then fill it; so much the better that the people come relatively free of charge because their education was obtained elsewhere. Critics argue that this politicizes the immigration and refugee system, but few have raised concerns about the effects of talent recruiting on the developing world.

South of the border, the situation is similar. When the poor spill over the borders into America, as they do from Mexico, alarm bells go off. But, less noticeably, the US has become home to 30 percent of Mexico's doctoral graduates; and over 60 percent of immigrants from the British Commonwealth Caribbean arrive in America with college or university degrees. In 2005, reporting for the UN, Arno Tanner, visiting Fulbright Scholar at the Migration Policy Institute in Washington, DC, determined that 88 percent of immigrants from non-industrial countries to OECD countries have at minimum secondary school education, and that "global labour migration is increasingly becoming a movement of the educated with their families, which means that, at least initially, the sending country loses a considerable part of its vocational elite upon emigration." While this global migration creates a temporary vacuum for giants like India and China, it is "more permanent and occasionally life threatening in sub-Saharan Africa or in politically and demographically more vulnerable countries, such as Pakistan and Turkey." Africa, Tanner states, "has lost a third of its skilled professionals in recent decades, and has had to replace them with 100,000 expatriates from the West, at a cost of $4 billion [US] a year."

Cited in the Tanner report, Philip Emeagwali—a renowned Nigerian computer scientist who now lives in the US—says that this out-migration makes it nearly impossible for most African countries to build a middle class.

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He describes Africa as having "a massive underclass that is largely unemployed and very poor, and a few very rich people that are mostly corrupt military and government officials." This slow but inexorable strangulation of the continent is doubly ironic, given Western leaders' embrace of the "African renaissance," and their commitment to helping the continent find "African solutions to African problems."

Siphokazi Phillip, international relations coordinator for DENOSA, the professional association of South Africa's nurses, told me that the recruitment of "all categories of health workers, with nursing being the most affected" continues apace in South Africa. He emphasized that Western health care associations recruit overtly through regular newspaper and magazine advertising campaigns. The biggest offenders, he says, are the US, Canada, Saudi Arabia, and the UK—apparently notwithstanding the efforts of the NHS and Britain's parliament—and such actions have dire "implications for the country, because they further deepen the staff shortages we have had for many years. The gap is getting wider." When I ask him about the mitigating effects of remittances, he is skeptical.

On a wall of the Odette Cancer Centre at Toronto's Sunnybrook Health Sciences Centre, a large world map identifies the countries of origin of the 140-member radiation therapy staff. Doctors, radiologists, and counsellors speak thirty-one languages, the display says, and have come from such diverse places as India, Iran, Tanzania, and Taiwan. This, you might say, is a picture of modern Canada, of multiculturalism in practice, and in many respects it is.

Twenty years ago, Khama Hanson moved from Jamaica to London, England, to study to become a radiation therapist. She returned to Jamaica, which had given her scholarship monies, for a three-year stint to repay her obligation, but packed her bags again, this time for Ottawa and then Toronto. She now works at Sunnybrook. "I always wanted to travel," she says, "and with this profession you can get a job anywhere in the world." She tries to believe that some good derives from Jamaicans being one of "the best in the world when it comes to sending remittances," but cannot deny that one of the Caribbean's major exports is its workforce.

Sheila Robson, a Brit, came to Canada in 1977. "Princess Margaret Hospital in Toronto was experiencing a desperate shortage of radiation therapists," she says. "They advertised in the UK, and nineteen of us answered the call." For Robson, it was both an adventure and a serendipitous financial move: her salary quintupled instantly. Still, like many back then, she intended to stay in Canada only a short time; thirty years later, she's still here, now as head of radiation therapy at Sunnybrook. In the early days, international recruitment as a strategy to address labour shortages tended to be from one First World country to another—Robson was trained in Newcastle, England—and for Canada, Australia, and England, significant immigration also occurred within the Commonwealth, which explains how Khama Hanson moved easily from Jamaica to England and then here. In the 1990s, as globalization knocked down walls, developing nations became fair game in the hunt.

During that hyper decade, for instance, Robson's own department at Sunnybrook participated in two mad scrambles to address shortages, both times sending officials on worldwide searches with the full support of two levels of government. Cancer Care Ontario, the provincially funded umbrella organization that oversees strategies to address cancer treatment needs, mounted the overseas campaign of advertisements and interviews. The federal immigration department recognized the campaign and "made us a desired profession," Robson says. On both occasions, the Canadian delegations found themselves in hot competition with other countries on the prowl for skilled personnel, especially the UK and the US. The Americans, Robson says, always offered great bonuses and higher salaries.

Today, while medical school enrolments are back to their pre-1993 levels, the pressure on Canada to take advantage of the developing world's skills is enormous. With our population aging rapidly and baby boomers starting to retire, medical needs and costs are rising dramatically. Provincial and territorial health care budgets in 1993 accounted for 32.7 percent of total expenditures. By 2006, they were soaking up nearly 40 percent. The trend lines and expectations are clear. Extended wait times remain a major problem—and private health care, everything from hip replacement clinics in Montreal to the new for-profit hospital in Vancouver, is stepping in to fill the breach. But a major part of the strategy is to go for the foreign trained. In Ontario, for instance, the Liberal government says that it has "doubled the number of international medical graduates to improve access to health care," and Michael Decter, former chair of the Health Council of Canada, confirms that the province has programs in place to speed up the process of accreditation for foreign-trained medical professionals already here. The question, of course, is whether such efforts simply amount to giving the green light to those wanting to leave their Third World situations.

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Many health services across Canada fear that foreign-trained professionals are the only staff they are going to get. In the Yukon, for instance, keeping medical staff is a perpetual challenge, according to Stuart Whitley, the territory's deputy minister of health and social services. In no small measure, it manages by attracting young international medical graduates (IMGs). "We have arrangements for them to practise here," says Whitley. "Special licences allow doctors who have come from other countries to practise, subject to such conditions as our medical council imposes. Sometimes those are supervisory—shadowing and so on." The territory has recently licensed doctors from Pakistan, Britain, and South Africa, but, Whitley acknowledges, the problem remains, and "we can never get enough nurses."

Too often, the Yukon—geographically isolated, with a population of just 31,000, and with few career advancement opportunities—is merely a portal for young medicos to move through on their way to metropolitan Canada. "We are constantly getting raided," says Whitley. "The bigger medical centres in the South come up and say, 'Here's what we can offer you.' IMGs come here, qualify, and then move on to some other part of the country." The result is a chain reaction, internal to Canada: outlying regions experience perennial shortages and are always in recruitment mode. Still, Whitley says that the Yukon government does not actively recruit overseas, sticking strictly to health fairs across Canada. "Everyone is aware of the complexity of the moral issues around the autonomy of doctors and other medical people to choose where they want to live and work," he says. "And if we poach the best and brightest [from developing countries], are we obliged to compensate in some way?"

Whitley's concerns don't seem to bother the Saskatoon Health Region. In March, the Saskatoon *StarPhoenix* published a column by the region's vice-president of human resources, Bonnie Blakely. Just back from a nurse recruiting trip to the Philippines, she was attempting to refute charges that offshore recruiting in poor countries was unethical. Not so, she argued; such efforts "enrich both communities." Nowhere did she acknowledge that Canada's ratio of nurses to population is 10 to 1,000, while in the Philippines it is 1.7 to 1,000. Rather, Blakely stuck to her guns, citing the Philippine government's support for the venture, claiming that the nurses would earn good salaries and send money back home, and pointing out that if Saskatchewan didn't scoop them, somebody else would.

Professor Labonté, who co-authored the book *Health for Some: Death, Disease and Disparity in a Globalizing Era*, explains that gross inequality of resources has given momentum to the movement of health care professionals. "The poorest countries are going through a collapse of their public health systems, often the result of dual crises in both financing and management," he says. "Meanwhile, globally, there is a brisk labour market for highly skilled professionals in many fields, but notably in health care. In that competition, the poor countries can't possibly compete." Health training, he says, is widely seen as a passport to a better life, a difficult trend to deal with for well-meaning organizations fighting "unethical recruiting."

Margaret Zondo, a Zimbabwean who works for the Presbyterian Church in Canada, confirms that skills migration is particularly devastating for African health care, "with [the loss of] teachers, engineers, and scientists close behind. It costs $200,000 [US] to train a doctor in Zimbabwe or South Africa," she says, "and they end up in places like Manitoba, where one in three rural doctors is from Africa." Zondo herself personifies the migration. Ten years ago, armed with an MBA from Edith Cowan University in Australia, she became the permanent secretary of Zimbabwe's Public Service Commission, a high-ranking job that left her in ultimate charge of 170,000 civil servants. It was a difficult time. In the mid-1990s, the International Monetary Fund compelled Zimbabwe to reduce its public service by 25 percent in order to qualify for continued foreign loans and aid. The effect, Zondo says, was that skilled and educated people were cut loose, and many of those who kept their jobs were underemployed and forced to moonlight. (Zondo described a close friend, a linguistics professor, who double-shifts as a chauffeur for a wealthy businessman.) In 2001, with Zimbabwe spinning out of control, she bailed and came to Canada.

"These days, when South Africans leave to go to North America and Europe, Zimbabweans and Malawians move into South Africa to fill the gap," Zondo says. The hole left in Zimbabwe is partially filled by Cubans, who, having been recruited by the Zimbabwean government, are paid more and in foreign dollars, two facts that cause considerable resentment. (Remittances, Zondo adds in an aside and with obvious frustration, are fine for family and friends, but they don't stimulate local economies, and, worse, they "hold down unrest, helping governments survive that shouldn't.")

Another absurdity was pointed out three years ago by the Commission for Africa, convened by then British prime minister Tony Blair. It argued that the number of foreign technical experts recruited by Africa far exceeded the

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number of skilled migrants leaving the continent. That is, for every educated African national making an exit, the developed world responds by sending more than one medical professional, engineer, lawyer, teacher, government analyst, or environmental planner. It's madness, Zondo says: "The very least the West could do is use more of that [foreign aid] money to employ *our* skills." Indeed, estimates vary, but as much as 35 percent of the total foreign aid sent to Africa each year goes to pay the salaries of foreign professionals.

In an attempt to address one aspect of the issue, the United Nations Educational, Scientific, and Cultural Organization (UNESCO) and Hewlett-Packard have engineered a unique partnership called Piloting Solutions for Reversing Brain Drain into Brain Gain for Africa. It provides grid-computing technology to universities in Algeria, Ghana, Nigeria, Senegal, and Zimbabwe, and aims to establish information-sharing links between researchers who have stayed in their home countries and those who have left. Without access to top-flight research in the North and West, the strength of African universities diminishes, which in turn makes it increasingly difficult for them to attract the best and brightest. The University and College Union in the UK, which devoted itself to an in-depth study of the issue two years ago, is now advocating the development of programs "aimed at encouraging African higher education unions to organise and develop such that they can themselves argue for capacity building work in the education sector in their home countries."

These are noteworthy efforts, but ultimately long-term solutions require the contributions of a very broad circle on both sides of the divide. In a recent press release, Dr. Danielle Grondin, director of the migration and health department for the Geneva-based International Organization for Migration, argues that "international migration of health human resources is not a good or a bad thing, per se. Its effects depend on the policies and flanking measures put in place to guarantee equity, access, and quality of services in accordance with the particular national situation." While allowing that "pull factors, especially the promotion and enforcement of ethical recruitment practices," should be addressed, the IOM stresses that "retaining health care workers in sending countries means addressing factors that often push them to leave, including difficult working conditions, low salaries, excessive workloads, and lack of career prospects or training opportunities." The IOM, that is, places at least as much responsibility on the sending countries.

Labonté notes that "as much as we rich countries have obligations to stem this, the so-called source countries have responsibilities themselves." Kenya is a case in point, he says. It is home to thousands of trained nurses it desperately needs but cannot employ, due to a lack of money to pay them, and a lack of money or means to set up clinics—all the organizational and

management shortfalls that paralyze a country. "The Philippines," he says, "deliberately trains nurses for export, hoping for the remittances they will send back to the country, while enduring shortages at home. What are you supposed to do about that?"

While any road to a long-term and equitable solution is fraught with pitfalls, Keith Martin, the federal Liberal critic for international development and a medical doctor who has visited Africa twenty-six times, laments that Canada isn't doing much of anything. He points to the Commonwealth Code of Practice for the International Recruitment of Health Workers, a 2003 proposal in which the signatory countries agreed not to recruit actively; Canada wouldn't sign on. Instead, in 2005 the Liberal government adopted measures to speed the training and certification of foreign health care professionals already resident in Canada, so we could use them here more expeditiously and effectively. "If we're going to do that," Martin says, "we're obliged morally to help on the other side." His prescription? "For every international health care worker we take on here, we should train two in their country of origin… The present government could do it, [but this] would mean big changes at the Canadian International Development Agency, where getting anything through is like pushing sand uphill," Martin says.

Canada provided $3.7 billion in foreign aid in 2005–2006, mostly through CIDA. It is a far cry from the 0.7% of GDP that Prime Minister Pearson long ago established as our goal, but what is equally lamentable is the hypocrisy of one arm of government, CIDA, sending aid for medical purposes to Third World countries, while another arm, Citizenship and Immigration Canada, encourages the skilled health care professionals from those countries to emigrate to Canada.

The choice for Canada appears clear: recruit more foreign health care professionals, or train more of our own. Given that the per-student cost to governments of undergraduate medical school education is upwards of half a million dollars, it would appear unlikely that there will be a dramatic increase in class sizes. As some have asked, what is the point of expensive training if you can get somebody else to do it for you?

The global choice is either to find ways to reduce the drain of medical professions from strapped Third World countries, or watch as half the world continues to become much worse off than it already is. In order to reduce foreign recruiting, Ronald Labonté believes Canada needs to follow Britain's lead: ensure it is training its own supply of health care professionals. In the meantime, on the issue of compensation he agrees with Keith Martin. The problem, however, is that such compensation systems would only truly work under multilateral agreements — of which, presently, there are none. If Canada, for instance, paid for the training of two doctors in South Africa in return for receiving a fully trained South African doctor, what guarantee would it have that its new doctor would stay here, or that the two doctors trained in South Africa wouldn't move elsewhere? Thus, while Labonté asks rhetorically, "Could Canada play a role?" and answers, "Well, somebody needs to start," ultimately only a multinational approach will solve the vexing problem of foreign aid in reverse as it pertains to health care.