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Globalization and Health Equity Unit

Recruiting foreign-trained health human resources:

Practices and perceptions of Canadian health organization recruiters

Vivien Runnels, Corinne Packer and Ronald Labonté

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This document is intended for those that participated in this study and decision-makers who might find research on health human resources recruitment in Canada helpful. The authors welcome comments and suggestions.

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Ethics: The study that is reported here was approved by the University of Ottawa Research Ethics Board. In order to respect the anonymity of informants, we have removed geographical and personal identifiers. We also refer to the respondents' affiliated institutions, which included regional and provincial health authorities, hospitals, and community-based recruiting organizations, as "health organizations", to avoid the possibility of identification of participants.

List of Acronyms

CAR	Canadian Association of Radiologists
CIC	Citizenship and Immigration Canada
CIDA	Canadian International Development Agency
CIMC	Citizenship Immigration and Multiculturalism Canada
CMAJ	Canadian Medical Association Journal
FTE	Full time equivalent
HFO	HealthForceOntario
HRSDC	Human Resources and Social Development Canada
LDC	Least Developed Country
LHINs	Local Health Integration Networks
NOC	National Occupational Classification
OECD	Organization for Economic Co-operation and Development
RNs	Registered Nurses
SSA	sub-Saharan Africa

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Chapter 1: Introduction

Over 7% of nurses and 22% of physicians in Canada are foreign-trained (Canadian Institute for Health Information, 2009; Canadian Institute for Health Information, 2008). The majority of health professional migrants come to Canada already in possession of skills, and sometimes with considerable training and experience. In addition to those who are admitted to Canada without pre-arranged employment, an estimated 400 foreign-trained physicians arrive in Canada each year with pre-arranged employment and are already licensed to practice (Schumacher, 2005). The costs of training all of these individuals have largely been borne by countries other than Canada.

Health professional migrants come to Canada from diverse countries[1] (see Tables 1 and 2, and Figure 1). The number of physicians and nurses and other health professionals trained in developing countries, such as those in sub-Saharan Africa (SSA), and now working in Canada, seems substantial when seen as a percentage of the workforce of the sending country (Canadian Institute for Health Information, 2009). Available information indicates that doctors trained in sub-Saharan Africa and working in 8 Organization for Economic Co-operation and Development (OECD) countries may represent up to a quarter of the current workforce in those countries, ranging from 3% in Cameroon to 37% in South Africa (World Health Organization, 2006, p 100). (See also Hagopian, 2004; Clemens and Pettersson, 2007 and Mullan, 2005 for other numbers).

1 Source countries are not only countries of birth, but may also be where people received medical and nursing training. The countries from which people emigrate to Canada, therefore, are not always synonymous with country of birth or country of training. Although we were interested in physicians and nurses that had trained in sub-Saharan Africa and other developing countries, we learned that some health human resources (HHR) from these areas are not necessarily born in SSA countries. There were reports, for example of Indian physicians and African physicians training in South Africa and then moving to the United Kingdom and from there to Canada.

Table 1: Top 10 countries of graduation for foreign-trained physicians, according to province/territory and in Canada, 2007[2]

Province / Territory	Country of MD Graduation										
	United Kingdom	South Africa	India	Ireland	Egypt	United States	France	Poland	Pakistan	Philippines	% of Total Foreign Trained MDs Represented by Top 10 Countries in each province/ territory*
Newfoundland	35	36	51	50	18	2	0	7	28	6	70%
P.E.I.	7	2	3	3	0	0	2	0	3	0	71%
Nova Scotia	106	32	81	53	24	32	3	41	40	7	71%
New Brunswick	30	12	46	12	10	7	14	14	19	12	59%
Quebec	39	8	27	19	110	82	359	37	10	12	39%
Ontario	845	352	691	523	333	196	40	168	117	105	63%
Manitoba	86	122	58	42	40	9	3	26	21	17	71%
Saskatchewan	72	234	109	45	13	6	2	14	39	19	75%
Alberta	322	475	144	147	44	40	7	55	75	22	72%
British Columbia	526	693	145	191	29	118	9	50	34	25	75%
Yukon Territory	2	2	1	2	2	1	0	0	0	0	59%
N.W.T.	2	3	1	0	0	0	0	0	0	1	50%
Nunavut	0	0	0	0	0	0	0	0	0	0	0%
Total (in Canada)	2,072	1,971	1,357	1,087	623	493	439	412	386	226	65%

*Notes: Percentage of foreign-trained grads represented by top 10 countries equals sum of the physicians represented by the top 10 countries/ total number of foreign-trained graduates.

2 Source: Adapted from Scott's Medical Database, Canadian Institute for Health Information as cited in: Canadian Institute for Health Information. Supply, Distribution and Migration of Canadian Physicians, 2007. Health Human Resources Ottawa: CIHI, 2008, p 119.

Table 2: Percentage of Foreign-Trained Registered Nurses (RNs) by Country of Graduation, in Canada by Year[3]

Country of Graduation	Percentage (%) of Foreign Registered Nurses by Year							
	2006	2005	2004	2003	2002	2001	2000	1999
Australia	1.8	2.1	2.2	2.2	2.5	1.5	1.9	ND
France	ND	ND	ND	ND	ND	1.5	ND	ND
Hong Kong	4.7	5.0	5.3	5.6	6.0	5.9	6.9	6.4
India	5.6	5.3	4.8	4.7	4.5	4.4	4.3	4.3
Jamaica	ND	ND	ND	ND	ND	2.9	2.7	ND
Netherlands	ND	ND	ND	ND	ND	ND	1.1	ND
New Zealand	ND	ND	ND	ND	ND	1.5	1.2	ND
Philippines	30.8	30.3	29.3	27.9	27.1	26.5	23.8	23.5
Poland	3.4	3.3	3.3	3.2	3.0	2.9	2.8	ND
United Kingdom	17.9	18.8	21.4	23.3	24.5	26.5	28.6	30.5
United States	6.4	6.5	6.6	6.9	8.2	8.8	9.0	9.4
Other	29.4	28.8	27.0	26.2	24.1	17.6	17.7	26.0

ND= no data

3 Sources: 2006 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 2006. Ottawa: CIHI, 2007, p 48.
2005 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 2005. Ottawa: CIHI, 2006, p 44.
2004 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 2004. Ottawa: CIHI, 2005, p 47.
2003 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 2003. Ottawa: CIHI, 2004, p 30.
2002 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 2002. Ottawa: CIHI, 2003, p 78.
2001 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 2001. Ottawa: CIHI, 2002, p 70.
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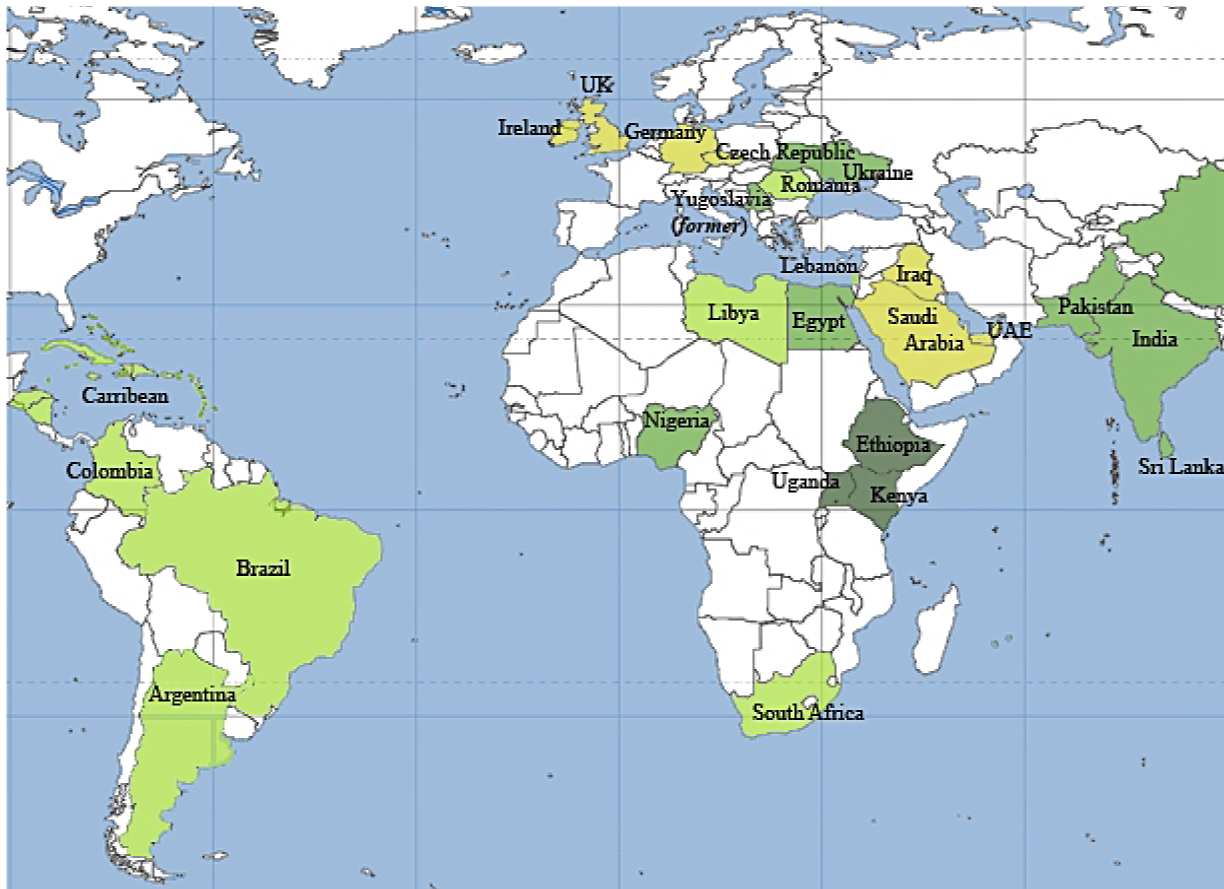
1999 values: RNDB, CIHI. as cited in: Canadian Institute for Health Information, Workforce Trends of Registered Nurses in Canada, 1999. Ottawa: CIHI, 2000, p 34.

Figure 1: Canadian recruiters' personal knowledge of source countries of health professionals migrating to Canada[4]



In a previous study, we looked at the migration of health professionals from sub-Saharan African countries, and the impacts of international recruitment (Labonté et al., 2006). As a result of conducting this study, our interest and concerns continued with questions about the processes that were used to recruit health human resources particularly from developing countries. How were developed countries, such as Canada, going about recruitment of HHR internationally? What are the experiences of Canadian recruiters of foreign-trained health human resources? This report, therefore, is a result of an enquiry focusing on the experiences and roles of a sample of recruiters in the public sector who recruit foreign-trained health human resources in Canada.

4 We utilized the World Bank list of economies to determine the economic status of countries from where health professionals have migrated. Source: World Bank list of economies (April 2010) Accessed 01/04/2010. URL:http://siteresources.worldbank.org/DATASTATISTICS/Resources/CLASS.XLS

Study methods

We interviewed recruiters from urban, underserved, rural and Northern areas in five Canadian provinces known to be recipients of health professionals from developing countries, including sub-Saharan Africa. These health organization recruiters worked for different organizations who recruited doctors, nurses and other allied health professionals for primary and acute publicly-funded health care. We did not interview recruiters who were associated with provincial initiatives such as HealthForceOntario Marketing and Recruitment Agency, or from hospitals that served psychiatric, geriatric, developmentally handicapped and rehabilitation populations, or had less than five permanent beds; private hospitals that are funded outside public health plans were also not included in the study.

After receiving approval from the University of Ottawa Research Ethics Board, we sent an initial request to the administrative heads of health organizations (such as Chief Executive Officers) to grant permission for staff recruiters to participate in research. Our first contact to the administrative heads was by email, and was followed by a telephone call. We next used a modified version of Dillman's methods for contacting potential participants which involved further email requests and telephone calls, registered letters sent to those from whom we had not received a reply, and a follow-up telephone call (Dillman, 2000). In total, we requested interviews with 64 health authorities and hospitals. We had six refusals to participate and 14 withdrawals. A number of organizations and authorities did not respond to our repeated requests for interviews. Those organizations that agreed to participate referred us to the appropriate staff members for an interview.

Table 3: Number of Health Authorities and Hospitals Approached for Interview per Province and Results (No Response, Declined, Withdrew or Accepted)

Province	Approached	No Response	Declined	Withdrew	Accepted
Manitoba	11	1	2	3	5
Saskatch-ewan	12	2	2	4	4
Alberta	9	7	0	1	1
British Columbia	6	2	2	1	1
Ontario	26	0	0	5	21
Total	64	12	6	14	32

The questions that we used are outlined in Appendix A.[5] All interviews were digitally recorded, and transcribed by a professional transcriptionist. In order to respect the anonymity of informants, where quotes are used, we have removed geographical and personal identifiers, including the names of all health organizations. We note that recruiters gave answers from their perspectives, experiences and knowledge. Although all interviews were approved by the organizations' chief executive officers, answers did not necessarily reflect official organizational policies or views. We use the informants' quotes (in some cases, edited for brevity) to illustrate the points made. We also note that much of the information that was reported applies equally to in-country or domestic recruitment, because many foreign-trained HHR are already in Canada before they seek employment, or are recruited.

This report on the practices and perceptions of Canadian health organization recruiters forms one part of the SSHRC study. In addition, we conducted some preliminary work into developing a methodology for evaluating the costs and benefits of recruiting foreign-trained health human resources.

5 This report focuses on the practices and perceptions of health human resources recruiters. The questionnaire also included questions concerning our interest in learning about the extent of movement from sub-Saharan African countries in particular and other developing countries, but also in getting a generalized picture of migration routes to Canada of international medical graduates (IMGs), internationally educated nurses (IENs) and other health care professionals. Saskatchewan, for example, has traditionally been associated with recruitment of health professionals from South Africa. We also asked recruiters to rate and comment on policies which have been proposed to balance the rights of people to migrate with the losses that occur to countries through their emigration.

Costs of recruiting internationally trained medical graduates and nurses

We received some anecdotes with regard to costs (See Box 4 at the end of Chapter 3), but also sought to formally identify costs associated with the recruitment and workplace integration of foreign-trained health professionals. For our study, we hoped to come up with a preliminary identification of these costs and benefits with a view to a future cost-benefit analysis. There are direct and indirect, tangible and intangible economic and healthcare-specific costs and benefits associated with health professional acquisition and workforce integration.[6] Some of these costs and benefits are quantifiable, others are not.

Our enquiry took some initial steps which included: identifying issues or fields that are critical for the economic study of the recruitment of foreign-trained health human resources; gaining access to holders of data; assessing existing data and their accessibility; and finally determining the feasibility of a comprehensive cost-benefit analysis.[7] Assessing these costs and their benefits would mean being able to determine if these costs, in economists' terms, are social welfare improving; that is, whether an investment of tax revenues into IMG accreditation (for example) is a more socially desirable investment than the domestic training and education of health professionals. A number of healthcare stakeholder organizations, agencies and institutions were determined to have time-series data on the tax-financed costs for different components of integration programs, but in varying amounts and with different terms of access. Similarly, time-series data on earnings of licensed and practising foreign-trained health professionals and other labour market information could be obtained from a number of healthcare and non-health care organizations.

Beyond the preliminary scoping of data sources and their accessibility, the undertaking of a cost-benefit analysis is complex and demanding. One collaborative project has been undertaken in Western Canada and the Territories. The Western and Northern Health Human Resources Planning Forum, has provided some helpful information and data on the processes and costs of assessing, training and integrating foreign-trained health human resources into the health workforce in part of Canada.[8]

We think it might be helpful for local health authorities to have a clearer idea of their recruitment costs on a per capita basis (although these costs are likely to vary in any given time period, and the contributions to recruitment programs by federal and provincial authorities will also vary, so results are inevitably conditional upon a number of factors), and to be able to evaluate their recruitment programs. We can also

6 Successful integration is defined as "the ability to find work that uses one's education, training and experience and provides compensation commensurate with one's human capital." (Hum and Simpson 2004, p 47, cited in Weiner N., 2008).

7 For a literature review related to this study, see "The costs and benefits of health worker migration from East and Southern Africa: A literature review" by Rudi Robinson. Equinet Discussion Paper 49 August 2007. Accessed 01/04/2010. URL: http://www.sarpn.org.za/documents/d0002875/Health_equity_Africa_Robinson_Aug2007.pdf

8 http://www.hhrpforum.com/

suggest that an investment of time and resources (for example, by the World Health Organization or the Global Health Workforce Alliance) into developing a basic methodology that can be used to identify the necessary data and their treatment, for use in carrying out an evaluation of the costs and benefits of recruitment of foreign-trained health human resources at the country level, will help both sending (source) and receiving (recipient) countries produce evidence for action.

Structure of the report

The report is structured as follows: Chapter 2 is an introduction to HHR issues in Canada, and sets the context in which the recruiters work; Chapter 3 describes the means and methods that recruiters use in their practice, and the involvement of third party recruiters and provincial ministries of health in recruitment; Chapter 4 describes recruiters' perceptions and experiences with HHR in negotiating the processes of education, immigration, licensing and regulation, and the roles that some recruiters play in settlement of HHR and the final Chapter closes the report with some general comments on the recruitment of foreign-trained health human resources.

Chapter 2: The Canadian Context and Health Human Resources

Canada, like much of the rest of the world, currently faces shortages, maldistribution and misutilization of health human resources. Based on a minimum density of 25 HHR (doctors, nurses and midwives combined) per 10,000 population, the World Health Organization has calculated a shortage of 4.3 million HHR worldwide (World Health Organization, 2006; Global Health Workforce Alliance, 2006). Studies have shown that lower maternal, infant and under-5 mortality rates are due to the interventions of doctors, nurses and midwives (Chen et al., 2004). In addition health workers make it possible to achieve health system reforms, scale-up interventions and address health inequities (WHO, 2006). In the global situation, Canada is comparatively well off in terms of HHR density.

Table 4: Density of Physicians per 10,000 Population in Selected Countries[9]

Country	Physicians per 10,000 Population	Year
Canada	19	2006
United Kingdom	23	1997
South Africa	8	2004
India	6	2004
Ireland	29	2006
Egypt	24	2005
United States	26	2000
France	34	2006
Poland	20	2005
Pakistan	8	2005
Philippines	12	2002

Current ratios would suggest that Canada does not experience severe shortages, but for a variety of suggested reasons which include maldistribution and possible misutilization or inefficiencies of doctor and other health professional resources,

9 Source: WHO Statistical Information System (WHOSIS), Core Health Indicators, 2008. Accessed: 01/04/2010. URL: http://apps.who.int/whosis/database/core/core_select_process.cfm

many geographic areas experience shortages.[10] According to the Canadian Nurses Association (Canadian Nurses Association, 2002) Canada will experience a shortage of 78,000 registered nurses (RNs) by 2011 and 113,000 RNs by 2016. Whether there will be a shortage of doctors in the near or middle future is not as clear. However there is current concern, supported somewhat by the inability of some Canadians to register with family doctors, that there will be insufficient numbers of family physicians and general practitioners to meet, if not needs, then certainly demands. In addition, shortages of specialist doctors are predicted; although again this 'shortage' is supported only loosely by the existence of waiting lists for some specialist treatments. As one example, the current (2004) radiologist-to-population ratio is 1:18,000; the Canadian Association of Radiologists (CAR) suggests that 1:13,000 is a more appropriate target (El-Jardali & Fooks, 2005).

Table 5: Density of Nurses/Midwives per 10,000 Population in Selected Countries[11]

Country	Nurses/Midwives per 10,000 Population	Year
Canada	101	2006
Australia	97	2001
Hong Kong	No data	---
India	13	2004
Jamaica	17	2003
Netherlands	146	2006
New Zealand	89	2003
Philippines	61	2002
Poland	52	2005
United Kingdom	128	1997
United States	94	2000

These predicted shortages are in part explained by changes in the age structure of the health system workforce. About one third of the physician workforce is in the over-55

10 The methods of calculating (adequacy and) shortage of HHR are inexact and irregularly applied. Ratios of health professionals to population are one means of broadly assessing the adequacy of HHR to serve populations. Vacancy rates are indications of positions that need to be filled. Inability to fill positions after a protracted period of time is another general means of assessing real shortages. The measurement of 'true' shortages of HHR in the sense of distributional inequalities, can be applied to entire regions in the aggregate (as WHO calculations do with regard to primary health care including doctors, nurses and midwives), or designated by type of worker e.g. nurses, doctors. Such estimates also need to take into consideration the specific needs of a region, for example, where there are greater numbers of elderly people there may be greater need of geriatricians. For further discussion of measurement of shortages of HHR, see, for example, Dussault & Franceschini (2006), Pong & Pitblado (2001), and Munga & Maestad (2009).

11 WHO Statistical Information System (WHOSIS), Core Health Indicators, 2008. Accessed: 01/04/2010. URL: http://apps.who.int/whosis/database/core/core_select_process.cfm

age group. A bulge in the population in Canada caused by the post 2nd World War baby boom also means that doctors, nurses and other health professionals will be needed to replace those who are retiring, to provide baby boomers and their 'echo' children with health care. Additionally, fewer graduates are training as family doctors contributing to a shortage of family physicians. More are going into specialty training which delays full entry into the workforce (Hawley, 2004).

Other contributors to a potential shortage of doctors and the predicted shortage for nurses include evidence of maldistribution of HHR. HHR preferences for work in urban areas, means that it is easier to staff major centres in Canada than to staff distant northern and rural hospitals and practices. Work habits are also changing: doctors are less likely to work the long work weeks that they have worked in the past. To assure time to look after their families, female doctors work shorter hours than male colleagues (Hawley, 2004). Changes to population structure also have other implications for health care and health human resource planning. For example, baby boomers aged 60 and older have different demands and require different expertise in the healthcare system, for 'age-related ailments' such as knee and hip replacements, in comparison to their 'echo' children who are currently in their reproductive years (Basu and Halliwell, 2004, p 19)[12]. As one study respondent stated:

> "The truth is we're going to hope to get people immigrated (sic) because we're not turning out enough doctors to replace the old people who are working 60 to 70 hours per week…And with more female [physicians] [we're] going to need more physicians because they are going to take time off to have children".

It is important to note that 'shortages' do not sit in an easy relationship with the requirements of balanced budgets. During the time of data collection for this study, for example, the Rouge Valley Health System in Ontario announced the cutting of 72 nursing positions in a plan to balance the budget.[13] The cutbacks were put into effect, not because the nurses were not needed, but because hospital budgets were constrained.

Planning for HHR

The Royal Commission on the Future of Health Care in Canada (the 'Romanow Commission') (2002) noted the "immediate and looming shortages of some health care providers, especially nurses" and made a number of recommendations with regard to health human resources planning, including: "a comprehensive plan for HHR" because "there is currently no viable mechanism for health human resource planning in Canada …" (Romanow, 2002, p 36). At the national level, Task Force Two (2006) which was a partnership of national, provincial and territorial healthcare organizations

12 For a useful summary of these issues, see , for example, British Columbia College for Family Physicians BCCFP HHR Responses Conversation on Health 2007. Accessed on 01/04/2010. URL: http://www.health.gov.bc.ca/library/publications/year/2007/conversation_on_health/media/HHR2_Comments.pdf

13 http://www.thestar.com/News/Canada/article/413143

and governments, investigated and proposed planning recommendations for the doctor workforce in Canada to ensure "… the right kind of physicians, trained to offer the right kind of care… at the right time …in the right parts of the country …" (Task Force Two, 2006, p 5). The recommendations included recognizing foreign-trained doctors as part of the planning landscape, ensuring a sufficient number of postgraduate positions to allow qualified international medical graduates to enter practice and accommodating Canadian re-entry applicants (i.e. Canadian nationals who receive their health professional training overseas). Yet, six years after the Commission's report, "the federal leadership and support that is needed to develop a central planning mechanism is missing ..." (Silversides, 2008, p 1116).

Over the course of our data collection, Ontario was undergoing its second year of reorganization of regions through the institution of Local Health Integration Networks (LHINs)[14] (started April 1 2007); while Alberta re-centralized its health system in 2008, unifying its regions into one super-region, the Alberta Health Services Board.[15] We observed rapidly changing provincial ministerial responses with regard to HHR, and steps taken to work with regulatory colleges and new infusions of resources to address HHR issues. Actions at the level of provincial ministries suggested responses to recognized shortages in HHR. Other steps, such as making a distinction between direct (active) and passive recruitment, seems to have made the recruitment and employment of foreign-trained health professionals more palatable. For example, an ethical recruitment statement posted by Health Force Ontario includes "avoiding direct marketing to their physicians…protect(ing) the health care systems of developing nations and under-served jurisdictions." [16]

14 http://www.lhins.on.ca

15 (See for example, De-Regionalizing Alberta: The Road to Reform or Collateral Political Damage? And then there was one. Steven Lewis. Health Care Issues May 20 2008).

16 http://www.healthforceontario.ca/Jobs/MarketingandRecruitment/EthicalRecruitmentStatement.aspx

Chapter 3: Getting recruits

HHR recruiters came from a variety of backgrounds. Some had human resources experience or personnel specialist backgrounds, while others had professional health care experience. Some, but not all had considerable professional experience as physician and nurse recruiters. We learned from our recruiters that not all of them were paid staff, but occasionally included interested and concerned volunteers. Recruiters' roles were to directly recruit HHR. They were not directed to confine recruitment to domestic trained HHR, although in practice many did retain a focus on domestic recruitment. In addition to recruiting nurses, doctors and other allied health professionals, some recruiters reported recruiting 'newer' health professional positions. These included physician assistants, not currently regulated in Canada but making their entrance on the health human resources stage[17] and nurse practitioners[18], who are currently estimated to form only 0.4% (2006) of the total RN workforce (Canadian Institute for Health Information, 2008, p 12), but a profession that is increasingly in demand. Some positions were reportedly created in attempts to retain potential staff until they had completed regulatory and licensing requirements.

Box 1: Physician recruiters in Canada

Physician recruiters have formed their own association, the Canadian Association of Staff Physician Recruiters. The Association's membership criteria indicates that "Membership is open to non-profit Physician Recruiters employed or retained by hospitals, hospital corporations, clinics, health care regions or authorities, public sector, government agencies or communities to recruit and retain physicians for that entity. Membership is limited to Physician Recruiters who are not employed by Recruitment or For-Profit Agencies." http://caspr.ca/pages/about_membership.

In addition to their roles to directly recruit HHR, respondents worked to support and help enquirers negotiate complicated structures of licensing, and federal and provincial immigration processes and programs. This meant that many recruiters coordinated information, and developed and maintained personal contacts across a variety of federal and provincial government ministries and other organizations relevant to

17 Physician Assistants have practiced in the Canadian Forces and in the United States for over 40 years. There is a Canadian Association of Physician Assistants (http://www.caopa.net/). At the time of writing, McMaster University in Hamilton, Ontario and the University of Manitoba have physician assistant training programs.

18 A nurse practitioner (NP) is a registered nurse with additional education in health assessment, diagnosis and management of illnesses and injuries, including ordering and interpreting tests and prescribing drugs. (CNA and CIHI (2006) The regulation and supply of nurse practitioners in Canada: 2006 update. Ottawa: CIHI. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1263_E&cw_topic=1263. Also Canadian Nurses Association, The Nurse Practitioner (Ottawa: CNA, 2003), [online], cited June 15, 2005, From cna-aiic.ca/CNA/documents/pdf/publications/PS68_Nurse_Practitioner_June_ 2003_e.pdf.

immigration, education, licensing, regulation and employment.[19] These aspects of recruiters' roles are reported in Chapter 4.

Few recruiters reported having any specific organizational policy with regard to the recruitment of HHR. A specific policy on international recruitment was therefore not part of organizational policy portfolios. Some recruiters felt that policy was needed, and in one case there were plans in place to develop such a policy. However, a number of factors, including time appear to mitigate against its development.

> "The importance of policy is really quite key. I do appreciate it, but who has time to sit and develop them?"

Recruiting from other countries

We asked informants about the recruitment of all foreign-trained health care professions, including doctors, nurses, specialist nurses, pharmacists, and others. The majority of the recruiters that were interviewed had little or no involvement with recruitment from other countries.

> "We are not doing a lot of international recruitment. We do not have a lot of international recruits coming into our organization."

> "International recruitment is not a strategic thrust for us at all."

> "I shudder at the word 'recruit' internationally because other than offering information, we're not actively soliciting them."

Most respondents stated that they "haven't gone overseas and recruited." Some recruiters added that they received few enquiries from overseas: "Not a lot from overseas. It's primarily once they arrive here." The majority of respondents reported that in addition to not generally recruiting internationally, they were also not targeting countries outside of Canada to recruit HHR. Some participants included the United States in their understanding of domestic recruitment, "We don't go knocking on anybody's door, you know, outside of North America." Other recruiters reported personally targeting HHR in Australia and New Zealand, although these two countries were not recent targets. There were a couple of references to recruitment in countries where recruiters were aware of layoffs. There were occasional references to the 'ethics' of recruiting from some countries: "I know there's a concern about taking professionals from countries that are not well resourced anyway."

International recruiting or recruiting directly from other countries is not the same as recruiting foreign-trained health professionals. In many cases, trained individuals have already immigrated to Canada and apply for jobs after arrival. Recruiters often work with individuals who have been internationally trained who are already in Canada.

19 There are a number of projects some already in place and others proposed such as the Creating Access to Regulated Employment (CARE) for Nurses bridge training project across Canada. http://www.care4nurses.org/

Respondents reported that some recruitment campaigns were aware of some campaigns conducted overseas. For example, in 2008, Capital Health in Alberta conducted a mass recruitment drive in several countries.[20] Other external campaigns have been conducted by provincial health ministries. For example, HealthForceOntario Marketing and Recruitment Agency have conducted campaigns in the United States.[21] (See also Box 2 below).

Recruiters' advertising plans ranged from integrated and planned media campaigns to "try whatever you can." Most recruiters use multiple means to advertise. Recruiters are aware of the importance of using the appropriate media to reach potential recruits, e.g. "a large component of older nurses …are not that computer savvy so we have to be very delicate of when we go into a print advertising situation versus being on the internet." The most successful methods of recruiting appeared to be those that were tailored to specific professions.

Outside of posting on internal job boards, individual methods of advertising and recruitment included print advertising, internet advertising (hospital websites and government websites), internet-facilitated social networking sites (Facebook, LinkedIn), internet classifieds (for example, Workopolis, monster.com and charityvillage.ca), third party or 'head hunters', attendance at conferences, annual meetings, HHR job fairs, and hosted receptions. Radio and television campaigns were also reported. Recruiters told of specific domestic recruitment campaigns which included activities that ranged from site visits to training institutions to talks with new graduates. Other types of recruitment strategies and methods extended to provision of space for networking and referral, an internet version of word of mouth.

The focus of advertising strategies was not always about "selling a job and selling it big." Some recruiters indicated "I want to sell my region because I think my region has some benefits … this is really a good place to live, work and play."

20 http://vueweekly.com/front/story/healthcare_qualified_statements/

21 Canada targets WNY doctors. Buffalo Business First Western New York's Business Newspaper. Friday February 27, 2009 Accessed from http://buffalo.bizjournals.com/buffalo/stories/2009/03/02/story3.html on November 10, 2009. HealthForceOntario Marketing and Recruitment Agency is the Ontario government's agency providing services to support newcomers through the licensure and registration process (Health Force Ontario Access Centre), including job listings (HFO Jobs), and is specifically responsible for the development and execution of required marketing, recruitment and retention activities. http://www.reuters.com/article/pressRelease/idUS159826+23-Sep-2008+PRN20080923

Box 2: External campaigns

1) Recruitment campaigns outside Canada have gained some attention in the media. http://www.cbc.ca/canada/saskatchewan/story/2008/03/11/nurses-recruit.html For example a 2008 campaign to the Philippines by Saskatchewan cited as being "part of the government's campaign pledge to hire 800 nurses to alleviate the nursing shortage" in addition to health region involvement, was set up with the involvement of the Government of the Philippines, the Government of Saskatchewan and the Ministry of Health, and the Government of Canada. (Delegation returns from successful nursing recruitment trip to Philippines) http://www.gov.sk.ca/news?newsId=2483d074-e7e7-4d20-884b-13edd808529c.

2) According to a January 29, 2008 news release, the goal of a recruitment campaign in the United Kingdom, was to attract "experienced U.K.-licensed nurses to the Vancouver area…All recruits are qualified to practise in the U.K. and may originally be from communities around the British Isles as well as countries such as Ghana, Jamaica, India, Zimbabwe and the Philippines. Some of the successful candidates are also Canadian-born nurses who wish to come 'home.'"

The campaign involved attendance at a number of job fairs and a major nursing congress in the U.K. More than 600 interviews of experienced nurses were conducted. According to the news release, in 2007 a total of 325 nurses were hired, with a number of nurses waiting to be hired, and others participating in a pre-screening process. http://www.providencehealthcare.org/RecruitmentCampaign.htm and www.nursevancouver.com.

3) Alberta hospitals were engaged in "headhunting" Filipino nurses working in Ireland, through Fil-Overseas (Ireland) Ltd, a recruitment company. Media reports noted offers of fast-track work visas, better wages and low-interest-rate car loans to recruits. http://www.independent.ie/national-news/canadians-are-headhunting-our-foreignborn-nurses-1042350.html. The website of this recruitment company (which did not appear to have been updated recently) is currently showing advertising for RN interviews in 2008, for nursing opportunities for River Valley Health in the Fredericton area in New Brunswick (October 2009).

Print

Printed advertisements in newspapers were noted by some recruiters as the least effective means of recruiting HHR. One recruiter recalled an advertisement in a major national Canadian newspaper and "it brought absolutely not one single response… print advertising is like the worst way to find a doctor." Other recruiters did not dismiss print advertising. "…some people still like to open the paper and look and see that there's a position." Another recruiter reported that newspaper advertisements invited responses from candidates who were not qualified.

Recruitment by print also included using fax and email blitzes, university journals and student agendas, association news bulletins, magazines, journals and professional

journals (both country-specific and international), hospital newspapers and newsletters. The term "journals" was used to refer to academic journals such as the Canadian Medical Association Journal (CMAJ) and the British Medical Journal, as well as professional journals (for example Canadian Nurses Association Journal, Emergency Nurses Association, Medical Post and Outlook), industry journals (the Standard), and commercial publications such as Just for Canadian Doctors, Canadian Operating Room Nursing, Critical Care Nursing and more. Many journals are also available online.

Some recruiters and departments advertise in journals that have international reach although their recruitment targets are not specifically those outside of Canada and the United States. None of the recruiters reported knowledge of recruitment of specialties outside of Canada, although we found evidence of advertisements in South African and Indian medical journals.

Job fairs and conferences

There were two types of job fairs mentioned, those attached to colleges and universities, which are low cost to the recruiting organizations, and job and career fairs not attached to educational institutions that have a fee for attendance. Recruiters see it as very important that they present their own organization prominently and frequently at universities within their own provinces. "We're very big on making sure that we're always in their face…" There was some participation reported in job fairs across different parts of the country and at times in the United States, but "that's been less of a focus lately, because of diminishing returns." Conferences were not viewed as a major location for recruitment.

Word of mouth, and relationship building

Recruiters reported that personal contact and word of mouth constituted the best means of recruiting staff as the following quotes suggest:

> "Word of mouth is the best advertisement money can't buy…"
>
> "The best way? Word of mouth. Somebody knows someone that would be good here that we get in contact with."
>
> "I don't know if it's primarily just overseas but I know within the community base people tend to refer their friends to the organizations. One of our biggest ways of attracting people is word of mouth."
>
> "We do a tremendous business in word of mouth and basically our recruits do an awfully good job referring their friends. Satisfied and happy customers bring more customers to your door."

Another respondent said, "if you're in the (specialty) world, that's a more intimate community and you're more likely to know people in other centres who work in that

world …of the contacts that we get, one out of three or four typically come from that (community).”

For a small numbers of specialties, we were told, recruitment is done informally by word of mouth by the health professionals themselves. Some organizations had considered the establishment of referral programs as a useful adjunct to encourage word of mouth.[22] Recruiters themselves build on relationships developed through the recruitment process by keeping in contact with recruits and asking them for further recommendations. One recruiter felt that, regardless of the employment outcome, if you were helpful to recruits then the favour was likely to be returned, “Our philosophy from the beginning has been you (the potential recruit) never forget the hand that helped you when you had nothing in your own.” These relationships clearly are seen to have instrumental value beyond the relationship with the recruit.

Other means of building relationships include helping spouses or partners of potential recruits by connecting them with local communities and businesses. Recruiters also try to keep in touch with local people who leave the area to train elsewhere, either inside or outside Canada, and, when they can, to provide them with temporary training opportunities when they come back home for their holidays.

Using the Internet

The use of the Internet and international access to the Internet means that potential domestic and foreign recruits can learn about advertised positions. Thus, while health organizations may not specifically participate in international recruitment, their recruitment and advertising has international reach. The Internet provides the same information to a person “whether you’re in South Africa or in India or in Regina, Saskatchewan or in Ottawa…The information is the same, the message is the same, the opportunity is the same.”

Recruiters were generally enthusiastic about the Internet, internet classifieds sites and electronic posting boards. Internet classifieds sites such as Workopolis and charityvillage.ca, however, garnered both positive and negative comment. Some organizations’ websites were linked to Workopolis where information about openings is duplicated. “It’s one of the more popular ones so it directly links job searchers to our website - as soon as they apply they’re booted into our website.” A more recent venue for advertising for physician positions is on the Canadian Association of Staff Physician Recruiters Association website.

Hospital websites are reportedly used extensively by potential candidates. One large organization recruiter reported “we probably get in the neighbourhood of 26 to 30,000 applications a year off of our website.” A recruiter with a smaller organization estimated that one third of its enquiries were through its own website, also suggesting that the website is an important entry point for enquirers. In general, many hospital websites

22 Referral programs pay bonuses to existing staff members who refer others to the employing organization.

are linked via the internet to larger entities such as HealthForceOntario's website and Workopolis. Some smaller organizations are also linked to local community websites.

Internet and associated electronic media are used in particular for targeting younger recruits such as new graduates, and as a means of maintaining communications with potential recruits. Some health professions prefer to use web-based applications including email and social media websites such as Facebook to communicate. The impression obtained from our interviews is that use of the internet to post positions is leading to the abandonment of other routes of recruitment, although some of those interviewed had never used internet classifieds, and small organizations do not always have their own websites.

Recruiters suggested that many applications received through the internet were essentially unsuitable in terms of appropriate qualifications, or quality. As one recruiter noted, "(through) something like Workopolis we tend to get a lot of junk...we get the volume but we don't necessarily get the quality that we're looking for." Even in situations of shortage, recruiters are very concerned to find the right candidates for available positions. "We're looking for the superstars all the time. We're looking for shiny best. We are always trying to find the best candidates." That internationally trained medical graduates must be prepared to go through multiple hoops before they can gain employment serves as an indirect means of assessing the 'quality' of an applicant. "I can tell them what the process is going to be like up front and I have people that say 'I don't really want to do that' so it helps us identify who the real interested candidates are… it helps us determine whether or not…they (are) willing to put in the effort."

Despite the apparent importance of the internet and websites, we found no evidence of recruiters and their organizations using website statistics to critically assess the impact of their use on recruitment, for example, tracking particular interest in certain positions or determining popular webpages, or origins of enquiries, or testing numbers of hits or downloads.

Third party recruiters

Third party recruiters, or search firms, sometimes referred to as 'head hunters,' are for-profit organizations and agencies that provide contract services to health organizations. Third party recruiters may perform roles that Regional Health Authority and hospital recruiters and human resources staff do not perform because of lack of time, or lack of resources or expertise to source potential recruits. One respondent noted that she gets calls from headhunters about once a month looking for recruits. It was also suggested in a small number of interviews that contracting out of recruitment and other human resources services was becoming more common across Canada.

Box 3: Head Hunters - Medhunters

According to Business Week's website, (retrieved October 27, 2009) "Medhunters operates as a job board for healthcare professionals. It focuses on listing healthcare jobs from across the United States, Canada, and internationally. The company, through its website, MedHunters.com, matches healthcare job seekers with health care positions in the United States, Canada, Australia, New Zealand, the United Kingdom, and the Middle East." http://investing.businessweek.com/businessweek/research/stocks/private/snapshot.asp?privcapId=4173163

The company offers a variety of service offerings, including direct links to hospital or other websites, and several methods of searching e.g. through employers, through specific job postings. The company was founded in 1996 and is headquartered in Toronto, Canada.

A perusal of the Medhunters website on October 27, 2009 showed 171 healthcare jobs listed for Canada. Some of these single postings advertised multiple positions. Although many advertisements were for public sector positions, the majority was nursing and nursing support positions in the private sector. http://www.healthecareers.com/employer.asp?aff=MH&SPLD=MH&celgn=&email=

http://investing.businessweek.com/businessweek/research/stocks/private/snapshot.asp?privcapId=4173163

Provincial ministries of health and recruitment

Provincial ministries of health appear to be playing an increasingly active role in recruitment, both domestically and internationally. Individual provinces have set up gateways for recruitment of all health professionals, and specific sections that provide information to internationally trained HHR. These include HealthForceOntario (HFO) and **HealthForceOntario Marketing and Recruitment Agency**, Alberta Health and Wellness, BC Health Match (which is described as "a comprehensive, no-fee, health care recruitment service for the province of British Columbia")[23] HealthCareersinSask.ca and, in Manitoba, through the Ministry of Health's health careers website www.healthemployment.ca.[24] Manitoba, for example, has a Physician Resource Coordination Office which works directly with applicants on the steps needed for recruitment, immigration, and licensure. At the federal government level Human Resources and Social Development Canada (HRSDC) and Citizenship Immigration and Multiculturalism Canada (CIMC), have particular roles to play with regard to ena-

23 http://www.healthmatchbc.org/default.asp

24 HealthEmployment.ca is funded by the Manitoba provincial government to coordinate the recruitment of physicians.

bling immigration of temporary foreign workers and permanent residents by issuing visas and work permits.

Comments by respondents with regard to the various provincial ministry of health websites and services ranged from the negative to the superlative. For example, with regard to physician recruitment, HFO received some praise from recruiters: "It's very efficient, very good and they are marketing it as one place, one-stop shopping for the Province of Ontario so that means everyone has the same kind of exposure." Health Match BC was called "an invaluable resource to us by developing their piece on international recruitment" by another recruiter. But some commented on a perceived disconnect between provincial bodies' enthusiasm to recruit and place rapidly, and colleges' requirements for licensure which were lengthy and difficult for foreign-trained health professionals.

Record keeping of internationally-trained HHR

Recruiters rarely saw a need to keep records of countries of training or cultural backgrounds of foreign-trained HHR. One organization was interested in building information about cultural backgrounds in order to work with local communities and to give newcomers an introduction to local cultural and ethnic facilities and resources. A lack of interest in keeping records may have been related to an assessment that any information to be gained was not worth the time and effort, or that human resources record keeping systems had limited capacities.

Costs of recruiting internationally-trained HHR

As part of our interviews, and to help build a framework which would assist in identifying the costs of recruitment of foreign-trained health professionals, we collected some anecdotal reports of costs from recruiters. These costs were limited to those at the level of the health authority which recruiters knew about. Most recruiters were not responsible for budgeting processes nor did they have input into departmental, global hospital or authority budgets. The costs that they cited included the costs of full-time equivalent (FTE) recruiters and support staff for recruitment purposes, and funds for expenses incurred in recruiting health professionals. However, some recruiters were employed to carry out multiple tasks in the broader context of human resources. Not all of their tasks were related specifically to recruitment, integration or retention activities, so FTE costs were not an accurate reflection of total allocations in these areas. In the organization of recruiters' work, there were rarely any distinctions made between recruitment of foreign-trained health professionals and domestically-trained health professionals, although recruiters thought that there were differences in costs. Lack of evidence may have prevented the determination of cost differences in recruiting domestically- or foreign-trained health professionals, as well as evidence-informed decisions about conducting recruitment campaigns domestically or externally. Our collected data were impressionistic and did not allow us to come to any robust conclusions

with regard to the costs of recruitment incurred at the level of health authorities (See Box 4, below for some reports of costs).

Box 4: Costs of recruiting foreign-trained HHR

One study participant had roughly estimated the amount of staff time required to recruit a nurse. "Locally trained nurses, two to three hours investment…some province-trained nurses take a little more (5, 6 or 7 hours work through phone calls etc.). International recruitment [is] labour intensive [about] 20-40 hours of investment to get an international recruit."

This same recruiter argued that "(if) you give me a domestic recruiter I can probably make 200 to 300 hires a year whereas if I get an international recruiter, in one year's time they'll start to trickle in to the point of maybe, maybe 30 to 40 a year."

From this perspective it appears that there is a strong relationship of recruitment with proximity of candidates to the organization: the further the nurse recruit is from the home organization, the more the recruitment costs.

The same thinking, however, did not apply to recruitment for experienced and specialty physician positions: "There's the other side of the coin … by getting somebody who has five to ten years of experience in a clinical specialty and not having to train them (domestically) is, in fact, cost effective." This meant that any high costs incurred in recruiting experienced and specialty positions far outweighed the costs of training them to the same level.

Chapter 4: Supporting recruits

Some HHR recruiters have developed considerable expertise in navigating the immigration, education and licensing processes of foreign-trained HHR. As one recruiter claimed, “we can literally take a CV from any point in the globe today, study it and come back to them within hours, with step by step what you need to do in order to get a license to practice in our province.” Nonetheless, even with the help of recruiters, getting a license to practice is a complicated process for foreign-trained health professionals. Part of the challenge is related to the division of federal and provincial government responsibilities, and Canada’s separate provincial regulatory colleges which assess health professionals.[25] Provinces have different requirements and non-standardized lengths of time to process applications for licensing, such that some recruiters reported other provinces (some of which were not included in the study sample) as preferred entry points for immigration, licensing and employment because they were easier and faster for applicants to negotiate. Another part of the challenge is coordinating immigration, licensing and employment so that candidates can start work and earn income as soon as possible.

Box 5: Opportunities Ontario: Provincial Nominee Program

Although an earlier pilot Provincial Nominee program specified health professions, Opportunities Ontario: Provincial Nominee Program does not have any restrictions on occupation, as long as the occupations fall in the National Occupational Classifications (NOC) O,A or B i.e. in any managerial, professional or skilled trades occupation; and that employers are having problems recruiting qualified, skilled workers within those occupations (http://www.ontarioimmigration.ca/english/PNPabout.asp). At the time of interviewing, Ontario’s pilot Provincial Nominee Program was in its early stages, and few recruiters in Ontario were aware of the program. Those that were, thought that it was “not that helpful…because you have to have everything else in place first and you can’t do that in Ontario for licensure.” Another respondent thought that, “…it was a very quick turnaround to date. We put in our first three pre-screened applications (for the Provincial Nominee Program) on a Thursday, we had the approval the following Wednesday, and then the individual will apply to CIC (Citizenship and Immigration Canada) for an expedited work permit and permanent residence status.” The Provincial Nominee Program is also associated with fees. Elsewhere in Canada, the Provincial Nominee Program is reportedly well used: “Virtually all of the candidates that we have brought on board, assuming they are looking for citizenship, then we are absolutely willing to sponsor them from day one for the Provincial Nominee Program.”

25 The Canadian Nurses Association counted 25 regulatory bodies. Jeans, M. E., Hadley, F., Green, J., & Da Prat, C. (2005). *Navigating to become a nurse in Canada. Assessment of international nurse applicants. Final report.* Ottawa: Canadian Nurses Association.

Education and licensing

Different standards in source country education and training act as one obstacle to licensing for immigrants, and for returning Canadians who have trained outside of Canada. "I have a (specialist) in the United States who's a Canadian citizen but the training in the U.S. is two years where in Canada it's three years…So the individual said 'Oh I have to go back to school for a year, - not interested' so (the specialist) is going to stay in the United States. It makes it very difficult to bring them into Canada."

Box 6: "Go back to square one and train as a specialist or get an academic position"

One recruiter reported, "our biggest challenge is to take a specialist, maybe in their 40s and 50s and they've got to pass the Royal College exams… if they don't pass it then they have to go back and do some more training…they've got to get back into the mindset of studying for exams and that sort of thing." Those doctors who are sufficiently experienced may consider the 'academic physician' route. We received information about mature and experienced physicians with graduate degrees who were interested in locating to Canada. "The academic licensure comes in handy because that lets you work, build your CV, publish and hopefully get your promotion within five years with I think two one-year extensions. (You) can get promoted to associate professor and then you get your certificate." However combining practice and academic work is demanding, and permanent employment status is awarded on the basis of performance not only in clinical practice but also in research production. To gain this licence involves dedicating 40% of time towards research. "… it puts a lot of pressure on these people and … even despite their best efforts, they're overloaded with clinical activity and are going to find it hard to find the 40% time to do research and to be productive …and then what do they do?" (University professors and 'high-level' researchers are also eligible for provincial nominee programs).

For nurses there were varying reports of the length of time it takes for IENs to become licensed to practice. One of the challenges for nurses as one recruiter understood it, is: "you can only write your exam for your college for registered nurses exams in Canada, so let's say if the nurse wants to practice in Manitoba or [elsewhere in] Canada they have to come over here to write their exam…so it probably takes a good six months for them to get over here to start working as a grad nurse - or even longer." From the immigration side of things, "they have to do their medical, they have to contact the College, they might have to do the English exam and this is all done usually from the home country." Additionally, on the employer's side, they need to obtain a labour

market opinion to support the immigration process. One recruiter mentioned, "We realize it is a long journey and there are some differing options. There could be people who, for example, who are already here and who have a credential but they need to go back to (higher education) for a course." Recruiters that provided estimates of the length of time for nurses to become licensed mostly mentioned in the range of 6 – 12 months. These estimates did not include language proficiency. One recruiter reported that the length of this process overall had deterred the health organization from pursuing internationally educated nurses.

Recruiters viewed the regulatory colleges, and the "long and cumbersome" process of licensing, as a major obstacle for potential recruits and for employing organizations to hire them. At the same time as they complained about the colleges, recruiters recognized that the licensing and regulatory process is fundamentally concerned with quality assurance of HHR, and that the purpose of the process includes protecting the public from inadequate training or incompetence: "It's a good system in that way because it's very difficult for … somebody who has money to compromise the system in any way. It's a very objective system." Another said, "they're somewhat of a safety net for us … someone has to meet certain criteria before they can ever step foot in the door."

Recruiter assistance to foreign-trained HHR

In general, the assistance that recruiters and organizations provided to foreign–trained HHR extended to helping negotiate pathways to education, licensing and employment. This involves "walking people through the process (of registration) or giving them advice;" "putting them in contact with the right people, helping them with all paperwork if we have to and provide a lot of support." As this participant explained, "We offer individual counselling if they come to us…we arrange interviews with the appropriate clinical manager, they work with the hiring process and then we give them a job offer. We help them with their immigration and then counsel them…" Recruiters do not have money to pay for applicants' exams or upgrading, nor do they always have the resources that they would like to help potential recruits.

In order to attract and retain both domestic and foreign-trained HHR, the provinces offer financial incentives to the recruits. We found limited evidence of financial incentives specifically for foreign-trained HHR, except in the context of recruitment campaigns. Nurses recently recruited from the Philippines to Manitoba were eligible to apply for relocation assistance of up to $8,000 from the Nurses Recruitment and Retention Fund.[26]

The respondents did not talk specifically about the much-touted example of a taxi driver who was a doctor in his home country; however, there were stories of physicians who were 'lost' to the system, abandoning medicine as a result of the obstacles.

26 http://news.gov.mb.ca/news/index.html?archive=2008-11-01&item=4792

"There's kind of a mixed bag in terms of some (who) made it, and others (who) didn't… those are the folks that you'll hear about driving cabs because they were marooned… Some of them gave it up, went and sought other occupations, others luckily went to the States on the IMG programs in the States [who] I'm gonna say were a little bit more welcoming. There was certainly more opportunities [in the U.S]…" Another recruiter offered a story: "I became friends with a (specialist) … who needed a residency [but who] ended up putting their funds into a corner store, and (the specialist) never did go back to medicine. You must be very determined at 35 or 36 to go back into residency and back into training." Similar delays and setbacks in the education and licensing processes apply to returning Canadians who are also "lost" to Canada: "They don't realize what's going to happen, they go over and expecting to come back that it's going to be quite easy … but we're losing them."

Some recruiters also assumed a role of linking new immigrant workers with local communities. Some recruiters reported working wherever possible with local settlement organizations. Some recruiters also reported linking new immigrants with mentors originally from the same country. These efforts were associated with attempts to build representative workforces. In association with recruiting a diverse work force, some recruiters encouraged raising awareness of different cultures within health organizations through diversity training, and cultural awareness and sensitivity training programs. They also encouraged efforts to enhance recruits' understanding of "the way our health care system works, the language we use, and how they communicate what they need from staff."

Recruiters were generally interested in finding ways to encourage all levels of governments to coordinate immigration, settlement services, and assessment of qualification and experience for equivalency. This would enable seamless immigration, employment and settlement processes for incoming migrants.

Chapter 5: Global policies and local discussions

Although policy-making with regard to the recruitment of foreign-trained HHR was out of the hands of the HHR recruiters in our study, recruiters gave us some insights into informal discussions that take place around policy. Views on the 'ethical' recruitment of foreign-trained HHR mirrored discussions that have taken place in the academic literature centred on human rights. The human right to seek migration and the obligations of countries to provide the means of meeting the human right to health appeared to conflict. One recruiter said, "if you pull a health professional from an African country….we may have a hard time recruiting but they have a hard time replacing." Another recruiter said, "Are we robbing one country to save another? The organizations that I talk to really didn't feel that, because in some countries there's actually an abundance of nurses. There [are] more nurses than there are jobs. Or there's no funding. There may be vacancies but there's no funding to bring these people on board. So, is there an ethical issue? Well if they're unemployed, I don't think there is." Recruiters felt migration would be reduced "if these countries can create some stability and some potential for economic growth and some positive sense of future, then people will want to stay and practice their profession there." Other recruiters thought along the lines of this participant: "I don't believe Canada should be actively sourcing health care professionals out of developing countries…That being said… people do have a right to move…We wouldn't put an ad in South Africa looking for health care professionals but if a South African came to us saying, you know 'I'm looking to move to this province' we wouldn't say no."

Policy options and recruiters' opinions

In order to stimulate discussion around policy options and policy-making with regard to recruitment of foreign-trained HHR, we presented recruiters and asked them to give us an impression of support for a policy. 1 is an impressionistic 'no support' and 5 is 'high support'.

This chart shows a summary of the ratings applied to various policy options as scored by the recruiters. High support is dark blue and medium support is red. Black and green are no and low support. Yellow is a middle score. The most highly rated policy option was c) Better health human resource planning in receiving countries such as Canada to minimize recruitment outside Canada. The next one was a) Ethical codes on recruitment from developing countries where there is an existing shortage of health professionals.

Figure 2: Recruiters' scores on policy options

Key

a. Ethical codes on recruitment from developing countries where there is an existing shortage of health professionals.
b. Government reparations to source countries for training and health system loss that has resulted from the migration of health professionals.
c. Better health human resource planning in receiving countries such as Canada to minimize recruitment outside Canada.
d. Increased development assistance to strengthen health systems in source countries that minimize some of the health system factors that encourage people to leave - or 'push' factors.
e. Requiring mandatory in-country work after graduation of trained health workers in source countries, i.e. for a specified time in a specified location (sometimes called bonding).
f. Requiring financial repayment by trained health workers to public training institutes in the case when no in-country work takes place after graduation.
g. Focus on training auxiliary or lower-skilled workers in source countries, which might decrease their attractiveness to health systems in receiving countries.
h. Management of migration through bilateral or multilateral agreements that encourage temporary stays only and return health workers to their source country.
i. Two-way staff flows which allow health workers from the receiving country to provide a period of service to the source country,
j. Voluntary financial contributions from those who have emigrated to be directed to the health systems of the source country.
k. Assigning a share of income tax payments made by migrants to a development fund, or some other form of bilateral tax agreement.

For recruiters, an understanding of ethical work meant conducting their recruitment activities with respect for recruits, and in a professional manner. This included a sense of responsibility to support those countries that have little in the way of health care and health care professionals, but also understanding the right of people to seek migration where conditions 'push' them to leave. Some of the evidence that supported a sense of responsibility for others was demonstrated in health organizations' allowing foreign-trained HHR, particularly physicians, to return to their home countries to provide a period of service or pro bono work.

Participation in the study raised some issues about recruitment of foreign-trained HHR that some recruiters had not previously considered. For example, "I guess it causes us to think about things that maybe we hadn't necessarily thought about … I found the questions thought provoking…" On the whole, the majority of recruiters had participated in some discussions of issues related to recruiting foreign-trained HHR, and identified those involving ethical issues. One recruiter said, "We will recruit from places like the U.K. or try to repatriate Canadian grads from the United States because there's not the same ethical problems that we might run into otherwise. … We are very conscious of not poaching from countries that are in desperate need." Similarly, "I personally will not fly to the U.K. or somewhere else and try and pillage that country. I do not believe in specifically pillaging an organization or a country. I will promote my opportunities in ethical and professional and moral ways… if we go and take a developing nation and pull them down, we're not making the health care any better for anybody."

Canada is not alone in trying to address the problems presented by global and local shortages of HHR. In the European Union states, there is ongoing discussion surrounding the free movement of services, funds, products and human resources, including health human resources. (e.g. European paper (Commission of the European Communities, 2008). The U.K., for example, has taken a number of steps towards self-sufficiency of doctor resources although these have not been without problems for doctors from non European Union countries already in the United Kingdom (British Medical Association Parliamentary Unit, 2009). Norway will only recruit from within the EU as part of its specific code of ethical recruitment, although a recent policy coherence report prepared by an all-party committee noted that this would inevitably create incentives for those nations to fill their own shortages from low-income countries in crisis, "the domino effect that is believed to take place when Norway recruits from a country in Europe, and this country in turn recruits from other countries that finally employ personnel from developing countries."[27] The Norwegian commission also identified various compensation schemes suggested for mitigating the subsidy from poor to rich countries: shared tax revenues, extra charges on visas transferred back to the native country, continued tax obligations in the native country and direct repayment of

27 The Policy Coherence Commission, Coherent for Development? How coherent Norwegian policies can assist development in poor countries. Official Norwegian Reports, 2008, pp. 147-148.

public education costs. These measures, it acknowledged, are challenging because health professional émigrés do not necessarily remain in the country to which they first migrate: How will such costs be equitably allocated?

Pan-Canadian work is taking place on the harmonization of approaches to recruitment, regulation, and access to licensure (RSPSC, 2006). At the global level, discussion of coordination of standards for health human resources with regard to harmonization of specialist training, continuing medical education and continuing professional development, and establishing global standards for assessing equivalency, is similarly ongoing.[28] In theory, these efforts should ultimately provide some assistance to HHR and the recruiters that we interviewed. It may also have the effect of deterring health workers unlikely to qualify for practice in Canada from seeking migration; but could also incentivize those already qualified to migrate, and those lacking sufficient qualification to upgrade their credentials in a carefully targeted way.

The recruiters that we interviewed have important local knowledge with regard to recruitment of HHR. They identified what they perceived to be failures of domestic provincial and national policy, and failures to recognize and encourage the training of domestic population resources, youth and aboriginal peoples. Their conclusions with regard to recruitment of foreign-trained health professionals, point to both local and global policy solutions that are practical and ethical: As one of the recruiters thought, "Recruitment starts at home. When you look at a pie, there's four pieces, and three of them are local solutions or national solutions. Only one is international… going for an international solution is always your last resource in terms of effort."

28 See for example, a PowerPoint presentation at www.lgs.lt/_upload/1180338571PresentUEMS.Vilnius.2007.ppt. Other evidence to such discussions include: a discussion of policy proposals simplifying registration of physicians through different pathways and selected countries that include Australia, Hong Kong, the Republic of Ireland, New Zealand, Singapore, Switzerland, South Africa and the UK. http://www.cpso.on.ca/uploadedFiles/policies/consultations/PathwaysBackground56.pdf.
Also Baumann, A., Blythe, J. (2008) Globalization of higher education in nursing. *OJIN: The Online Journal of Issues in Nursing*; Vol. 13 No. 2 Manuscript 4. Available from: www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/No2May08/GlobalizationofHigherEducation.aspx.

Appendix A: Outline of questions to key informants

Advertising and Recruitment Strategies & Use of Resources

1. What types of advertising or recruitment strategies does your organization generally employ?
2. What types of advertising or recruitment strategies does your organization use for specific positions (as opposed to a general call?)
3. Do you have a website where you advertise your openings?
4. As part of your recruitment efforts do you subscribe to employment websites, such as monster.com, workopolis.com where resumes are posted?
5. Is all of your recruiting and advertising handled internally or do you use a third party for some, or all, of your advertising and recruitment initiatives?
6. Reflecting upon your recruitment and advertising initiatives in general, what is the reach of your initiatives? That is, where do your initiatives usually target? How many countries do your initiatives reach?
7. In addition to formal recruitment and advertising methods, are you aware of informal methods of recruitment? Such as word of mouth, informal networks, or other means?
8. Approximately how many full time equivalent (FTE) staff members does your organization employ for i) recruiting domestically trained health professionals? ii) recruiting foreign-trained health professionals?
9. Do you have an annual budget or any estimates regarding the costs to your organization or region/area for the recruitment of foreign trained health professionals?

Foreign Trained Health Professionals

1. Does your organization keep any records of the numbers of foreign-trained health professionals hired and their country of training?
2. Does your organization recruit and/or employ any physicians, nurses or other health professionals from any developing countries?
3. Does your organization recruit and/or employ any physicians, nurses or other health professionals from sub-Saharan Africa (SSA) countries?
4. Would you say that the developing countries (including sub Saharan countries) that your organization recruits from has changed over time?

5. What countries have you recently started to target or see yourselves targeting in the near future?

Immigration Programs and Licensing

1. Has your organization made use of any immigration programs, such as the Provincial Nominee Program, to help settle and or recruit foreign trained health professionals?
2. What do you think about these programs? Have you been satisfied with them? Have there been any problems?
3. Are you aware if the foreign-trained health professionals working in your area or organization are entering on temporary permits or as permanent residents?
4. To your knowledge do foreign-trained health professionals have difficulty obtaining a license to practice in Canada?
5. On average, how long does it take foreign-trained health professionals to become licensed to practice in Canada?
6. Does your organization assist foreign-trained health professionals to obtain their licence to practice or to upgrade/advance their skills?

Intention to Stay or Return

1. Do you know if most of the foreign-trained health professionals your organization has recruited intend to stay in Canada, or return to their country of origin?
2. To your knowledge, are very few, some, or many health professionals returning to their country of origin?
3. If and when health professionals return, do you know approximately how much time they would have been practicing in Canada?

Organization Policy

1. Does your organization have a policy on the recruitment of health professionals?
2. Do people in your organization think that Canada needs to recruit foreign-trained health professionals?
3. Should Canada be looking to recruit more or less foreign-trained health professionals?
4. What would you suggest is the best way to address losses for developing countries whilst balancing individual rights to migrate? Do you have any other suggestions or general thoughts with regard to Health Human Resources migration from developing countries to developed countries?

5. Which of the following policy options might be supported by your organization/department? On a scale of 1-5, where 1 is no support and 5 is high support, how much do you think your organization would support this policy approach?

   a. Ethical codes on recruitment from developing countries where there is an existing shortage of health professionals.

   b. Government reparations to source countries for training and health system loss that has resulted from the migration of health professionals.

   c. Better health human resource planning in receiving countries such as Canada to minimize recruitment outside Canada.

   d. Increased development assistance to strengthen health systems in source countries that minimize some of the health system factors that encourage people to leave, - or ‘push’ factors.

   e. Requiring mandatory in-country work after graduation of trained health workers in source countries, i.e. for a specified time in a specified location. (sometimes called bonding)

   f. Requiring financial repayment by trained health workers to public training institutes in the case when no in-country work takes place after graduation.

   g. Focus on training auxiliary or lower-skilled workers in source countries, which might decrease their attractiveness to health systems in receiving countries.

   h. Management of migration through bilateral or multilateral agreements that encourage temporary stays only and return health workers to their source country.

   i. Two-way staff flows which allow health workers from the receiving country to provide a period of service to the source country,

   j. Voluntary financial contributions from those who have emigrated to be directed to the health systems of the source country.

   k. Assigning a share of income tax payments made by migrants to a development fund, or some other form of bilateral tax agreement.

6. If you don’t think that bilateral or multilateral agreements are feasible or appropriate, do you think that anything else can or should be done?

Appendix B: Sub-Saharan and Least Developed Countries in Sub-Saharan Africa, and Canadian Development Policy Countries

The table below shows the list of sub-Saharan countries. In 2009 there were 50 Least Developed Countries of which 33 were African.

Canada's development policy focuses on specific countries. In 2009, countries of focus in sub-Saharan Africa for the Canadian International Development Agency (CIDA) were Ethiopia, Ghana, Mali, Mozambique, Sudan, Senegal and Tanzania. Outside of sub-Saharan Africa, focus countries and areas include the West Bank and Gaza, Ukraine, Bolivia, Caribbean region countries, Colombia, Haiti, Honduras, Peru, and in Asia, Afghanistan, Bangladesh, Indonesia, Pakistan and Viet Nam.[29]

29 Source: http://www.acdi-cida.gc.ca/CIDAWEB/acdicida.nsf/En/JUD-51895926-JEP

Table 6: Sub-Saharan African (SSA) Countries, Least Developed SSA Countries and SSA Countries Targeted by Canadian Development Policy in 2009[30]

Angola	Ethiopia ♣	Nigeria
Benin	Gabon	**Rwanda**
Botswana	Gambia	**SaoTome and Principe**
Burkina Faso	Ghana ♣	**Senegal** ♣
Burundi	**Guinea**	Sierra Leone
Cameroon	**Guinea-Bissau**	Somalia
Cape Verde	Kenya	South Africa
Central African Republic	Lesotho	Sudan ♣
Chad	Liberia	Swaziland
Comoros	Madagascar	Tanzania ♣
Congo	Malawi	Togo
Congo, Democratic Republic of	Mali ♣	Uganda
Côte d'Ivoire	Mauritania	Zambia
Djibouti	Mozambique ♣	Zimbabwe
Equatorial Guinea	Namibia	
Eritrea	Niger	

Key
♣ - Denotes countries that are targeted by Canadian development policy
Bold font: denotes least developed countries (LDCs)

30 http://www.un.org/special-rep/ohrlls/ldc/list.htm.

Appendix C: Authors' biographies

Vivien Runnels M.Sc., is a student in the Population Health doctoral program and a Research Associate with the Globalization and Health Equity Research Unit at the Institute of Population Health, University of Ottawa. She has worked as a research assistant to Ronald Labonté, the principal of the Globalization Knowledge Network of the WHO Commission on Social Determinants of Health. She is a former research coordinator, vocational rehabilitation counsellor and secondary school teacher.

Corinne Packer Ph.D., is Senior Researcher at the University of Ottawa's Institute of Population Health, working on global health equity matters. Her principal research interests include reproductive health and human rights, the international migration of health professionals, and comprehensive primary health care.

Ronald Labonté Ph.D., is Canada Research Chair in Globalization and Health Equity at the Institute of Population Health, Professor in the Faculty of Medicine, University of Ottawa, and adjunct Professor in the Department of Community Health and Epidemiology, University of Saskatchewan. His current research interests include globalization as a 'determinant of determinants;' ethics, human rights and global health development; global migration of health workers; revitalization of comprehensive primary health care; and globalization and the health of Canadians.

Appendix D: Associated publications by the authors

Runnels, Vivien; Packer, Corinne; Labonté, Ronald. Reflections on the ethics of recruiting foreign-trained health professionals (in process: Human Resources for Health)

Packer, Corinne; Runnels, Vivien; Labonté, Ronald. Does the Migration of Health Workers Bring Benefits to the Populations They Leave Behind? Impacts on health via wealth and knowledge transfers in Rebecca Shah, ed. Ethics and the International Migration of Health Workers (Palgrave Macmillan, 2010).

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