

The brain drain of physicians from developing countries to Canada: A matter of human rights

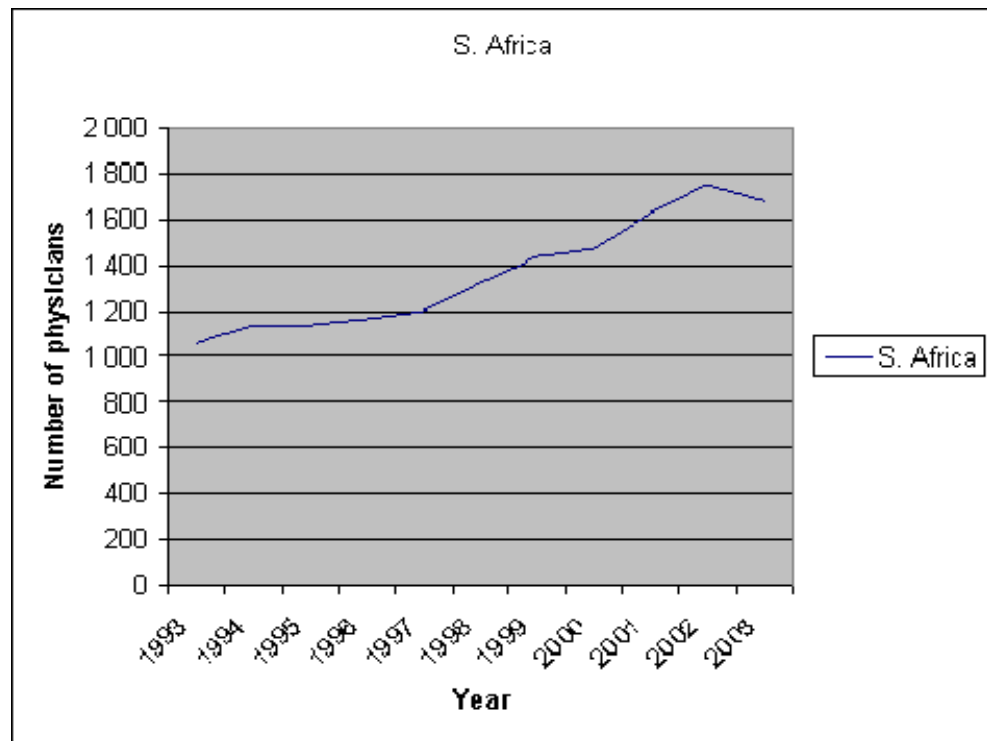
By Ronald Labonte and Corinne Packer

Historically, Canada has depended rather heavily on foreign-trained physicians to staff its health system. In 2004, 22 per cent of licensed physicians in Canada were foreign-trained. Together with other Anglo-American countries (the United Kingdom, United States, Australia and New Zealand), Canada has become a key 'recipient' country of physicians trained abroad. While the immigration of health and other professionals to Canada is not new, what has changed in recent decades is the number of physicians coming from developing countries which themselves are facing severe health human resource shortages.

In the case of sub-Saharan Africa (SSA) countries, the emigration of their health professionals is undermining efforts to provide adequate levels of health care service and, more importantly, to address the enormous challenges posed by the HIV/AIDS crisis and other pandemic diseases, such as tuberculosis and malaria. These countries are not only losing their physicians, they are also losing the financial investment they made in training their physicians. The result is a net wealth transfer to already rich nations from chronically under-resourced nations dealing with a large portion of the global disease burden.

Canada is one of only a small handful of high-income countries in the world that receive a large portion of physician émigrés from the SSA region, South Africa being the most important source country (see figure above). SSA source countries most affected by the out-flow are not sitting back and taking it. South Africa, in particular, is demanding recipient countries take measures to stem this flow, first and foremost by refraining from actively recruiting physicians from the region. Their complaints have not gone unheard. Among health circles, the brain drain of health professionals has become very topical. The World Health Organization has dedicated an entire decade to the matter. The International

Number of Physicians from South Africa Practicing in Canada, 1993-2003



Southam Medical Database, CIHI. Statistics gathered at special request of authors and issued by CIHI on August 12, 2005.

Organization for Migration has committed resources and staff to the issue. Researchers are increasingly tackling the matter – even the World Bank has dedicated an entire book volume to analyzing this phenomenon.

The questions we have to ask ourselves are: What does the brain drain mean in human rights terms? Are there clear violations on the part of source countries? Or should the discussion begin and end with the rights of physicians who, like all other human beings, are free to migrate? All of these facets are next considered.

Inadequately protected rights in source countries leading to migration

It is abundantly evident in the literature on migration in general and brain drain specifically that health care professionals are leaving their countries in sub-Saharan Africa because their fundamental rights to work, to an adequate standard of living and to security are not being protected.

Articles 23(1) and 25(1) of the Universal Declaration of Human Rights respectively recognize that “[e]veryone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment,” and that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family.”

Without a doubt, physicians in SSA countries, *if* they are able to obtain work and *if* they are paid on a regular and commensurate basis, are better able to support themselves and their families than individuals without these skills. However, the struggle to sustain an adequate standard of living is persistent and its outcome uncertain. Moreover, in many cases, individuals cannot depend on an adequate social security system to support them in the event of unemployment, illness or retirement. In the overwhelming majority of cases, physicians seek to migrate because these basic rights are not secured or are at risk of being violated.

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Compounding this struggle to obtain an adequate standard of living and just and favourable working conditions is the threat to personal security that individuals face in many SSA countries. Both the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights stipulate that States must ensure that everyone has the right to security of person, recognizing the absence of security as an obstacle to the enjoyment of many other rights.

The brain drain literature and findings of studies indicate strongly and clearly that the cycle of movement from under-developed to developed countries will only begin to diminish when the root causes of migration are addressed. This is not earth-shattering news. The Cairo Declaration and Program of Action, adopted at the International Conference on Population and Development held in 1994, describes the complexity at hand, stating that “[t]he long-term manageability of international migration hinges on making the option to remain in one’s country a viable one for all people.”

However, it also recognizes that to make this option viable, “countries of origin and countries of destination must cooperate.” So what then are the human rights obligations of destination (recipient) countries such as Canada?

The human rights obligations of recipient countries

State Parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) are obliged to *respect* the right to health in other countries. Their unilateral actions or international negotiations should not limit the abilities of other countries to fulfill their own obligations under Article 12 (right to health) of the ICESCR. Paul Hunt, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, explained in his recent report to the Commission on Human Rights what this means with regard to health human resources:

[D]eveloped countries should ensure that their human resource policies do not jeopardize the right to health in developing countries. If a developed country actively recruits health professionals from a developing country that is suffering from a shortage of health professionals in such a manner that the recruitment reduces the developing country's capacity to fulfill the right to health obligations it owes its citizens, the developed country is *prima facie* in breach of its human rights responsibility of international assistance and cooperation in the context of the right to health.¹

In our view, there is a smoking gun where recruitment is concerned. Whether one sees it as passive or active, the recruitment of foreign-trained physicians to Canada is happening. Immigration programs (notably the Provincial Nominee Program) and policies adopted by the federal government make it easier for foreign-trained health professionals to come to work in Canada. Moreover, Regional Health Authorities and clinics, which operate under provincial jurisdiction, are actively recruiting in SSA countries in the traditional sense that they have targeted job announcements to health professionals in SSA countries through journals consulted by health professionals in the region.

State Parties to the ICESCR are also obliged to *protect* against infringements of this right by third parties such as corporations, by ensuring that third parties over whom they have legal or political influence respect the enjoyment of this right in other countries. This obligation should prevent Canadian health authorities from using the services of recruiting agencies in developing countries with a shortage of health professionals. Whether, and the extent to which, they presently use such services is presently unknown to us. A final obligation bearing on wealthier nations is a requirement to aid poorer countries, through international assistance and cooperation, in their abilities to *fulfill* the progressive realization of this right. Official development assistance (ODA) is one indicator of commitment to this obligation, although not the only one. With respect to the brain drain problem of SSA countries, Canada's failure to be self-reliant in domestic health human resources – creating a *de facto* “pull” on health care professionals from these countries that undermines their ability for the progressive realization of this right – arguably abrogates Canada's obligations under Article 12.

So whose right to health prevails?

Canada accepts and licences foreign-trained health professionals because there is a significant shortage of domestically produced professionals and considerable under-served (rural) areas. Foreign-trained health professionals fill important gaps and, as a consequence, health care is made more available and accessible to Canadians. Canada is thereby better able to fulfill its obligations under the right to health in accepting foreign-trained health care professionals. In the case of developing countries, however, migration

has the exact opposite impact on the State's ability to secure the right to health. The loss of their health professionals through migration means they are unable to ensure availability, accessibility and quality. The emigration of their health care professionals therefore contributes to their abrogation of obligations under the right to health.

Judith Bueno de Mesquita and Matt Gordon recommend a human rights framework applicable to both source and recipient countries in their book *The International Migration of Health Workers: A Human Rights Analysis*:

Governments of countries of origin should improve rights in work for employees in their home country by strengthening their public systems, including better human resources planning. They should allocate a health share of the State budget commensurate with generally recognized international benchmarks and international agreements that they have signed up to. They should possibly adopt a range of other appropriate measures for meeting the right to health that are fast to implement in the short term, including auxiliary worker training, managed migration and a contract with health staff trained in the public system that invokes an obligation to the public health system for a period of time after training is completed. [Recipient] country governments should increase the resources available for countries of origin to strengthen health systems through positive and explicit acknowledgement of the human rights impacts of hiring of international staff, known as restitution.²

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Paul Hunt, drawing his recommendations largely from the Plan of Action to Prevent Brain Drain issued by Physicians for Human Rights, advocates, among other things, compensation, stating that, “depending on resource availability, States should provide aid to developing countries so as to facilitate access to essential health facilities, goods and services ... Aid policies should include support for human resources in the health sector.”³ At the same time, he points out that it is fundamentally disingenuous to provide overseas development assistance, debt relief and other forms of aid with one hand while simultaneously taking health professionals trained at the expense of developing countries with the other. “Recipient and other developed countries must therefore address their own inadequate production and retention of health professionals, adhere to ethical recruitment principles, help strengthen health systems in source countries and promote macro-economic policies consistent with human rights.”⁴

The most appropriate response to the problems arising from migration of physicians and other health care professionals is an integrated one, combining prevention (reducing the mitigating factors leading to migration) and ensuring that any improvements in the right to health are achieved without any negative repercussions to the right to health of others in source countries and without express limitation of any other rights, including freedom of movement and rights in work. The responses will not be easy but they are necessary and, from a human rights perspective, they are non-negotiable obligations.

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1 United Nations General Assembly (UNGA). The right of everyone to the enjoyment of the highest attainable standard of physical and mental health [Report of the Special Rapporteur on the Right to Health] 12 September 2005; UN doc A/60/348., para. 61.

2 J. Bueno de Mesquita and M. Gordon, *The International Migration of Health Workers: A Human Rights Analysis*, Medact, London, 2005, pp. 5-6.

3 UNGA [Report of the Special Rapporteur], *op. cit.*, note 9, para. 64.

4 *Ibid.*, paras. 73-81.

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