

THE PERVERSE SUBSIDY: CANADA AND THE BRAIN DRAIN OF HEALTH PROFESSIONALS FROM SUB- SAHARAN AFRICA



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The Canadian health care system is one of the places where push comes to pull in terms of attracting health care professionals from sub-Saharan Africa. The authors call this “the perverse subsidy”: the costs of training these professionals are paid for by “poorer people in poorer countries.” The pull to Canada is equally a push from Africa. Reflections on a pilot study on a labour mobility issue that is equally a question of conscience.

Notre système de santé est l’objet d’une inversion du rapport entre l’offre et la demande s’agissant d’attirer au Canada des professionnels de la santé de l’Afrique subsaharienne. Les auteurs parlent ici de « subvention perverse », les coûts de formation de ces spécialistes étant acquittés par « les plus pauvres des pays pauvres ». Pour l’Afrique, l’offre canadienne s’accompagne en somme d’un manque à gagner. Réflexion autour d’une étude pilote sur une question de mobilité de la main-d’œuvre, qui est aussi une question de conscience.

The 2006 *World Health Report* on the global “crisis” in health human resources (HHR) documents one sign of hope and two of despair for the health of many living in pandemic-racked sub-Saharan African (SSA) countries. Infant, child and maternal mortality all decline as health worker density rises. SSA has very low densities and is in immediate need of one million more health workers. Many of the health workers it has trained have left the continent for Canada, the UK, the US, Australia and New Zealand. How can Canadian health and federal authorities “manage” this flow without compromising the right of people to seek to migrate, the right to health of people in Canada and in Africa, and our repeated commitments to global health and human development targets?

Canada, like its market-liberal Anglo-American cousins, has long been dependent upon foreign-trained health professionals. Over 7 percent of our nurses and 22 percent of our physicians are émigrés. Of greater concern is that the past two decades have seen our supply of these émigrés increasingly coming from developing and poor, rather than developed and rich, countries. The result is a “brain drain” these nations can ill afford. The number of SSA-trained physicians and nurses working in Canada has risen sharply

in the past decade. Some provinces are more dependent on this supply than others. Over one-quarter of the licensed physicians in Saskatchewan and a sizeable minority in British Columbia, Alberta, Manitoba and Newfoundland are South African-trained, with significant concentrations of émigrés in rural or remote regions. This is good news for those living in underserved Canadian areas, but not for those in African communities coping with a greater burden of disease and less than 1/20th the existing supply of health workers that we enjoy in Canada.

The majority of these health professional émigrés come to Canada highly skilled, requiring only modest additional training or merely certification. Their training costs have been paid by poorer people in poorer countries, a “perverse subsidy” to the health systems of much wealthier nations. The 600-plus South Africans who have been licensed to practise in Canada since 1993, for example, represent a loss in that country’s public training costs exceeding \$70 million; by contrast, Canada saves some \$300 million to \$500 million in forgone Canadian training costs. (These are rough estimates, since precise data are not available, but the scale of the costs/benefits almost certainly

stands.) Even as the poor-to-rich-country HHR migration worsens, all the world's nations have pledged to meet the Millennium Development Goals and targets, three of which (reductions in infant and maternal mortality and HIV prevalence) are directly health-related and wholly dependent on health worker density.

It was in this context that we conducted a pilot study to map recent HHR flows from SSA to Canada. We sought to examine the reasons for the increased "push" (from Africa) and "pull" (to Canada). Most important, we wanted to assess the potential support for a limited set of "brain drain" policy options among a purposive sample of Canadian federal, provincial and health professional "stakeholder" organizations.

While focusing on the "pull" to Canada, our study participants were acutely aware of the "push" from Africa, which includes low salaries, economic depression, deteriorating work environments, political upheaval, diminishing quality of education for children, risks to physical security and spiralling demoralization as more staff leave. Some push factors may result from African country choices and others from the influence of wealthy nations. Zambia was cut off the "heavily indebted poor countries" debt cancellation program for a year when, partly as a result of raised health worker salaries and benefits to stem its brain drain, its public salary spending exceeded the level set by the International Monetary Fund as a condition for loans or debt relief. (We are still attempting to determine Canada's position, as an IMF shareholder, on that institution's insistence on salary spending caps such as that faced by Zambia.) Other factors leading to "push" include capital flight, poor trade deals and depressed global agricultural commodity prices, all of which have contributed to real declines in African income over the past two

decades and all of which involve policy decisions and actions of rich-world governments. In an increasingly integrated global market, national policy choices are no longer simply "national."

Pull factors to Canada, in turn, are the obverse of the push: improved remuneration, reasonable work conditions, physical safety and greater opportunities for themselves and

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their children. Canada's unwillingness or inability to ensure a strong and sufficient pool of domestically trained health professionals, by creating a domestic shortage, also functions as a "pull."

This latter point was echoed repeatedly by most of our respondents, who nonetheless maintained that active recruitment from SSA to Canada no longer occurs. (Examples of active recruitment include the physical presence of recruiting agents in source countries, or the egregious example of the Alberta government in 1998 flying a number of South African physicians and their families to Banff in a successful bid to entice them to emigrate.) For some, this exonerates Canada of responsibility toward SSA and other source countries for their losses. Others noted that new modes of recruitment exist that constitute an enhanced form of passive recruitment, including the following:

- The provision of Medical Council of Canada Evaluating Exams offshore enables physicians in foreign countries to become licensed to practise in Canada before emigrating. Foreign physicians with Canadian licences are more likely to be offered contracts by Canadian institutions, which ease immigration procedures.
- Advertising by Canadian regional

health authorities, private medical practices and recruitment agencies persists in southern African medical journals. Some ads are posted by Canadian-based recruitment companies; the Internet makes physical presence in South Africa unnecessary.

- Citizenship and Immigration Canada adopted a new points sys-

tem in 2002 which grants individuals with advanced education, experience and ability to speak English or French more points. This naturally biases toward highly trained professionals, especially those from English-speaking Commonwealth countries. Higher points equate to facilitated immigration.

- The Provincial Nominee Program (PNP) consists of individually negotiated agreements between provinces and the federal government. These agreements allow persons meeting labour shortages specified by the provinces to "fast-track" through the immigration process. To date, nine of Canada's provinces have implemented PNPs and at least two have created a special stream for health professionals.

In a digitally globalized world in which pull and push factors are worsening, or at least not improving, there is no real practical or ethical distinction between active and passive recruitment.

There is a flip side to the brain drain — the brain waste. There are several thousand foreign-trained health care professionals already in Canada who are unable to gain accreditation, often due simply to a lack of residency spaces to upgrade their

training to Canadian standards — hence the cliché of the taxi-driving foreign doctor. There are also many Canadians each year who obtain their training abroad (because of the very limited places in Canadian medical schools) and return to work in Canada but similarly encounter difficulties obtaining residencies.

These people represent untapped reserves which, if supported by enhanced funds for upgrading, could reduce future pull on health care pro-

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professionals from SSA. Most of our study participants made note that Canada loses some of its own physicians and nurses to other countries, particularly to the USA. This is true, although the numbers have been declining and, for physicians at least, are a fraction of the loss experienced by most SSA countries. The US, however, is predicted to experience serious shortages in physicians and nurses in the near future and is unabashed in its intent to recruit qualified (or potentially qualifying) professionals from anywhere and everywhere in the world, including Canada. Ironically, both countries have large numbers of qualified nurses who have left the profession, many because of the stressful working conditions and other unhealthy (and potentially correctible) aspects of our health systems. Addressing the push factors in our own health systems will go a long way in reducing the pull on those in other countries.

Eight possible and non-exclusive policy options to reduce or repair the brain drain were identified from the broader literature and policy debates, and presented to participants to gauge the extent of their organizations' support or rejection of them:

1. Increased self-sufficiency in domestic HHR training and supply (reduce pull)
2. Increased assistance to source-country health systems (reduce push)
3. Codes of practice for ethical recruitment (reduce pull)
4. Bilateral or multilateral agreements to manage HHR flows better (avoid source-country loss)
5. Reparation to source countries (reverse perverse subsidy)

6. Increase support for auxiliary workers in source countries (avoid pull)
7. Restrict entry for health professionals from grossly underserved countries (block push/pull)
8. Bond health workers trained at public expense (defer push/pull)

All respondents strongly favoured better HHR planning in Canada, arguing that increased domestic supply can reduce demand for internationally educated health professionals. This option is a key part of the *World Health Report's* recommendations to reduce the global HHR supply crisis. Most participants also supported strengthening health care systems in underserved source countries. Some felt this was already happening while others thought more could be done. Increasing Canada's health system and HHR aid to suffering source countries was not perceived as high on their organizations' present agendas — which traditionally do not engage on issues of foreign aid — but one that would likely be supported if promoted.

Another option was the adoption of a code of practice for ethical recruitment, similar to the one adopted by the United Kingdom and applied through-

out its National Health Service (NHS). The UK code essentially prohibits active recruitment of health professionals from a designated set of SSA countries facing their own domestic supply crisis. While none of the organizations interviewed had adopted such a code internally, some had issued statements against active recruitment of health care professionals from developing countries. Moreover, as we've noted already, the concept of active recruitment is devoid of much meaning today. Most participants expressed some level of support for the adoption of a voluntary or mandatory code of practice. Others thought that voluntary codes risked failure because of their very nature while mandatory codes would likely require too much monitoring for effective or efficient enforcement.

Participants were ambivalent toward the pursuit of bilateral or multilateral agreements to manage the flow of health care professionals (with the goal of no or little net loss in source countries). Some felt the drafting and adoption of such agreements would be particularly complicated with uncertain results. Others pointed out that, in the absence of a multilateral covenant, other countries could simply free-ride on any bilateral agreements Canada entered.

Four other options were nearly universally rejected:

1. reparation payments to source countries for (at minimum) their training cost losses (who pays what to whom, and why, if people come of their own choice?);
2. increasing the number of auxiliary health care workers in source countries who likely would not be skilled enough to gain entry into the Canadian job market or qualify under the present immigration ranking system for voluntary migrants (creates a second-class health system for Africans);
3. placing restrictions on the migration into Canada of health care professionals from underserved source countries (un-Canadian,

racist, a violation of human rights and why only *health* professionals?); and

4. bonding health care professionals to prevent their emigration from source countries (too easy to break or buy out).

This is a cursory summary and should not be taken as representative of any of the individuals who contributed to our study. It can nonetheless be distilled to two key Canadian response opportunities: increase domestic supply (reduce pull) and support for source-country health systems (reduce push). Canada is already doing more in both areas, but is it enough, and is it even the most strategic use of resources?

Fundamental to addressing pull factors is the achievement of domestic self-sufficiency. Unfortunately, this is years away, very costly and under threat from what American HHR researcher Fitzhugh Mullan calls the “great sucking sound” south of our border. Increasing spaces to qualify foreign-trained health workers may be a faster, less expensive option but could accelerate the inflow of foreign-trained health professionals unless it specifically targeted “brain-wasted” professionals already in Canada. It is unlikely our domestic supply will match what many believe will be the increased demand (especially in home care) for our rapidly greying demographic.

Ethical recruitment codes may also hold some merit, being credited now with a decrease in the number of SSA-trained nurses being registered with the UK NHS. (The gap is reportedly being filled by nurses from the Philippines and India, which raises questions about countries which intentionally produce health workers for export, despite shortages within their own borders.) Canada is also considering the merits of a memorandum of understanding with South Africa, which could provide some relief if it has some measurable “teeth” to it

and results in a net HHR gain — or at least no net loss — for South Africa.

Canada is focusing more of its aid on health, and more of that in SSA, but we have yet to live up to our repeated pledge of 0.7 percent of GNP to development assistance. One of the key recommendations of the *World Health Report* is that 50 percent of all health aid should go to health system strengthening, and 50 percent of that to training and retention of HHR. Such measures have the potential to reduce some push factors, but we have yet to receive a response from the Canadian government as to its position on this recommendation. There is evidence that community health workers trained below nursing skill level, but with higher-skilled support, can provide many of the basic primary health care services that could begin to reverse some of the deteriorating health trends in SSA. Our pilot study did not examine what mix of health professionals would be best in what country context, but if Canada were to increase dramatically its health worker training aid to SSA, careful scrutiny would be required of what mix of workers is needed over the short, medium and long term.

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one of improving international cooperation to one of increasing global interdependencies.

The reduction of border barriers to the flow of capital, goods and services in recent decades is allowing the rapid construction of a global *private* health care system, accessible to those who can afford it. From foreign investment in private health facilities, to medical tourism where individuals fly to specially built facilities in low- and middle-income countries offering diagnostics and surgeries at (usually) First World standards but (invariably) Second World prices, to private medical and nursing schools in developing countries training graduates for export to the private health systems in developed nations, commercial health entrepreneurs are seizing the growth opportunities of a liberalized world. Perhaps it's time for public health care/health training providers to do the same. Rather than re-erect national borders around our public health systems, we should be thinking of how we can increase their interdependencies globally.

For example: It is considerably less expensive to train health professionals in South Africa, or other SSA countries, than in Canada. Why, then, should we be favouring the (likely unattainable) notion of domestic self-sufficiency in supply? Instead, we could outsource some of our training needs to these

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countries, ensuring through faculty support and exchanges that training standards meet Canadian criteria. Essentially we would be purchasing training places overseas at costs that are lower than those in Canada, but high enough that the host country can turn a tidy profit that can be directed to

increasing its own domestic supply according to its own health worker mix.

A similar reframing logic could be applied to how we provide aid to failing health systems in developing countries. We assume that these systems should eventually become “sustainable” (aid jargon for self-sufficient), but in a world of increasing economic inequalities, is this defensible? Instead, we could begin to view health systems of developing countries as extensions of our own, in which aid is structured or committed to entrench exchanges of knowledge, human resources and even patients (within the ecologically sound limits of fossil-fuelled travel) as enduring features of a global public health system in progress.

Returning to the HHR example: Our suggestion could be dismissed as wildly romantic and improbable. Certainly the negotiations between countries choosing to walk together along such a path

would be daunting — to say nothing of how placidly Canadian training institutions might accept losing some of their growth revenues to institutions in other parts of the world, or the likelihood of getting provincial education ministries to cooperate with federal aid and foreign policy departments. Big policy problems — and the global crisis in HHR supply, particularly in SSA countries, is one — demand big policy solutions. Neither is this option any less daunting than the others now on the global health policy table that formed the basis of our study, options that have yet to gain much commitment or make much of a difference.

If acted on, this option would have much greater and more equitable global health impact than any of the others. The details need careful consideration. But the option, in broad terms, gives Canada a possible pathway through the competing policy quagmire of meeting its own HHR needs, respecting simultaneously the

right to seek migration and the right to health at home and abroad, and delivering a bit more toward developing countries facing dire health crises.

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