

The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada

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Executive Summary

Health professionals are a highly trained and valuable sector of the workforce. It is understandable that with shortages in most countries, health professionals have become very mobile, moving to take advantage of better salaries or better working conditions in other jurisdictions or other countries. In recent years, Canada has watched a significant number of doctors and nurses move to the United States in search of more money, better jobs or different opportunities. In turn, Canadian health system planners have welcomed health professionals from abroad who have settled here for similar reasons.

Canada has always relied on internationally educated health professionals (IEHPs) to play an important role in the health system. And now they form a substantial portion of it. For example, about 23 percent of Canada's general practitioners are foreign-trained and a similar percentage of specialists were educated overseas.

What is different now, and motivating this discussion about the ethics of recruitment, is that the recent waves of IEHPs who have come to Canada are arriving from developing countries, and especially from Africa and Asia. This mirrors the changing face of immigration in Canada generally as the proportion of immigrants from Europe and the United States declines and the proportion from Asia and Africa increases.

But in the case of health professionals, those source countries in Africa and Asia are concerned about the loss of highly-trained professionals from their own health care systems and particularly concerned with the possibility that developed countries like Canada are engaging in practices and developing policies specifically designed to encourage this immigration.

The problem came to a head in 2001 when South Africa's High Commissioner to Canada publicly rebuked Canada for recruiting so many doctors away from its struggling health system.

There are a number of questions that come to light in this report's analysis: what it means "to recruit" a health professional, what are the rights of individuals to move, what are the interests of states who invest in training health professionals and what are the responsibilities that nations owe each other within the international system. And while there are no easy answers to them, there are paths out of the maze of conflicting rights, interests and responsibilities that can allow Canadian policy-makers to both confront the issue and to develop policy options and instruments that can serve the interests of both the Canadian health care system and the interests of developing states in preserving and building their own systems.

The starting point is a consensus that recruitment of these workers from developing countries is a serious ethical issue – that it is inappropriate for nations as relatively wealthy as Canada to deal with their own domestic health human resource shortages and maldistribution by relying on the immigration of health professionals from developing countries.

The next step will begin with the recognition that Canada – at both the federal and provincial levels – needs to take seriously the commitments made to the public to achieve a greater level of domestic self-sufficiency in health human resources. Better planning at all levels – from the institution to the regional health authority to the province to the national level – can only help reduce the tendency to look to developing nations for human resources. But that kind of change will take time to implement and to have a noticeable effect.

One of the reasons for Canada’s lack of movement on developing effective ethical international recruitment guidelines has been the tendency to treat the issue of recruitment from developing countries separately from the broader context of domestic health human resource planning. The shortages and poor distribution of professionals currently plaguing the Canadian system are, in some large part, the result of domestic policy choices made in the past – choices often made without due consideration to indirect effects or unintended consequences. While no set of policy proscriptions can account for all of the unintended consequences, the likelihood of negative consequences can be limited by insisting on a more systemic approach to analyzing the issues at hand. Thus, the ethics of international recruitment has to be dealt with in the overall context of domestic health human resource planning.

Indeed, in our conversations with key informants we came to understand that any set of guidelines or any code of conduct would be unworkable unless it is part of a mix of policies to address the broader problems of Canada’s supply of health professionals. And, that mix must also include policy choices to assist developing nations with alleviating the “push” factors and the general framework for Canada’s immigration policy.

Ultimately, the policy levers that need to be pulled cannot all be pulled by a single jurisdiction within Canada. It requires some significant level of intergovernmental and interprovincial collaboration and cooperation. That being said, provincial governments must respond to the issues raised in this study. As part of their ongoing development of an integrated health human resources plan in consultation with key stakeholders, provinces should be taking steps to ensure that they address the questions raised here about the role of IEHPs and the appropriate manner in which all health professionals are recruited into the system.

Authors’ Note

This paper is based on two studies undertaken on behalf of the Workforce Planning Branch of Saskatchewan Health. The analysis and content are the responsibility of the authors and do not necessarily reflect the views of the Government of Saskatchewan or Saskatchewan Health.

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I. Introduction

The international migration of health providers to and from Canada is not new. Significant numbers of Canadian trained health professionals have, for example, migrated to the United States in search of better jobs, different opportunities and for a host of other, sometimes more personal, reasons. In turn, Canadian health system planners have recruited and/or admitted health professionals from abroad who have come for a similar range of reasons. Some come for the same reasons that immigrants have chosen to relocate to Canada since the 18th and 19th centuries – because the political, economic or social situations in their country of origin are such that they seek the stability and the opportunity that are provided in a stable, liberal-democratic state.

And it is important to note that internationally educated health professionals (IEHPs) have always played an important role in and formed a substantial portion of Canada's health system. What is different now (and what has motivated much discussion about the ethics of recruiting IEHPs) is that the recent waves of IEHPs who have come to Canada are now arriving from developing countries, and especially from Africa and Asia. On the face of it, this mirrors the changing face of immigration in Canada generally as the proportion of immigrants from Europe and the United States declines and the proportion from Asia and Africa increases.

But those source countries in Africa and Asia are, understandably, concerned about the loss of highly-trained professionals from their own health care systems and particularly concerned with the possibility that developed countries like Canada are engaging in practices and developing policies specifically designed to encourage this immigration.* This is what Labonte et al. have characterized as a “brain drain” of health professionals from the developing to the developed world at a time when developing nations are themselves facing serious health system crises. And that phrase, “brain drain,” should resonate with Canadians who themselves have been concerned about the loss of highly educated professionals – doctors, nurses, scientists, engineers, etc. – to the United States over the past decades.

In 2001, the South African High Commissioner to Canada criticized Canada for the relatively high number of South African physicians being recruited to Canada at a time when South Africa's own health care system was struggling.¹ If South Africa, as the richest African nation, can ill afford to lose its health professionals to the Western world, how can much poorer nations cope with this loss? It is because of these challenges that Canada, and other Western nations that significantly rely upon IEHPs, have been under pressure to confront the ethical implications of recruiting from the developing world.

Although there are significant ethical concerns surrounding the recruitment of individuals from developing countries by the developed world, several important issues must be recognized within the developing world concerning the migration process itself. First of all, the decision to leave one's country or region is intensely personal. One may leave because of certain “push factors” such as a dangerous working and living environment, or a lack of effective workplace supports

* Data on the current overall number of internationally educated health professionals practicing in Canada, at least as it relates to physicians and registered nurses, as well as some data on the source countries for IEHPs is found in Appendix I.

and compensation. Likewise, there are certain “pull factors” which make another country or region more attractive, such as a good quality of life for oneself and one’s family, improved working conditions and compensation or personal safety. Second, while the decision to migrate is a personal one, emigration has important ramifications for the country of origin, especially in the case of highly educated individuals. For example, a highly educated physician’s decision to leave his home country does not only reduce the workforce of that nation in absolute terms, it may also reduce that nation’s ability to train more physicians if that individual participated in training programs. Or, the position left open by the emigration may be very difficult to fill as developing nations face greater recruitment and retention challenges than developed countries.

Third, these losses are compounded in developing countries that contend with a disproportionate burden of disease with far fewer resources than developed countries. In fact, about 37 out of 47 sub-Saharan African countries do not have the World Health Organization (WHO) recommended ratio of 20 physicians per 100,000 population.² And while doctor to population ratios are, at best, a limited indicator of access to health care, it is indicative of the scope of the challenges facing this region. The World Health Organization also found that the out-migration of nurses from South Africa has resulted in difficulties with staffing and a number of pharmacies have had to close within Zimbabwe due to a lack of pharmacy personnel.³ These phenomena have important ramifications for health outcomes; for instance, the density of health providers across countries accounts for variations in maternal mortality, infant mortality and under-five mortality rates.

Fourth, the largest international sources of both specialists and general practitioners relocating to Canada are Asia and Africa.⁴ Indeed, most of the data regarding IEHPs relocating to Canada tends to be aggregated to regional or continental levels making it difficult to assess the impact of ethical recruitment policies on specific developing countries. For example, recruiting a physician from Japan would probably pose little or no impact upon that country’s health system, but recruiting an individual from Bangladesh might; yet the existing data would classify both of those physicians as Asian.

The one exception to this, which has been raised by various commentators, is that there is some information around the inflow of South African physicians to Saskatchewan, which is often used as a basis for discussing the informal sanctioning of Canada by South Africa in 2001.⁵ For instance, there are an estimated 1,500 South African physicians in Canada. In Saskatchewan, the dependence is higher where, in 2001, almost one in five of the province’s 1,530 doctors (17 percent) had earned their first medical degree in South Africa.⁶ Moreover, in 2000, there were about 300 doctors from South Africa practicing in Saskatchewan.⁷

Yet we know very little about why individual physicians choose to come to Canada or about how they chose Canada. Were they “recruited” by someone or some agency? And, if so, what form did that recruitment take? As is noted further in our discussion, there is some anecdotal evidence that much of the recruitment to some provinces is done through “word of mouth.” There is also some evidence that, in the past, Canadian employers were advertising vacancies in South African professional journals. We also need to address the “why” around migration, or the pull factors. For instance, provinces where there is an existing immigrant community from the source country may have an advantage in attracting further immigrants from that source country. For example,

the relatively large number of South African physicians in some western provinces may make those provinces attractive to South Africans looking to emigrate. And at the same time, the South African immigrants already resident in the West may themselves be actively encouraging family, friends and colleagues in South Africa to join them. Thus, while governments and employers may have actively sought out immigrants from specific developing countries in the past, there may now be what is in effect a self-perpetuating process of immigration that makes such active recruitment now unnecessary.⁸

What is evident from the analysis that follows is that what at first blush might appear to be a relatively straightforward issue is far more complicated. Critics, including some political actors, who simply decry the “poaching” of health professionals by the developed world from the developing world ignore a host of factors that go into understanding how and why people move. The well-intentioned sentiment that developed countries should not actively seek out health professionals from the developing world and “lure” them away with offers of higher standards of living, better working conditions and greater personal security rests on a simplistic understanding of the complex interplay of factors that go into the myriad of decisions that result in the migration of these health professionals.

There are no simple answers to these questions. But there are paths out of the maze that can allow Canadian policy-makers to both confront the issue and develop policy options and instruments that can serve the interests of both the Canadian health care system and the interests of developing states in preserving and building their own systems. Working through the maze begins, we believe, with a series of propositions about which there would appear to be little disagreement and which we hope can form the basis for developing policy options and instruments that can reconceptualize the issue from a zero-sum game into something that approaches one of mutual benefit for all parties:

- That a health professional, like any other individual, should have the right to emigrate from their home country to another country of their choice to seek out the opportunities such moves can provide.
- That many developing nations invest proportionately much more of their resources in the training and development of health professionals and that their own health care systems are profoundly more fragile than those of the developing world and that their populations have, by any measure, a much greater need to retain the services of their domestically produced health providers.
- That developing countries have a number of domestic factors that serve to reinforce the desire of health professionals to leave (e.g. war, political unrest, economic instability, social instability, etc.) – the so-called “push” factors.
- That external recruitment, while a valued “next best” policy option to domestic self-sufficiency, cannot and should not be unfettered: where the recruits are being drawn from and the manner in which they are recruited matters. Accordingly, Canada will need to clearly define the guiding principles underscoring recruitment practice and make some distinction between “active” and “passive” recruitment.

- That Canada's accountability to the international community for recruiting in an ethical manner needs to be balanced with ensuring that Canadians have reasonable access to health services. While ethical recruitment is a "motherhood" issue, it is not without some trade-offs.
- That Canada, like many developed nations, has itself serious shortages and maldistributions of health professionals, especially in rural, remote and northern communities.
- That developed countries' own health professional shortages and maldistributions are themselves the result of policy choices and decisions made over the years that have decreased the domestic supply of professionals and failed to retain professionals in underserved communities.
- That Canadian governments can learn from the international community's experience with formal instruments and agreements around ethical recruitment practices (e.g. the Commonwealth Code of Practice) in developing its own approach to ethical recruitment. Drafting a made-in-Canada approach will require a collaborative and inclusive approach which includes Canadian employers (who may perceive the guidelines as hindering their recruitment of providers), Canadian citizens, employers, providers, recruitment agencies and governments – this will enhance their acceptance of, and compliance to, the set of rules set out in the instrument.
- Finally, we will need to demonstrate that we are recruiting ethically. This goes beyond recording who is recruiting in Canada, what regions IEHPs are emigrating from, and how we are recruiting IEHPs. We also need to define what we mean by, for instance, fair or transparent recruitment practice and measure how we are doing against these benchmarks. This will require a further exploration of data collection infrastructures including the costs and resources needed.

In short, there is a consensus that there is a serious ethical issue to be confronted, namely that it is inappropriate for nations as relatively wealthy as Canada to solve its own domestic health human resource problems of undersupply and maldistribution by relying on the immigration of health professionals from developing countries. Unfortunately, any decisions about how to address these issues is undercut by significant disagreement as to how best to resolve the issue, who is responsible for taking action, and even on what is going on "down on the ground" when it comes to movement of people across borders.

For instance, we need a good definition of ethical recruitment and we need to make distinctions between acceptable or unacceptable behaviour. Most of this distinction is framed within a discussion of "active" and "passive" recruitment. For instance, one can conceive of active recruitment as the targeting of health professionals in developing countries in a manner that entices them to come to Canada when they might otherwise have not chosen to relocate. Passive recruitment is defined as individual action taken to relocate to Canada. But this is complicated by the fact that an individual is unlikely to make a decision to relocate in complete isolation. They may have been contacted by colleagues already resident in Canada or they may have been approached by a recruitment agency offering to make contact with potential employers on their behalf. They may choose Canada over another country because, as noted above, it may be easier to get their credentials recognized or because of an existing community of immigrants from home.

Making any distinction between “passive” and “active” recruitment requires a judgment call: “active” recruitment is generally deemed unacceptable, and “passive” as acceptable. However, making this judgment call is difficult at best since much depends on context and intent. For instance, the location of advertisements (e.g. on the Web sites of developing countries or in professional journals) obscures the distinction between acceptable and unacceptable recruitment practice. It is also difficult to tease out the ethics around the activities of recruitment agencies within developing countries who are working on behalf of Canadian employers. Moreover, the extent to which facilitators to the immigration process, including Immigrant Nominee Programs and the points system, used by Citizenship and Immigration Canada, which favours highly educated professionals, unfairly influences the decision of IEHPs to relocate to Canada needs more clarification.

Even if Canada makes a value judgment over (un)acceptable recruitment practice, there are some practical considerations. For instance, if one makes the blanket statement that the active recruitment of IEHPs from developing countries is unethical, then the question becomes “which countries”? First of all, this requires an agreement as to the criteria by which to include countries on such a list and furthermore, even if a country is included, there may be some allowances made around the specific regions or sectors (e.g. private or public) within a country whereby active recruitment is deemed acceptable.⁹

Addressing these concerns forms the basis of this paper. Using a thematic analysis of international instruments on ethical recruitment and the insights drawn from a series of key informant interviews with policy-makers, stakeholder organizations and health policy analysts from across the country[†] we pose some possibilities for a set of guidelines around ethical recruitment for the Canadian context. We begin by outlining the guiding principles which underscore good recruitment practice. We then provide definitions of ethical recruitment, discuss the distinction between acceptable and unacceptable recruitment practice, and outline possible routes for ensuring and monitoring compliance and evaluating the efficacy of a Canadian instrument in whatever format is chosen.¹⁰ We end with a set of options intended to stimulate further discussion and action.

[†] A list of the international agreements and policy statements as well as a discussion of the interview guide used in this study is found in Appendix II.

II. A Framework for Ethical Recruitment

It's fair to promote awareness of opportunity and recognize the freedom of international mobility without systematically targeting places that cannot afford to lose people (key informant).

We have talked for a long time about how we don't like the US coming up and taking our nurses and doctors, or other provinces poaching. If that's how we feel then we should be also playing by the same rules. We can't talk with only one side of our mouths (key informant).

Coming to grips with external recruitment practices is only one component of an overall issue of meeting the demands for health providers. Some Canadian communities face significant rural retention problems and many communities clamor for permanent physician services. Addressing these issues means, in large part, getting a firmer grasp on workforce planning in Canada. Therefore, developing a Canadian approach to ethical recruitment requires a broader conversation about workforce planning, which highlights self-sufficiency as the best first response, and external recruitment as a valued next-best option. As one of the key informants put it: “[External recruitment] is a tool as part of the discussion. And the discussion needs to be around [provider] supply and demand and national self-sufficiency. That's the prime directive. From that are some collateral issues like how do you meet supply? How do you meet demand?”

There are two possible routes to meeting demand: workforce self-sufficiency, which is acknowledged by the international community and the key informants as being the first policy response,¹¹ and external recruitment, which is perceived as a valued “next best option.” What is at issue and indeed forms the basis of the whole discussion around external recruitment, is *how* this recruitment is done and *where* recruits are drawn from. In other words, there are some parameters being imposed by the international community. If developed countries such as Canada wish to engage in external recruitment, it needs to be fair, transparent, consider mutuality of benefits and reciprocity, and adhere to the principles of global justice and personal autonomy.

There are thus many considerations that Canadians will need to disentangle. First of all, there needs to be agreement on the guiding principles which will govern recruitment practice by Canadians. Secondly, these guiding principles need to be clarified and linked to identifiable actions or best practice benchmarks. Third, “acceptable” and “unacceptable” recruitment practices need to be clearly defined within the scope of the agreement. Fourth, a set of guidelines around ethical recruitment on the wall does not necessarily translate into ethical recruitment practices. There is a value inherent in the symbolic nature of a set of guidelines around ethical recruitment and, in many cases, these guidelines can be enough to change behaviour. However, this symbolic value of the guidelines is mitigated by the very real need to offset any informal sanctioning by the international community. We need to provide evidence that we are recruiting in an ethical manner rather than simply pointing to the set of guidelines. Simply put, good intentions are not enough; they need to be backed up with evidence.

Guiding Principles

There are several guiding principles which emerge from the international instruments and key informant interviews which set the conditional parameters around external recruitment; that is, they set up the “how” and “where” which guide acceptable recruitment practice. These are as follows:

- Global justice;
- Personal autonomy;
- Transparency and accountability;
- Fairness;
- Mutuality of benefits or reciprocity between countries or jurisdictions;
- Provider competency;
- Equitable workplace practices; and
- Workplace and cultural integration.

These principles serve as guides for acceptable recruitment practice or best practice benchmarks. For instance, the principle of fairness is linked in the international instruments to open and honest representation throughout the recruitment process. The principles of mutuality of benefits and reciprocity can be, as one option, operationalized as the use of short-term exchanges or compensation for losses incurred as a result of recruitment activity, and so on.

The key informants provided some important insights around the principles and values underscoring ethical recruitment. Several informants noted that Canadians in general would accept these principles because Canadians are reasonable and fair-minded people who would consider how external recruitment impacts the health and well-being of people from developing countries. However, workforce shortages experienced by some Canadians have heightened concerns about accessing required care for themselves and their families. Thus an essential component will be an informational campaign which educates Canadians about the impact of unfettered recruitment of health providers from developing countries on the ability of these countries to meet their own demands for health services.

Global Justice

The overarching consideration throughout the issue of ethical recruitment is the recognition of the moral obligation that developed countries have to developing countries in not only ensuring fair recruitment practice, but to assist them in achieving workforce self-sufficiency, maintaining educational institutions, and providing quality of care.¹² Thus ethical recruitment requires an overall global systems approach which links the recruitment activities by one country to the health services of another.

Personal Autonomy

Individual autonomy, or the right to determine one’s own destiny, is an intrinsic part of the international instruments on ethical recruitment. In this respect, no one from developing countries should be barred from moving to pursue their own interests provided that they fulfill any obligations or contracts within their country of origin or do not interfere with the corresponding rights of others, in which case, a fair process for resolving conflicts should be implemented.

The theme of personal autonomy, for instance, was raised as an important consideration by key informants. Health providers from developing countries, they argued, have the inherent right to move to Canada whether for personal or professional reasons. In addition, once in Canada these professionals should not be unduly constrained from moving and taking up work in the community of their choice.

This can be something of a double-edged sword for Canadian governments. These governments may respond to critics of international recruitment (including the governments of source countries) by upholding the individual's right to choose to come to Canada to practice their profession, but then may want to impose limits on that right to practice in order to bolster service provision in underserved parts of the health system (e.g. rural or remote communities) which are, in reality, limits on an individual's mobility that are not imposed on domestically educated health professionals.

Transparency and Accountability

Because international recruitment of health professions occurs in such a wide variety of guises with an ever-changing cast of actors (which is further complicated in the Canadian case by the very decentralized nature of our health system), it is difficult to get a handle on who is doing what and how it is being done. Thus, holding actors to account for their actions and take responsibility for them is difficult. Indeed, one of the frustrations facing developing countries when attempting to confront Canada on this issue is that their point of access diplomatically to Canada is the national government. But the Canadian federal government has very limited capacity to enjoin provincial governments (not to mention regional health authorities (RHAs), individual institutions or individual communities) from engaging in what might be considered unethical recruitment practices.

Embedded within the international instruments is the stipulation that developed countries delineate their responsibilities to the source country and be accountable for their recruitment practices.¹³ Canada, in this respect, has certain responsibilities for recruiting in an ethical manner; for instance, we need to demonstrate to the international community that we are recruiting fairly, adhering to the principle of global justice and/or take responsibility for providing assistance (however defined) to developing countries. We need to outline therefore, what our lines of responsibility are to developing countries and be prepared to provide rationales for any divergences from our commitments. But in order to do this in any meaningful way will, as is discussed below, require a significant intergovernmental commitment on the part of Canadian governments to act collaboratively.

At the same time, the ability to act collaboratively is undercut by the fact that individual provincial and local governments and employers also have a responsibility to their constituents for ensuring reasonable access to quality care. Most Canadians, the key informants argue, are very reasonable if they consider the impact of international recruitment on the health and well-being of people from developing countries. At the same time, many of the key informants also noted that some Canadians are concerned about their access to a provider and will probably be indifferent to the avenue by which the provider was recruited to their community or where they are from. This acceptability would greatly depend on geography and the specific access needs of urban versus rural communities. One obvious policy area is the bolstering of domestic self-sufficiency strategies which would mitigate the need for external recruitment for hard-to-recruit areas.¹⁴

Fairness

One of the elements that is common to many of the international conventions and agreements examined is the requirement that individuals who are recruited by developed countries are given accurate information with regard to the working conditions and the treatment they can expect. Each IEHP is entitled to full disclosure about the processes involved within recruitment and the workplace environment so that he or she could make an informed decision and be protected against unscrupulous and exploitative recruitment practices. Accordingly, recruiting countries are advised to provide potential recruits with an honest representation about the position being applied for (e.g. job description, grading structure, salary, location, etc.), the process involved in immigration, legal and regulatory conditions, their contractual rights and obligations, the quality of life and physical security, cost of living, access to education, and the taxation regulations.¹⁵

Within the Canadian context, fairness translates into honest representation about the availability of opportunities, the processes involved in credentialing, the immigration process, and the nature of Canadian workplaces. Thus any media campaigns which describe Canada as a destination of choice will need to include information about the operational hoops involved in both immigrating to Canada in general and the processes involved in assessment and registration with a provincial regulatory body. One key informant made it very clear that any misrepresentation of fact about living or working in Canada is highly unacceptable.

Mutuality of Benefits and Reciprocity

Many of the international instruments include some manner of reciprocity including short-term exchanges and work placements, attachments/sabbaticals in developing countries, twinning schemes between health training bodies and hospitals, development assistance and compensation.¹⁶

The notion of compensation is rather controversial in Canada. Some commentators have linked Canada's refusal to formally adopt the Commonwealth Code of Practice because of the section on compensation.¹⁷ Moreover, it would be difficult in the Canadian context to determine the lines of responsibility, particularly if, according to the evidence, most IEHPs come to Canada due to personal communications or by assessing the desirability of a location through Internet advertisements. And, again, the decentralized nature of the Canadian health system becomes problematic in assessing who would provide compensation.

It is unlikely that the federal government would compensate developing countries for recruitment undertaken by provincial governments over which they have little control. Nor is it likely that provincial governments would agree to pay compensation for recruitment activities undertaken by private actors over which they may have limited control (though they could restrict the activities of public agencies such as regional health authorities and individual institutions, but likely not without some significant political fallout). If provinces did agree to compensation it would also immediately raise the question of who would compensate Province A when the health professionals they recruited decided to move to Province B to practice.

This is not to say that compensation in some form is completely out of the question or completely unworkable. Indeed, some of the key informants argued that compensating developing countries for losses incurred through out-migration at the very least requires further investigation and discussion by Canadian stakeholders.

Other suggestions by the key informants along these lines, include the incorporation of short-term exchange internships within the curriculum of health sciences training, and the general provision of aid to the source country. Exchanges and offers of training opportunities in developing countries can mitigate some of the impact of out-migration, but they also come with downside risks.

Opening training slots in Canadian universities to train physicians and nurses from the developing world in the expectation that they will return home to practice does not always work out as intended. Often these individuals decide they want to stay in their host country to practice and many who do return home find that their training is inappropriate to the practice of health care in a developing country with limited resources in terms of medicines, technologies and diagnostic techniques.

Provider Competency

Most of the instruments emphasize the role of national regulatory bodies in determining workforce and language competency and ensuring that the IEHP has the appropriate registration within their source country.¹⁸ However, there was a lack of consensus among the key informants on the need to include an explicit reference to any regulatory requirements within a Canadian set of guidelines around recruitment. For instance, language competency and expectations around levels of expertise required to practice in Canada is the purview of regulatory bodies. Therefore, including a set of guidelines around professional regulations in a Canadian instrument for ethical recruitment would be redundant. Moreover, they argued that there are already many safeguards built into the immigration and accreditation processes to ensure public safety.¹⁹

Other key informants noted, however, that an inclusion of these factors would serve to clarify and communicate the processes involved in the regulatory and licensure processes in order to mitigate any instances of fraud, lack of language competency, etc.

Equitable Workplace Practices

Most of the international instruments recommend that recruiting countries ensure that IEHPs are afforded the same workplace protections and treatment as their domestically educated counterparts.²⁰ Again, the key informants were mixed on this point on the necessity for including this principle within a Canadian instrument. For many of the key informants, this is a separate issue to ethical recruitment. Some raised the existence of domestic labour laws, which extend to IEHPs with or without a valid work permit.²¹

On the other hand, other respondents pointed out that including reference to Canadian labour laws within the set of guidelines for ethical recruitment would ensure greater clarity around Canadian labour laws which may factor into the decision to relocate to and work in Canada.

Workplace and Cultural Integration

Most of the international instruments include some aspect of the need to integrate IEHPs within the host country's health workforce and culture.²² Several of the key informants argued that comprehensive induction services for the IEHPs and their families are needed to assist them with integration in the Canadian culture and workplace environment. One key informant, along these lines, noted that one has to recruit the whole family and that this recruitment needs to provide

pertinent supports including, inter alia, assisting spouses with locating employment, educational opportunities for children, access to recreation, and access to the arts. Another crucial factor is that IEHPs are extended a welcome into the communities through social networking and inclusion.²³

Defining Ethical Recruitment

The key informants noted that there is value in the development of guidelines for ethical recruitment. For some, it represents a good start in the development of guidelines around appropriate practice by both recruiters and employers. It would, at the very least, allow Canadians to point to these guidelines as a policy response to international informal sanctioning. Several key informants raised the official complaint lodged by South Africa in 2001 about the number of South African physicians moving to Canada as an example. As one key informant noted that at the time: “Canada did not have much to fall back on by way of response... we did not have any documents which outlined where we stand on ethical recruitment practices.”

Balancing the health and well-being of Canadian with the health of people in developing countries requires that choices are based on a set of often competing principles. These conflicting values came into play when the key informants were asked to define ethical or “acceptable” recruitment practice. There was a broad consensus that ethical recruitment requires a balancing act between individual rights to mobility and an adherence to global justice. The following responses summarize this balance:

For me, ethical recruitment means taking into consideration the circumstances of the home jurisdiction and balancing the wishes of individuals to work wherever they choose. [It also means] understanding the investments made in the home jurisdiction. We need to be sensitive and show that we as a country are not over-depleting the health services from different geographic areas.

You have to recognize that it’s fair enough to promote awareness of opportunity – recognizing the freedom of international mobility without systematically targeting places that cannot afford to lose people.

One key informant stated that ensuring this balance may extend past recruitment activities to making investments within the source country to address the “push” factors which factor into the decision to leave.

Passive versus Active Recruitment

The distinction between active and passive recruitment involves a value judgment. Active recruitment is not by definition unacceptable and, indeed, all recruitment is in some way “active,” and it can be a valued policy response to meeting workforce needs. What is considered unacceptable or unfair is the targeting of developing countries as a source of health professionals. Interestingly, and not surprisingly, a number of key informants raised the issue of “have” provinces recruiting health professionals from “have-not” provinces as a domestic analogy for the kind of recruitment that should be deemed unacceptable. Whether this analogy holds is a matter of some debate, but it does raise an important element concerning the

challenges faced by governments when trying to frame the parameters of what would be ethical recruitment practices.

The recruitment of internationally educated health professionals by individual provinces or RHAs within a province is itself linked to the issue of the mobility of health professionals within Canada generally. A province like Alberta has, because of its current economic boom, become a magnet for health professionals from other jurisdictions. As such, it reaps the benefits of the investments made in training by less well-off provinces which, despite increasing the number of health professionals being graduated, are left with seemingly irresolvable shortages. Charges that Alberta is “poaching” health professionals from other provinces are, quite understandably, met with the response that individuals are merely exercising their legitimate right to seek out better professional and personal opportunities – a right to mobility clearly guaranteed in the Canadian constitution.

While there are a host of differences between a situation where a health professional leaves Cornerbrook for Calgary and one where he or she leaves Durban for Victoria, comparing the two does force one to confront the difficulties in differentiating active versus passive recruitment.

The specific mechanisms which constitute “active” recruitment, however, are not clearly defined in the international instruments. For instance, within the United Kingdom’s Department of Health Code of Practice active recruitment is defined as: “advertising employment opportunities within the UK healthcare sector and then acting in such a manner as to secure employment for that individual.” Otherwise the scope of actions which constitute active recruitment is left open to address all eventualities.

Furthermore, it is deemed acceptable to actively recruit from developing countries provided that there is an agreement about the guidelines and rules between the developed and developing countries. For instance, Wonca (World Organization of Family Doctors) deems it acceptable to recruit and advertise positions in the context of a Memorandum of Understanding between countries.

The key informants were more forthcoming about the actions constituting unacceptable recruitment practice. These actions are as follows:

- Bringing health providers to visit communities²⁴;
- Sending out e-mails;
- Setting up booths at job fairs in developing countries; and
- Advertisements in the professional journals of developing countries.

Passive recruitment, on the other hand, is often defined through the principle of personal autonomy. Passive recruitment in this respect is generally perceived to constitute action instigated by individuals in applying for positions and immigrating without third party involvement (e.g. recruitment agencies). For instance, the UK Department of Health and the Scottish Executive encourage IEHPs from developing countries to apply for positions within the United Kingdom and immigrate there provided that they do so without any third party involvement such as recruitment agencies. British National Health Service employers are encouraged to consider *unsolicited* applications for advertised posts directly from international recruits.

From the perspective of the stakeholders interviewed, passive recruitment encompasses the actions taken by communities and recruitment agencies to “advertise” a community or region as a desirable place to live and work. Towards this end, the key informants argued that the following constitute passive, and thus acceptable, recruitment practice by provinces, Canadian employers and private recruitment agencies²⁵:

- Posting job vacancies on Canadian-based Web sites;
- Advertising Canadian communities on Canadian-based Web sites; and
- Matching applicants with positions in Canada.

As one key informant noted: “[If an IEHP comes across our Web site] here is what you’ll need to know about practice requirements, immigration information, the regional health service system and the communities in the regions and what we have to offer... We will give you enough information to make your own informed decision about whether this is something that you would like to pursue. This is fine.” In this light, the Web sites advertising vacancies in a health region or a community as a destination of choice constitutes acceptable action, provided that the information provided in these advertisements is factual and available on Canadian-based Web sites (e.g. the Web sites of Canadian regional health authorities).

There are, however, certain ethical considerations around passive recruitment. Canadian recruiters and employers need to ensure that an IEHP who has applied for and been given a position in Canada has met any outstanding obligation to his or her country of origin (e.g. taxation or bonding obligations).

Yet, the line between the passive acceptance of immigrants and the active recruitment of immigrants is somewhat fuzzy. Canada has clearly structured its immigration system toward specific kinds of immigrants in recent years and to varying degrees it works to facilitate the entry by those who meet the criteria. As noted above, the government’s interest is in highly skilled and professional immigrants of whom IEHPs are but one subset, albeit one which is a key focus of the provincial nominee programs. And at some point in the immigration process, the process itself becomes “active” insofar as it facilitates the immigration of IEHPs. Indeed, it can be argued that it would in fact be unethical to not provide services aimed at integrating IEHPs into the communities into which they arrive. Having agreed to accept an immigrant, presumably one bears some responsibility for insuring their successful integration into their new community.

In the end, attempting to clearly distinguish between active and passive recruitment and to pinpoint the moment where passive recruitment policies cross the line to become unethical recruitment may be unhelpful when drawing boundaries between when recruitment of IEHPs is acceptable or unacceptable. That the distinction is not helpful, though, does not eliminate the ethical dilemma that faces developed countries when it comes to the migration of IEHPs.²⁶ Indeed, it is hoped that by moving past the attempts to categorize this process as “active” and this process as “passive” one can actually begin to think about the kinds of policy responses needed to respond to the very real concerns raised by developing countries that Canada is depleting their health workforce. The challenge, therefore, is in the level of explicitness in defining which active recruitment practices are acceptable or unacceptable and further, which jurisdictions are essentially off-limits for active recruitment.

Development of a Proscribed List of Countries

One of the most defining features of the United Kingdom's Department of Health Code of Practice is the development of a list of developing countries whereby active recruitment is off-limits.²⁷ The key informants were asked if Canada should follow the United Kingdom's lead in developing such a list. For the most part, the key informants stated that this might be an effective strategy, though there are several qualifiers.

First of all, the circumstances of countries could change rapidly, thus monitoring a country's eligibility would require both up-front costs and devoted resources for monitoring purposes. For instance, one key informant noted that: "If a list is created there must be a plan to maintain, update and make sure it's a 'living' list."

Second, often the health care sector of a developing country is viewed through a Western model and may not directly fall into specified categories around service provision. For instance, some countries may have more resources devoted to preventative and/or public health care which shifts their health care needs and thus have different workforce needs. Finally, the selection of countries would be tricky since the criteria used in the selection process may be contradictory. One stakeholder used the example of Cuba, which has a relatively low income level but a "great health system."

When asked by what criteria countries could be included on a list of this nature, several key informants commented that this would require a "multifaceted" approach which delved into the economic, social and political conditions as well as the workforce capacity within and across the country. The following are suggested criteria for inclusion on a proscribed list of countries:

- Gross Domestic Product (GDP);
- Population health indicators; and
- The ratio of health providers to population.

Care must be taken when choosing and using these criteria because they do not tell the whole story. One important consideration is that while the GDP of a country may be used to denote the classification of a country into developing or developed countries, there are geographical, and socio-economic differences around workforce needs within countries. Thus it is difficult to determine which regions or countries have dire circumstances around workforce capacity and which do not – for some countries or regions, losing one nurse may pose a problem while another region could cope with the loss of 100 nurses. It also depends on the skills sets and competencies of the health provider. The loss of a nurse practitioner has different ramifications for accessibility to primary care than the loss of a nurse providing basic care. The loss of a midwife in a region negatively impacts the health of pregnant women and children, and so on. Finally, there is an additional complexity around the practice of overtraining health providers for export as a means of getting money back to the country through remittances.

Compliance, Monitoring and Evaluation

None of the international instruments are legally binding on their signatories and thus do not rely on any formal sanctioning to ensure compliance.²⁸ Only one of the key informants recommended legal sanctioning as a measure to ensure compliance by Canadian actors. The vast majority argued that this is not necessary or practical given the substantive legislative changes that would be needed. Indeed, the very presence of a set of standards would be enough to ensure behavioural changes they argued.

At the very least, the development of a set of guidelines would govern expected recruitment practice by Canadian governments, employers and recruitment agencies. This is dependent on the level of awareness that these bodies have about these guidelines and their willingness to change behaviour should they be found to be in violation of the guidelines.

One possible form of informally securing compliance is by including recruitment practice within performance reports between regional health authorities and the provincial governments. Regional health authorities (RHAs), for instance, may be held to account for any recruitment practice through their performance reports.

Ensuring compliance by the private sector would be much more difficult and most of the key informants stated that they did not know how this could be put into practice. One suggestion is for regional health authorities to create voluntary agreements with the private sector which includes performance reports conducted on an annual basis. Another suggested that performance evaluations can be drawn up by regional health authorities who contract services from private sector employers.

There are several important considerations around ensuring compliance to a Canadian set of guidelines. First, there is a need for consensus building and “buy in” by relevant stakeholders. For instance, the World Health Organization (WHO) argues that support by all relevant groups is essential for the successful implementation of an instrument on ethical recruitment.²⁹ This requires the identification of the actors who might oppose or support the development of a set of guidelines. A number of key informants argued that some employers may be resistant to the adoption of a set of guidelines around ethical recruitment since it may be perceived as impeding their ability to recruit health providers to their service area. According to one key informant, “When stakeholders can’t get staffing they get frustrated. They want a band-aid solution.” Second, the acceptance of, and thus compliance with, a set of guidelines for ethical recruitment would depend on communications and awareness campaigns which highlight the underlying principles and expected recruitment practice.

Knowing if employers, individuals, countries, recruitment agencies, etc., are complying with the guidelines on ethical recruitment depends on the clarity around expectations and a system or infrastructure which monitors what is going on “down on the ground.” While the international instruments stipulate the need for a monitoring system and provide some clear suggestions,³⁰ no jurisdiction has to date developed a mechanism which monitors compliance, by detailing who is recruiting IEHPs, where IEHPs are being recruited from, or, more importantly, *how* they are

being recruited.³¹ This weakens the accountability of recruiting countries to the international community.

The key informants also argued that a system should be set in place in order to monitor the voluntary compliance to the set of guidelines on ethical recruitment by all parties including the private sector – though for the most part, monitoring the latter is more difficult since, as one key informant remarked, the private sector is not required to report on their activities.

There were two main streams around monitoring compliance noted by the key informants. First of all, they argued that how IEHPs are being recruited can be monitored through the following means:

- Monitoring the number of ads in the professional journals of developing countries;
- A short survey given to IEHPs upon entry into Canada which includes questions around the manner in which they were recruited and by whom;
- Creating a mechanism to document complaints of unethical recruitment practices by recruiting agencies in particular and countries in general; and
- Building in an audit of recruitment practices by public employers (e.g. RHAs) within their performance reports.

The respondents also stressed the need to monitor the inflows of IEHPs into Canada in order to demonstrate the level of reliance on external recruitment to meet demand. To this end, it was suggested using current data sets to detail where the recruits are being drawn from. The Canadian Institute for Health Information (CIHI), for instance, already produces a data set on the percentage of IEHPs coming into Canada and where they are educated.³² Thus, significant increases in the number of IEHPs in a jurisdiction would be immediately apparent.

A related issue to monitoring is that of measuring and evaluating the impact of an instrument on ethical recruitment against expected or desired outcomes. Unfortunately, none of the existing codes of conduct or international agreements contain indicators or expected outcomes that would allow one to readily determine whether the agreements or codes constitute an effective policy response.

Presumably, though, one could use the regular monitoring of compliance as a proxy for effectiveness. Insofar as a code of conduct, for example, contains procedures for monitoring compliance and reporting on violations of the code, the number and nature of those violations should decline as recruitment behaviour comes into line with the code's provisions. Even insofar as sanctions remain informal – perhaps no more than publication of monitoring reports – and rely on an actors desire to not be seen in violation of the code then the fewer violations reported could be taken as at least a rough measure of a code's effectiveness in changing behaviour.

III. Policy Options and Choices

There are several interrelated and often contradictory issues which emerge from the evidence gathered. First of all, while this is rather obvious, developing a policy response on ethical recruitment is extraordinarily complex and governments in Canada can move in a variety of directions either individually or collectively.

Acting alone, the Government of Canada could choose to sign one of the existing international conventions such as the Commonwealth Code. In doing so, it would send a strong signal that it takes the issue seriously and that it wants to take responsibility for its actions. Yet, in the first instance, the Government of Canada itself does virtually no recruitment of health professionals (international or domestic) and, more importantly, it could do little to ensure provincial compliance with the code and would have no authority over the actions of regional health authorities or individual institutions in terms of insuring their compliance. But in signing something like the Commonwealth Code, Canada raise expectations in the international community that it could in fact live up to its terms.

Collectively the federal government and the provinces could either authorize Canada to sign an existing international code of conduct (and thereby signal provincial willingness to be bound by the terms of the code) or work to design and implement a Canadian code of conduct as part of an intergovernmental agreement or accord. But the reality is that we appear to be a long way from either scenario at this point. There are too many unknowns about what compliance to something like the Commonwealth Code would mean for individual provinces or what role the federal government might want or need to assume in terms of monitoring to make this palatable to provincial governments. In terms of intergovernmental collaboration to design a “made in Canada” policy response, there has yet to be any serious discussion of these issues in this arena to let one have much hope that this is going to be a priority in the near future. And indeed the intergovernmental sensitivities on a number of health human resource issues (such as the aforementioned case of interprovincial competition for health professionals) make it even less likely that there will be sustained action on this front any time soon.

For their part, individual provinces have the authority to design and implement codes of conduct that would apply in their own jurisdiction and which could have any level of enforcement and compliance mechanisms to which they could bind RHAs, hospitals and even private sector agencies. In designing such a code, each province would have to confront the political challenges that would undoubtedly arise. The more restrictive the code and the more the provincial government appears to be setting itself up as a kind of “recruitment police” then the more RHAs, hospitals and underserved communities would no doubt balk at restrictions on their ability to recruit and provincial governments would be accused of limiting access to needed health professionals for their constituents.

Moving down this road would require a sustained conversation with both the public and the stakeholders within the province in order to create the conditions necessary for the kind of “buy in” needed to make the code effective and practicable. And in order for such a dialogue to be effective and yield results, it has to be situated within a broader conversation about health human resource planning more generally – one that looks at issues of domestic supply and demand for

health professionals, the interprovincial dimensions of both health workforce mobility and education and one that examines what it might mean for the individual provinces and the nation as a whole to be “self-sufficient” in health human resources.

Although individual action on developing some kind of policy framework that would articulate a provincial approach to ethical recruitment of IEHPs might yield something of a patchwork of policies across the country whereby different provinces have different approaches, this might still be where there is the most optimism for positive action. One of the strengths of a federal system is that it allows for policy innovations in a single jurisdiction that can, we hope, be eventually replicated and adapted across other jurisdictions. If one or two provincial governments were to begin a process of articulating a framework for ethical recruitment practices, it could lay the groundwork for such processes in other provinces. That this leads to a pan-Canadian framework agreed to by all governments might be a good outcome, but it is hardly a necessity and the absence of such an outcome does not constitute a policy failure.

What follows then are some observations about how individual governments in Canada could proceed to develop policy responses to the question of ethical recruitment generally and the role of internationally educated health professionals within the health care system more specifically. In doing so, we return to many of the categories and issues noted in the examination of the existing international agreements and to the observations of those interviewed for this study.

General Principles

Both the literature review and interviews point to some areas which governments may want to address both in the development of policy approaches to recruitment (including the possibility of a formal Code of Practice) and the context in which it is discussed, developed and implemented. Most of the existing Codes of Practice and Position Statements emphasize a balance between personal autonomy (i.e. the right of a person to move to another country to seek employment or a better life) and the responsibility that developed countries have not only to not unduly harm developing countries but to assist them in meaningful ways in building their own path towards development.

There is little point in trying to discern whether the health care needs of one country (or one province for that matter) outweigh or trump those of another. But what is relevant is the relative resources that a country can bring to bear to meet those needs. Developed countries like Canada have at their disposal not only access to much greater financial and other resources necessary to meet the health needs of Canadians but its relative prosperity, political and social stability gives it a much greater range of policy options to choose from than is the case with the nations of the developing world. One must keep in mind that whatever the shortcomings of Canada’s health care system and of its health human resources situation, it is a situation that stems largely (but not entirely) from choices made and not made by Canadian governments at both the federal and provincial level. Thus, in the debate over the recruitment of internationally educated health professionals there should be a clear bias in favour of policy choices that do the least harm to those countries that have fewer resources and fewer policy options.

Addressing these balances will require the development of a clearly articulated framework which posits workforce self-sufficiency as the first policy response to addressing the demands for health providers. Much of this is already present in the provincial health human resource planning documents and in intergovernmental agreements. The key informants, on this note, argued that more needs to be done to utilize the existing domestic workforce, which includes IEHPs who have immigrated for personal reasons (e.g. refugees). What emerges from the existing international agreements and discussions with both national and provincial key informants is that external recruitment is the next best option to workforce self-sufficiency.

Yet there are parameters around external recruitment which emerge from the existing Codes of Practice and Position Statements and the key informant interviews. Recruitment needs to be aligned with an overarching principle of global equity. That is, it must take into account the relative capacity of states to put domestic resources towards solving a problem as well as the differential impact that the loss of resources may have on a country that loses domestic resources. Developed countries have an obligation to be much more transparent about the relative gains and losses that are accumulated in the recruitment of IEHPs – both with their own publics and with the source countries affected.

The effectiveness of an agreement will be determined by translating these guiding principles to a set of best practice benchmarks and ultimately into clearly defined and operationalized performance indicators.³³ These performance indicators have several important usages. First of all, they would communicate to the international community and to Canadians that its governments are targeting self-sufficiency as a first policy response and engaging in fair and transparent external recruitment to fill vacancies as the next best option. Second, they would provide evidence that Canadian governments are engaging in fair, transparent, equitable, and just recruitment practice. Performance indicators would also set up the framework by which to evaluate their overall workforce action plan, of which external recruitment is one component.

Scope of the Policy Response

In confronting the issue of the ethical recruitment of IEHPs, individual provinces have the potential to take a leadership role in developing policy responses that will likely influence other governments in the country. What is apparent, though, is that however far the government wishes to go, it has an obligation to proceed in a manner that brings as many as possible of its partners in the health care system on board. This is not only for practical political reasons (i.e. that it is easy to develop effective policy when the goals, expectations and desired outcomes are shared by those who are affected by the policy choice) but also for good policy reasons (i.e. compliance is more likely when there is agreement on the need and value of that compliance).

So, in the first instance, a dialogue needs to begin within provincial governments about the issues discussed in this paper. This is not an issue just for provincial health departments. There are other departments, namely those responsible for labour market and immigration policy, which need to be part of the development of the policy response. There are stakeholders and other parts of the health system that also need to be involved in a dialogue about that response.

The ultimate goal of that policy response can take a number of forms. It can be a relatively straightforward policy statement outlining expectations when it comes to the recruitment of IEHPs or it can be the eventual creation of a full-fledged code of conduct that comes with a fully articulated process for monitoring and enforcement. It can involve the creation of a new agency to oversee and monitor compliance or it can be accommodated within other existing structures within government departments. And there are many variations that could be articulated between (and perhaps even beyond) these alternatives.

The stakeholders, RHAs, and other government departments all have to be engaged in order to ensure that any policy statement, code of conduct or monitoring mechanism can be effective. Some level of consensus is going to be needed, but the process itself need not get hung up on a desire for unanimity if it commits itself to an incremental process building on the existing levels of agreement and working towards, if necessary, a more fulsome and comprehensive response.

Active versus Passive Recruitment

As we noted above, at the heart of much of the debate about the recruitment of IEHPs is the distinction that is made between active and passive recruitment. The international codes of conduct all attempt to make the point that recruitment per se is not the issue – there will always be recruitment and one has to respect the right of an individual to choose to move across borders for whatever reason. But it is the practice of developed countries in some way “targeting” individuals in developing countries that should be restrained. But the line between “active” and “passive” recruitment is not always clear and at times can depend on where one stands relative to the recruitment process.

Defining passive and active recruitment runs into many operational issues and thus governments will need to consider a number of points:

- Passive recruitment is usually used to describe situations when an individual decides on their own to apply for a position in another country without any direct contact with a recruitment agency or potential employer. Some of the key informants extended this definition to include actions taken by employers, communities or others to promote their workplace or community as an attractive destination for potential applicants. Still others would include matching services provided by recruitment agency – where a third party seeks out appropriate job opportunities for a person – as essentially passive recruitment. But once one moves from the very simple description of an employer being willing to accept an application from a person from abroad, there is less and less agreement about what distinguishes active from passive recruitment within the literature and amongst the key informants interviewed.
- While the existing agreements, such as the UK Code of Practice are open-ended in their definition of active recruitment to “cover all eventualities,” the key informant interviews explicitly defined unacceptable recruitment practice as recruitment through ads in professional journals and setting up booths at job fairs.

- The active recruitment of health providers from developing countries is often framed within a mutual agreement between developed and developing countries. For instance, the United Kingdom Department of Health stipulates that: “No active recruitment will be undertaken in developing countries by UK commercial recruitment agencies, or by any overseas agency sub-contracted to that agency, or any healthcare organisation unless there exists a government-to-government agreement that healthcare professionals from that country may be targeted for employment.”³⁴
- Likewise, in the Melbourne Manifesto, Wonca recommends that short-term exchanges take place within the scope of a Memorandum of Understanding.
- Another mechanism used by the United Kingdom is a list of countries whereby active recruitment is off-limits. The key informants, while seeing the value of such a list, raised a number of concerns. Some argued that this would involve both up-front and sustainable resources, the latter serving to monitor changes in the economic status of countries. If the agreement is pan-Canadian, the resources for this type of monitoring system could be shared.

Incentives and Sanctions for Compliance

None of the existing agreements, policy statements or codes of conduct are legally binding. Rather they serve as overarching guidelines or best practices. None of the key informants suggest that encoding the principles on ethical recruitment within legislation was either desirable or necessary. They argued instead that even having some form of guidelines in place may well serve to change behaviours, in much the same manner as professional codes of conduct.

A government’s approach will depend on how “directive” it wants to be on the issue in terms of limiting the ability of RHAs, individual institutions and the private sector in proscribing certain recruitment practices. This can range from public statements noting the province’s “expectation” that recruitment be undertaken in accordance with a provincial policy statement or code of conduct through to building such expectations into service agreements and accountability documents with RHAs who in turn would be required to ensure that the institutions in their regions also comply.

Given the decentralized nature of recruitment in the Canadian system – the fact that it can occur in a wide variety of contexts – it would seem advisable for governments to begin to engage the interested parties (RHAs, major hospitals, key stakeholders) in a dialogue to shape the recruitment guidelines prior to their being issued. Beginning the process with as much “buy in” from those who currently do the recruiting will lay the groundwork for the implementation of a policy that has a greater likelihood of success. This is especially important insofar as the ultimate goal is to change the culture of recruitment in the province through voluntary compliance rather than through legislative direction coupled with sanctions.

Monitoring and Evaluation

The issue of compliance and more so with accountability, would be greatly strengthened with a centralized, uniform and reliable data set on not only who is immigrating and being registered in Canada, but also the means by which they were recruited and by whom. As noted above, much depends on the guiding principles which underscore the policy response. If, for instance, the success of the agreement translates into fair and transparent recruitment practice, then these principles need to be defined and operationalized. If success means demonstrating that workforce self-sufficiency is the first policy response to workforce shortages, then performance indicators around self-sufficiency will need to be developed and integrated within an overall framework.

Regardless of how “success” is ultimately defined, monitoring and evaluation processes will require a uniform and reliable data collection infrastructure. An effective and comprehensive data collection and analysis infrastructure is needed to monitor compliance and evaluate the impact of the Code on recruitment by government and other agencies and employers across Canada. The issues around what information will be collected, what start-up and sustainable resources will be necessary, how costs for data collection will be allocated and shared, the identification of existing databases, and how it can be uniformly collected will require further exploration. One key informant argued that this would prove to be difficult since recruitment happens at so many levels, including at the community level, the regional health authority level, the provincial level and internationally.

IV. Conclusions

What is evident from both the international experience with codes of conduct and similar instruments around ethical recruitment and from the key informant interviews is that there is no obvious solution or quick fix to the issues that the recruitment of internationally educated health professionals from developing countries raises. Codes of conduct and policy statements are only as strong as the will to conform to them. And, as the key informants made abundantly clear, questions of “monitoring” and “enforcement” raise political sensitivities for those who could find themselves on the receiving end of whatever sanctions any code might contain.

And so the kind of dilemmas noted at the outset of the paper – the right of health professionals to move versus the right of citizens of developing countries to access the services of professionals whose training they invested in, the need for developed countries to be more sensitive to the costs endured by developing countries who find an already scarce resource being depleted by international recruitment versus those countries’ need to come to grips with the social and economic factors that “push” educated professionals to seek more stable environments, etc. – do not get resolved simply or quickly.

In the first instance, reducing the reliance on IEHPs from developing countries will begin with the recognition that Canada – at both the federal and provincial level – needs to take seriously the commitments it has made to the Canadian public to achieve a greater level of domestic self-sufficiency in health human resources. Better planning at all levels – from the institution to the

regional health authority to the province to the national level – can only help reduce the tendency to look to developing nations for human resources. But that kind of change will take time to implement and to have a noticeable effect.

That being said, there is a demonstrable need, we would argue, for provincial governments to articulate some kind of response to the issues raised in this study. As part of their ongoing development of an integrated health human resources plans in consultation with key stakeholders, provinces can take steps to ensure that the questions raised here about the role of IEHPs and the appropriate manner in which all health professionals are recruited into the system.

One of the reasons for the stalemate in the development of effective ethical recruitment guidelines internationally has been the tendency to abstract the issue of recruitment from developing countries out of the broader context of domestic health human resource planning in the developed world. The reliance of the Canadian system on IEHPs is long-standing and likely not going to change in the short-term. But the composition of those IEHPs has changed considerably over the past decades and this has raised the ethical issues discussed above. The shortages and poor distribution of professionals currently plaguing the Canadian system are, in some large part, the result of domestic policy choices made in the past – choices often made without due consideration to indirect effects or unintended consequences. While no set of policy proscriptions can account for all of the unintended consequences, the likelihood of negative consequences can be limited by insisting on a more systemic approach to analyzing the issues at hand. Thus, the ethics of international recruitment has to be dealt with in the overall context of domestic health human resource planning.

In the interim, a policy response on these issues – in terms of a statement, a set of guidelines or a code of conduct – has some merit as one part of the mix of policies needed to address the broader set of issues. Whatever form this response takes in and of itself will not resolve all of the issues raised, nor will it obviate the need to examine what other policy levers need to be pulled at the same time. The questions raised by the key informants in this work around monitoring, compliance and possible sanctions are enough to make a code unworkable unless it is rooted in a broader set of policy choices designed to deal with domestic supply of health professionals, the domestic distribution of health professionals (both within and between provinces), the need to assist developing nations with alleviating the “push” factors and the general framework for Canada’s immigration policy. Ultimately, the policy levers that need to be pulled cannot all be pulled by a single jurisdiction within Canada, but require some significant level of intergovernmental and interprovincial collaboration and co-operation. Insofar as the actions of a single jurisdiction provide precedent for others to follow, then that can be a step in the right direction.

Endnotes

- ¹ Ehman, A.J. and Sullivan, P. (2001). South Africa Appeals to Canada to Stop Recruiting its MDs. *Canadian Medical Association Journal*. 164(3). Available on-line at: www.cmaj.ca/cgi/content/full/164/3/387
- ² Hamilton, K. and Yau, J. (2004). *The Global Tug-of-War for Health Care Workers*. Migration Policy Institute. Available on-line at: www.migrationinformation.org/Feature/print.cfm?ID=271.
- ³ Ibid.
- ⁴ Torgerson, R., McIntosh, T. and Klassen, N. (2006). *The Role of Internationally Educated Health Professionals in Saskatchewan Health Care: Understanding the Issues, the Ethics and the Challenges*. Prepared for the Health Workforce Planning Branch, Saskatchewan Health.
- ⁵ Ehman, A.J. and Sullivan, P. (2001). South Africa Appeals to Canada to Stop Recruiting its MDs. *Canadian Medical Association Journal*. 164(3). Available on-line at: www.cmaj.ca/cgi/content/full/164/3/387. Accessed July 11, 2006
- ⁶ Ibid.
- ⁷ CBC News. (2000). *South Africa Accuses Saskatchewan of Doctor 'Poaching.'* Available on-line at www.cbc.ca/news/story/2000/09/26/doctors000926.html. Accessed November 16, 2006.
- ⁸ Ehman, A.J. and Sullivan, P. (2001).
- ⁹ One note of interest here is the inclusion of China on the NHS Employers list of proscribed countries which has the caveat that: "The Chinese Government have asked that China be removed from this list but requested that no recruitment should take place in small rural areas." This brings up the issue of regional and sectoral workforce shortages and needs.
- ¹⁰ The existing international instruments fall into three basic areas: Codes of Practice, Guidelines and Position Statements. A Code of Practice outlines the rules governing acceptable behaviour and while not legally binding carries with it an expectation of compliance by affected parties. Position Statements also reflect the broad policy of a given organization and are often formally adopted. Guidelines are interpretations of policy and often outline more detailed and practical information regarding behaviour and norms and are often not formally adopted. Within this sampling of instruments, governments, both at the national and international level, have drawn up Codes of Practice ethical recruitment, which set down the best practices around recruitment and human resource management. For instance, there are two sections to the NHS Code of Practice. The first section delineates a set of Guiding Principles around ethical recruitment. The second section is more detailed in a sense, providing employers and recruitment agencies with a set of best practices to use in complying with the Code. The Commonwealth Code of Practice also contains a set of guidelines within its Companion Document. Provider groups, on the other hand, such as the International Council of Nurses (ICN) and the World Medical Association (WMA) tend to favour Position Statements and Guidelines. One exception is the *Melbourne Manifesto Code of Practice* which was adopted by the delegates to the Wonca World Rural Health Conference held in Melbourne in 2002. For better detail of these categories, see the World Health Organization (forthcoming). *Management of International Health Worker Migration: Agreements on Ethical Recruitment and Other Policy Options*.
- ¹¹ The international discourse posits workforce self-sufficiency as the best option for addressing workforce shortages. Indeed, countries are urged within the existing national and multinational agreements to "put their own houses in order" rather than depending on external recruitment for their workforce supply. The International Council of Nurses Position Statement, for instance, highlights the need for improved workforce planning at the local and national levels to offset a reliance on IEHPs: "ICN condemns the practice of recruiting nurses to countries where authorities have failed to implement sound and effective workforce planning and to seriously address problems which cause nurses to leave the profession and discourage them from returning to nursing." Likewise the World Medical Association urges countries to ensure effective policies to ensure self-sufficiency through educating adequate numbers of physicians, taking into account its needs and resources. Effective workforce planning strategies are also outlined within the Wonca Melbourne Manifesto. For instance, Wonca urges governments to ensure the availability of adequate undergraduate and post-graduate training posts, to make improvements to working conditions and educational opportunities, to implement strategies which encourage providers to work in areas of need, and to consider alternative and innovative ways to ensure the provision of care including the use of multidisciplinary teams and intersectoral collaboration. They also recommend that countries identify and effectively utilize the skills of providers who have already immigrated due to personal reasons but who have been unable to find work.

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- ¹² The World Medical Association explicitly links three levels of global justice which link moral obligation with corrective action and mutual respect: “Distributive justice requires an equitable allocation of resources among individuals and groups. Corrective justice requires action to address inequities. Procedural justice requires that efforts to achieve equity respect the rights of all who are involved.”
- ¹³ According to the Commonwealth, for instance, countries need to clarify their goals around ethical recruitment practice and, if they diverge from this goal, be prepared to provide their rationales.
- ¹⁴ There are a plethora of policy responses to workforce demands which have emerged in recent years in Canada. See, for instance, Canada’s *Framework for Collaborative Pan-Canadian Health Human Resources Planning* which is available on-line at: www.hc-sc.gc.ca/ahc-asc/alt_formats/ccs-scm/pdf/public-consult/col/hhr-rhs/PanCan_HHR_Framework_sept-05_e.pdf. Accessed November 15, 2006. The Canadian provinces have also developed their own health workforce planning action plans and frameworks which detail region-specific approaches to workforce planning. For instance, see Saskatchewan Health. (2005). *Working Together: Saskatchewan’s Health Workforce Action Plan*. Government of Saskatchewan: Regina. Available on-line at: www.health.gov.sk.ca/hplan_health_workforce_action_plan.pdf. Accessed November 2, 2006.
- ¹⁵ The International Council of Nurses, for instance, explicitly denounces any recruitment practice which exploits nurses or misleads them into “accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience” within their Position Statement. What is needed is good faith contracting which protects nurses from false information, withholding relevant information, misleading claims and exploitation. Honest representation in the recruitment process is also stipulated in the Commonwealth Companion Document.
- ¹⁶ The benefits accrued to the IEHP are further extended in the event of short-term exchanges. One example of this is the development of a Memorandum of Understanding (MoU) between the United Kingdom and South Africa, which encourages the creation of short-term education and practice opportunities for South African health providers in the NHS and vice versa. Under this MoU, doctors and nurses work within the United Kingdom for a set time period, after which they return to their own country where their positions are kept open. This mutual time-limited reciprocal exchange of health providers promotes the sharing of clinical skills and the exchange of best practices and expertise within various areas. The Commonwealth Code of Practice also urges developed countries to consider means by which to assist the source country, which could include technical and financial assistance, access to specialist training and repatriation of skilled health workers. This extends to assistance in developing the qualifications, training, education and expertise of IEHPs so that, when returning home, they could add value to the health care systems in the source country.
- ¹⁷ Labonte, R., Packer, C., Klassen, N., Kazanjian, A., Apland, L., Adalikwu, J., Crush, J., McIntosh, T., Schrecker, T., Walker, J., and Zakus, D. (forthcoming). *The ‘Brain Drain’ of Health Professionals from Sub-Saharan Africa to Canada: Findings and Options*.
- ¹⁸ The United Kingdom’s Department of Health and Scottish Executive Codes of Practice, for instance, explicitly outline the requirements needed for practice in the United Kingdom, which include the requirements around language competencies and the levels of expertise required for registration with a relevant regulatory body. IEHPs are also required to undergo criminal background checks and to meet health and safety standards. The ICN also outlines the need for appropriate nursing legislation, which would assist regulatory bodies in determining the standards around education, competencies and standards of practice which facilitate the ability of IEHPs to practice as a nurse. The CNA Position Statement likewise outlines the need to ensure quality of care through licensure and registration which monitors clinical and language competency and a good understanding of Canadian culture and the Canadian health care system. Moreover, the CNA argues that initial licensure and registration needs to be consistent and equivalent across Canada and be comparable to the requirements for domestically educated nurses. Nurses should also be provided with explicit and complete information about the status of assessment, and information about the distinct process for applying for provincial or territorial nursing licensure and registration, the process for Canadian immigration, and the nature of nursing employment in Canada should be made available to IEHPs even before they enter into Canada.
- ¹⁹ Criminal and medical background checks are required within the Canadian immigration process. For instance, Citizenship and Immigration Canada requires the provision of police certificates from all countries where the applicant has lived for six months or more since the age of 18 as part of the immigration package. Those who pose a security threat will also be refused admission. Immigration to Canada also entails a medical exam for

individuals and their family members when applying for permanent residence status or to stay in Canada for a period of greater than six months under the federal *Immigration and Refugee Protection Act* (2002).

- ²⁰ For instance, due to reports of exploitation and discrimination experiences by overseas nurses, the United Kingdom's Department of Health Code of Practice stipulates that IEHPs are covered under the same labour laws as domestically educated health professionals (DEHPs). Likewise, the Commonwealth Companion Document delineates the recognition of high workplace standards through the following statement: "There must be no discrimination to recruits in terms of pay and other employment conditions; access to training, education and other career development opportunities and resources; the right to join and have access to unions and other professional, vocational and representative organisations; and supervision and disciplinary arrangements." The ICN also emphasizes the right of all nurses to freedom from discrimination in the workplace (e.g. working conditions, promotion, etc.), good faith contracting (e.g. protection from false information and misleading claims, equal pay for work of equal value, access to grievance procedures, a safe work environment, effective orientation/mentoring/supervision, access to employment trial periods, and freedom of association. The SRPC recommends fair and standardized assessments and training and equitable working conditions for internationally educated physicians. Accordingly, internationally educated physicians in Canada should also have access to timely and cost-effective mechanisms for evaluation, which is tiered according to their training. The SRPC also call for mechanisms which would assist physicians with upgrading skills and ensuring access to reasonable, time-limited and fair return of service policies and to reasonable working conditions comparable to Canadian physicians (e.g. reasonable hours of work, and on call rotas).
- ²¹ Foreign Worker's Guide to Labour and Employment Laws in Canada. Available on-line at: www.naalc.org/migrant/english/pdf/mgcan_en.pdf. Accessed August 1, 2006. Saskatchewan Labour Standards can be found at www.qp.gov.sk.ca/documents/English/Statutes/Statutes/L1.pdf. Accessed August 30, 2006.
- ²² The Commonwealth Code of Practice, for instance, explicitly states that fair recruitment practice entails the provision of counseling about the new culture and advice on labour and licensing laws in the host country. This includes access to counseling about their new culture and advice on labour and the relevant licensing laws. IEHPs should also receive information on the specific position, where they will be working, and the terms and conditions of employment as well as information about their new community including "access to public services, established social networks, available cultural support and local places of worship." The United Kingdom Department of Health and the Scottish Executive stress the need for comprehensive and culturally-sensitive induction services which ensure that IEHPs are clinically and personally prepared to work safely and effectively within the United Kingdom health system. This includes the provision of information about accommodations, how to register with a general practitioner or dentist, professional organizations, and union representation.
- ²³ There are many community-based and government supports in place to assist immigrants with adapting to the Canadian cultural milieu and workplaces. The Saskatchewan Institute for Applied Science and Technology, for instance, offers a course on Orientation to Nursing in Canada for Internationally Educated Nurses. Another example of this is the Enhanced Language Training program, which facilitates language competency for the Canadian workplace.
- ²⁴ Two of the key informants used the example of the action taken by the Alberta government to bring a group of South African physicians to Lake Louise for a visit and offering them financial incentives in order to recruit them to the province as constituting unacceptable active recruitment. None of the key informants qualified this as relating to the context of severe physician shortages as noted by Labonte, R. et al. (forthcoming).
- ²⁵ Canadian-based recruitment agencies often have their own code of ethics around recruitment practice. One example of this is the Canadian Association of Staff Physician Recruiters (CASPR), which provides recruitment services for communities, local hospitals and other health care organizations. CASPR is guided by a Code of Conduct which can be located on their Web site at <http://caspr.ca/>. Accessed August 16, 2006.
- ²⁶ Indeed, one can question whether Canada's overall focus on preferring highly skilled and professional immigrants does not pose some ethical questions about the extent to which such a policy depletes the limited human resources of developing countries by focusing on those with the most or the most potential social and economic capital. But such a critique is beyond the scope of this paper.
- ²⁷ This list began with a focus on South Africa and the West Indies; the list was eventually broadened in 2003 to include several other countries including Ghana, Nigeria and Zimbabwe. Currently, there are over 150 countries on the proscribed list, which is available on the NHS Employers Web site. This list is mutable. For instance,

Pakistan was added to the list in April of 2005. The selection of the countries on the proscribed list was made in partnership with the Department for International Development (DID) and uses the Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC) list of aid recipients as a reference point. The criteria used include the economic status of the country (though this is not explicitly defined) and the number of health providers available and also includes countries from whom the United Kingdom has agreed not to recruit. See the NHS Employers. *List of Developing Countries*. Available on-line at: www.nhsemployers.org/workforce/workforce-558.cfm. Accessed August 16, 2006.

- ²⁸ The Commonwealth Code of Practice, for instance, is set up as a consensus document rather than as a legally binding document which makes recommendations for ethical recruitment behaviour. Having said that, the instrument encourages governments to consider developing incentives for recruitment agencies to comply with the Code, though the articulation of specific mechanisms is left open to definition by governments. This will need to be extended to private recruitment agencies: “Governments often state that whilst they observe ethical practices or are guided by Codes of Practice in the international recruitment of health workers, private recruitment agencies, which do not typically fall under the jurisdiction of the Ministry of Health, are not under any obligation to be so guided.” Thus, like the United Kingdom’s Department of Health model, the Commonwealth urges governments to “encourage and promote good practice among recruitment agencies by only employing and dealing with those agencies that comply with the Code. Agreements would then be made between private recruiters and the government of the country from which they are recruiting.” The other agreements do not specifically refer to any informal sanctioning or incentives; however, there are additional lessons to be drawn from the United Kingdom experience which uses market forces to encourage compliance by recruitment agencies. The United Kingdom’s Department of Health Code of Practice is, like other instruments, not legally binding. Indeed, the NHS trusts and the independent sector are urged to use the services of a list of recruitment agencies which comply with the Code. This list is available on the NHS Employers Web site. Any of these listed agencies, which are found to be noncompliant with the Code of Practice are removed from the list and the NHS Trusts are then informed of this removal. There are about 50 agencies listed on the NHS Employers Web site which comply with the Code of Practice. There are about 178 agencies to which the Code currently applies though it will be extended to 200 more agencies in the private sector, which also supply domestic staff to the NHS. The Commonwealth posits another important consideration. Compliance to a Code of Practice cannot be presumed without an awareness of its existence or the guidelines included within it. Thus, the Commonwealth urges that: “Governments and other institutions (those engaging recruitment agencies, or with power to issue licenses or other forms of accreditation to them) ensure that the agencies are aware of this Code of Practice and comply with it.”
- ²⁹ World Health Organization. (Forthcoming). *Management of International Health Worker Migration: Agreements on Ethical Recruitment and Other Policy Options*.
- ³⁰ The existing agreements refer to the need for an effective monitoring system to be put into place in order to locate noncompliant employers or organizations. For instance, the Melbourne Manifesto states that: “We believe there should be an international process to ensure the evaluation and monitoring of international migration of [health care providers] to inform this code.” However, the operational schematics for this monitoring and evaluation system are not detailed. The Commonwealth Companion Document makes reference to monitoring compliance by recruitment agencies through, for instance, an auditing system with recruitment agencies. Another strategy recommended by the Commonwealth to monitor and evaluate their ethical recruitment practices is the designation of a particular ministry or department to monitor and evaluate the implementation of the Code of Practice. This implies that recruiting agencies should keep records in such a way that they are able to demonstrate compliance with Codes of Practice. These monitoring agreements might also include the design and implementation of early warning mechanisms to detect non-compliance. It is also suggested that monitoring mechanisms are capable of detecting impacts such as general or specific staff shortages resulting from international recruitment. This requires the development of effective data collection on the movements of health providers within and outside of their borders on a regular basis. The Scottish Executive Code of Practice goes further by incorporating the development of a monitoring system around the compliance of agencies to the Code: “A monitoring tool will be sent to NHSScotland Boards on a bi-annual basis and relevant statistics will be extracted from this information to ensure that stringent monitoring is in place”, though the exact nature of this tool is largely left undefined. This is reiterated within the best practices benchmarks in which it states: “Bi-annual information on international recruitment trends including agencies used and countries targeted will be requested from NHSScotland Boards by the Scottish Executive Health Department and this data will be

monitored centrally.” The Scottish Executive, does, however, make an explicit statement about the incorporation of the independent sector within the overall mandate and the need for compliance with the Scottish Executive Code of Practice: “Where national contracts are signed to increase capacity in NHSScotland, compliance with the Code of Practice is a contractual obligation for all independent sector providers. The Code of Practice will also seek to encourage other NHSScotland commissioners to ensure that there is compliance when they are setting up local contracts with independent providers.” Finally, the International Council of Nurses’ Position Statement make an explicit statement about ensuring that recruitment agencies are regulated and monitored using performance indicators: “Recruitment agencies (public and private) should be regulated and effective monitoring mechanisms introduced, e.g. cost-effectiveness, volume, success rate over time, retention rates, equalities criteria, and client satisfaction.” There is also an explicit reference to disciplinary measures to sanction unethical agencies though this is left unexplored.

- ³¹ For instance, measuring the impact of the United Kingdom’s Department of Health Code of Practice on active recruitment is also offset by a lack of information about the role of the private sector in the recruitment process. Though the information is rather conflicting, there is some evidence of increases of nurses being registered in the United Kingdom who come from developing countries on the proscribed list. For instance, according to one study, there has been little change in the proportion of nurses coming to the United Kingdom from countries on the proscribed list, constituting about one in four registrations from non European Union countries. In another study in 2003, a substantial fall in the numbers of nurses from the West Indies and South Africa registering in the United Kingdom was recorded indicating some impact on employer behaviour. However, there has been an increase in the number of nurses from other developing countries such as Ghana, Nigeria and Zimbabwe. For instance, according to figures from the Nursing and Midwifery Council (NMC), between 1998/9 and 2002/3, the number of nurses from Nigeria went from 179 to 509. Likewise, in the same period, the number of nurses from Zimbabwe increased from 52 to 485. See, for instance, Bach, S. (2003). *International Migration of Health Workers: Labour and Social Issues*. Available on-line at: www.ilo.org/public/english/dialogue/sector/papers/health/wp209.pdf; and Stilwell, B., Diallo, K., Zurn, P., Dal Poz, M., Adams, O., and Buchan, J. (2003). Developing Evidence-Based Ethical Policies on the Migration of Health Workers: Conceptual and Practical Challenges. *Human Resources for Health*. 1(8). Another important issue here, which will remain to be assessed in the future, is the role of the private sector in the rising numbers of IEHPs, and especially nurses, going to the United Kingdom. The Royal College of Nurses, for instance, argues that instances of “backdoor” recruitment whereby nurses recruited by the private sector move to the public sector, distorts the picture. Nor is there any available information on the recruitment practices of the independent sector. The interplay, therefore, between the independent and public sectors and its impact on IEHP recruitment will need to be further assessed.
- ³² The Canadian Medical Association also has a database which allows for tracking the entry of physicians on a yearly basis.
- ³³ The best models are the Commonwealth Companion Document and the NHS and NHS Codes of Practice.
- ³⁴ Department of Health. (2004). *Code of Practice for the International Recruitment of Healthcare Professionals*. pp. 10.

Appendix I. The Current State of IEHPs in the Canadian Health Care System

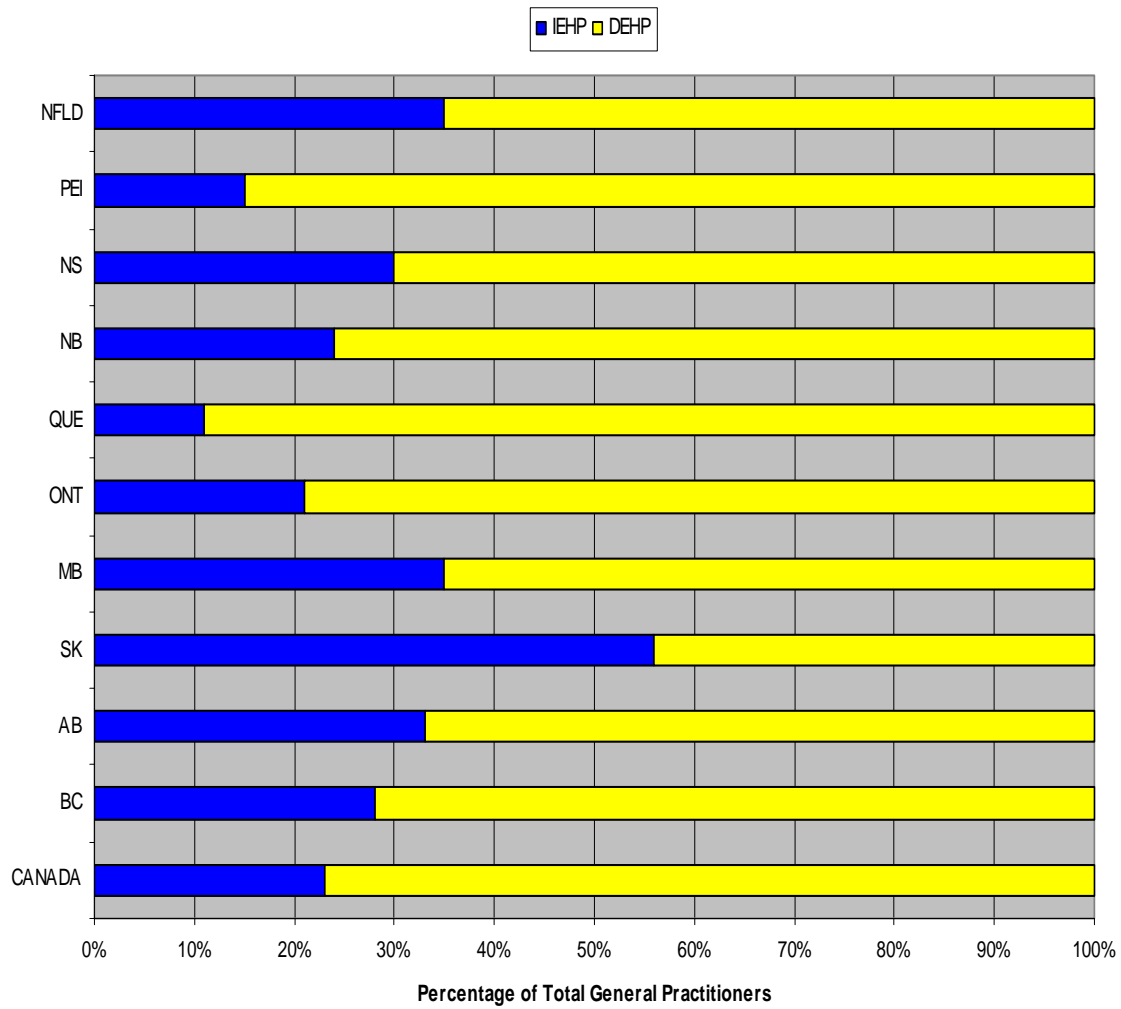
The Canadian health care system has always had a significant proportion of internationally educated health professionals, especially in terms of the number of foreign educated physicians (both specialists and general practitioners) practicing in the system. Indeed the proportion of internationally educated physicians, often termed international medical graduates (IMGs) has not changed substantially since the introduction of medicare in the late 1960s.

The first three figures below give a sense of the distribution of IMGs across the country in recent years. What is evident is that the proportion of IEHP physicians varies across the provinces. The reliance on IEHP physicians is clearly greater in western provinces than it is in Ontario and Quebec and what stands out about Atlantic Canada is the significant variation across those four provinces. Quebec's relatively low reliance on IEHP physicians is likely due to the fact there are simply fewer IEHP physicians with the required language skills to draw from.

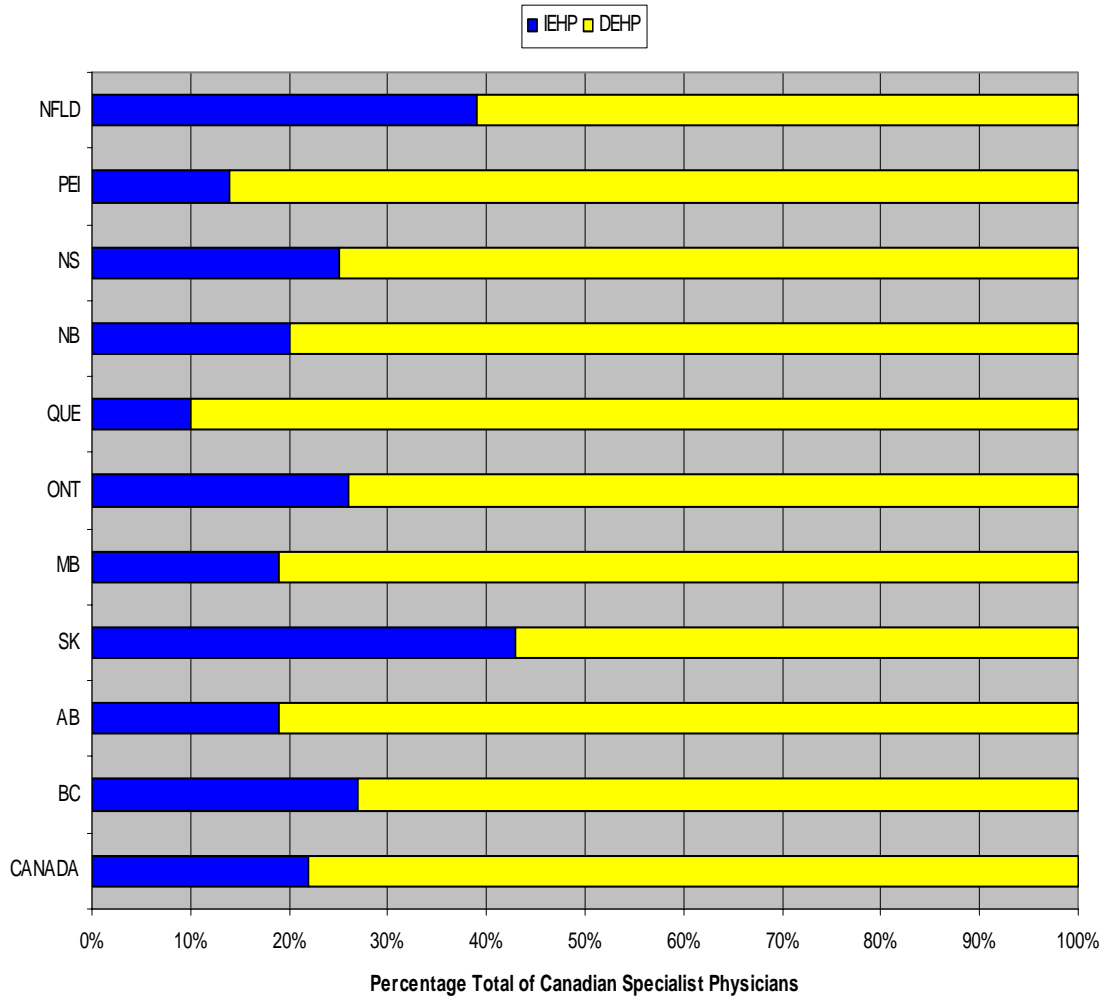
It is also interesting to note, as shown in Figure 4, that Canada is not very reliant on foreign-trained nurses, at least not at this point. Thus, the story about IEHPs in Canada is really about physicians far more than it is about any other health profession. There has been some significant growth in the presence of IEHP nurses in some provinces in recent years (notably in British Columbia), but Canada's overall reliance on these IEHPs is still far lower than a number of other developed states (e.g. the United States). There are a number of issues surrounding the recruitment of nurses from the developing world that differentiate it from the situation with physicians. There is some evidence, at least anecdotally, that some developing countries are training more nurses than they can themselves employ in the expectation that many of these nurses will emigrate to developed countries. In some cases, the Philippines being the most cited example, many of these nurses will emigrate by themselves, leaving spouses and families behind and, in turn, send some portion of their wages back to their home country. Thus, these expatriate health professionals become an important source of hard currency within the home country.

What Figure 5 demonstrates is that the composition of the internationally educated physicians in Canada is changing in terms of their country of origin. While the United Kingdom is still the largest single source for IEHP physicians in Canada, in the last decade more physicians have come from South Africa and an increasing number from India, Pakistan and Saudi Arabia.

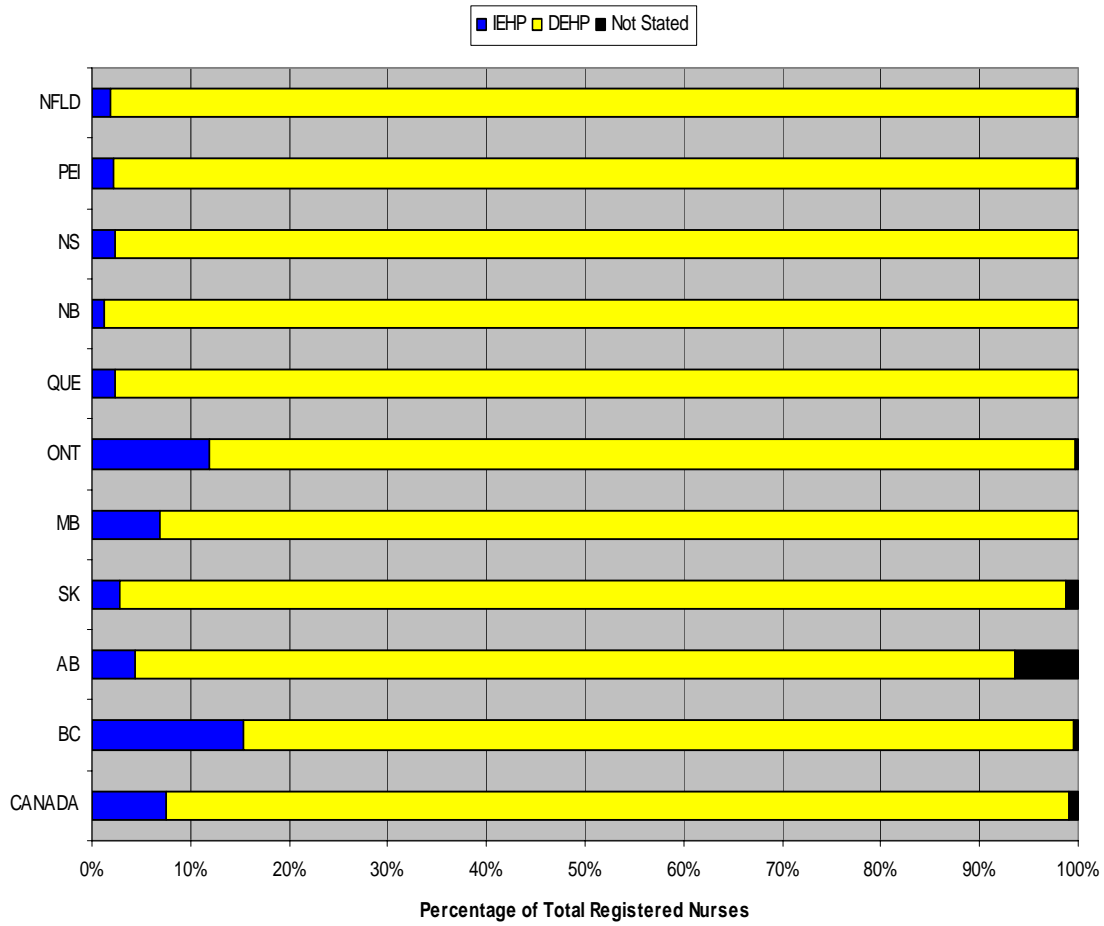
Canadian General Practitioners - IEHP vs DEHP (CIHI 2005)

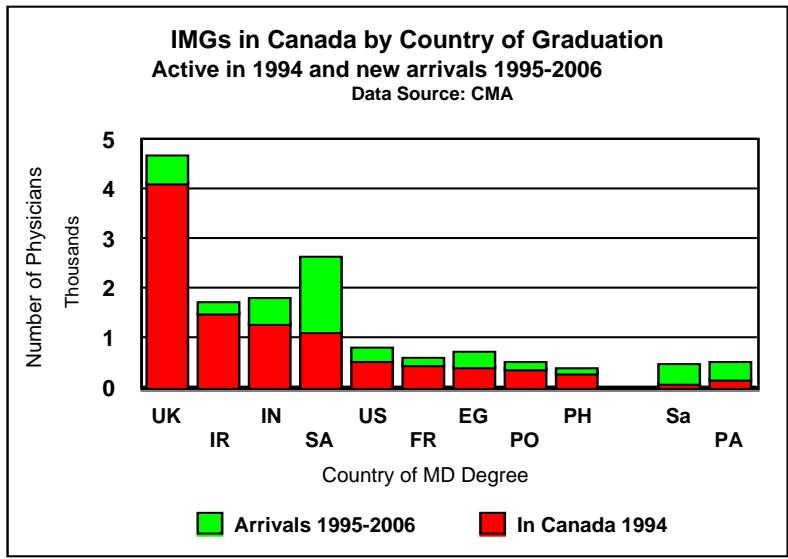


Canadian Specialist Physicians - IEHP vs DEHP (CIHI 2005)



Canadian Registered Nurses - IEHP vs DEHP (CIHI 2005)





UK = United Kingdom
 IR = Ireland
 IN = India
 SA = South Africa
 US = United States
 FR = France
 EG = Egypt
 PO = Poland
 PH = Philippines
 Sa = Saudi Arabia
 PA = Pakistan

Appendix II. A Note on Methodology

There were two iterative stages to this study. The first stage is a qualitative analysis of international instruments on ethical recruitment using a qualitative thematic analysis. The instruments selected for this study were available on the Internet and represent only the agreements on ethical recruitment drafted in English. The following instruments were analyzed within this project:

- The Commonwealth Code of Practice for the International Recruitment of Health Workers (2002) and Companion Document (2003);
- The United Kingdom Department of Health Code of Practice for the International Recruitment of Healthcare Professionals (2004);
- The Scottish Executive Code of Practice for the International Recruitment of Healthcare Professionals in Scotland (2006).
- The World Organization of Family Doctors (Wonca) Code of Practice for the International Recruitment of Health Care Professionals: The Melbourne Manifesto (2002);
- The International Council of Nurses' (ICN) Position Statement on Ethical Recruitment (2001);
- The World Medical Association (WMA) Statement on the Ethical Guidelines for the International Recruitment of Physicians (2003);
- The Canadian Nurses Association (CNA) Position Statement on the Regulation and Integration of Nurse Applicants into the Canadian Health System (2005); and
- The Society of Rural Physicians of Canada (SRPC) International Medical Graduate Policy: Recommended Strategies (2002).

More specifically, the following themes were used as guides for analyzing the international instruments and the key informant interviews:

- The guiding principles which underscore recruitment practice;
- The definition of ethical recruitment;
- The distinction made between “active” and “passive” recruitment;
- The value of developing a proscribed list of developing countries;
- Mechanisms for ensuring compliance;
- Mechanisms for monitoring compliance; and
- Mechanisms for evaluating the effectiveness of an instrument for ethical recruitment.

The information was organized and analyzed using a data capture matrix. Other themes which emerged were also captured and analyzed. The preliminary findings were incorporated into a short discussion paper and an interview schedule, which were sent via e-mail to several stakeholders in the summer of 2006. In all, 16 key informant interviews with Canadian stakeholders were conducted by telephone.

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