TURNING THE HEALTH PROFESSIONAL CAROUSEL: IS CANADA UNDERMINING HUMAN RIGHTS IN DEVELOPING COUNTRIES?

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This article will address the issue of health professional migration, with a specific focus on how this migration affects health systems in developing countries. The central question being examined is whether or not states have an obligation to ensure that their policies – or actions by private actors based in their states – do not undermine the delivery of healthcare in other states. After exploring this obligation, this article will analyze how the issue may be effectively addressed by drawing upon the experience of the United Kingdom; how successful has the U.K. been in meeting its obligation? What are the most effective policy responses for developed states to implement? By framing this problem as a human rights issue, it will be argued that developed countries have a moral and legal responsibility to mitigate the negative effects of active recruitment of health professionals from developing countries. In light the U.K.'s experience, Canada's potential role in undermining human rights in developing countries will be examined and policy recommendations will be made. Although the issue is complex, this policy analysis will centre on the unmet demand for health professionals as a primary driver of international migration, as it is argued that this factor may be most effectively addressed by developed states.

INTRODUCTION: INTERNATIONAL MIGRATION OF HEALTH PROFESSIONALS

Individuals have moved from one country to another for centuries; however, globalization has made migration easier, resulting in "a new dynamic in population movements in terms of size and velocity" (Bach 2003, 2). Even in the short term, the surge in migration is evident: it has been estimated that in 2000, 2.9 percent of the world's population – almost 175 million people – were living a country other than that of their birth, compared to one hundred million in 1995 (Stilwell et al 2003, 5). This increased mobility has facilitated the movement of health professionals, who constitute the largest group of skilled migrants (Martineau, Decker and Bundred 2002, 1). An estimated thirty-five million people work in health services worldwide; however, international migration has resulted in an inequitable sharing of "this essential global resource" (Martineau, Decker and Bundred 2004, 1).

The loss of health professionals presents a challenge to maintaining effective health systems in both developing and developed countries because the provision of adequate healthcare services depends on trained professionals. Although long recognized, the challenges arising from the migration of health professionals have not been comprehensively addressed. At the 1965 Edinburgh Commonwealth Medical Conference,

concerns about the effects of health professional migration were expressed, prompting a thorough study of the issue by the World Health Organization (WHO) (Ibid.). Released in 1979, the Mejia study reported that in 1972, 140,000 (6 percent) of the world's physicians were practicing in a country other than that of their nationality, while "86 percent of all migrant physicians were working in five countries: Australia, Canada, the Federal Republic of Germany, the United Kingdom…and the United States" (Bach 2003, 3). Despite the attention paid to the issue, the migration of health professionals increased and the Mejia study remained the only one of its kind until the WHO's *World Health Report 2006*, which focused on the global health workforce (see WHO 2006). It is widely recognized that the character of health professional migration has changed, as the number of migrants has increased significantly and the relocation is now "often permanent" (Eastwood et al. 2005, 1893). The nationalities of migrants have also changed, with new major source countries located in the Caribbean, Egypt, sub-Saharan Africa (SSA), Cuba and the former Soviet Union (Martineau, Decker and Bundred 2004, 2). The increased rate and shifting pattern of migration endanger the sustainability of health systems in many developing countries. Given the fragile nature of many of their health systems, the countries in SSA are most threatened by migration (Bach 2003, 5).

This article will address the issue of health professional migration, with a specific focus on how this migration affects health systems in developing countries. The central question being examined is whether or not states have an obligation to ensure that their policies (and actions by private actors based in their states) do not undermine the delivery of healthcare in other states. After exploring this obligation, this article will analyze how the issue may be effectively addressed by drawing upon the experience of the United Kingdom; how successful has the United Kingdom been in meeting its obligation? What are the most effective policy responses for developed states to implement? By framing this problem as a human rights issue, it is argued that developed countries have a moral and legal responsibility to mitigate the negative effects of active recruitment of health professionals from developing countries. In light the U.K.'s experience, Canada's potential role in undermining human rights in developing countries will be examined and policy recommendations will be made. Although focusing on the pull factors in developed countries "distorts a more complex picture" (Bach 2003, 7), this policy analysis will centre on the unmet demand for health professionals as a primary driver of international migration, as this factor may be most effectively addressed by developed states.

THE INTERNATIONAL HEALTH PROFESSIONAL CAROUSEL

Myriad factors influence the migration of health professionals, including individual choices, government policies and recruitment activities by governmental and private agencies. Complex "push" and "pull" factors influence individual choices to migrate, as conditions in the source state can encourage (push) individuals to leave, while conditions in receiving states attract (pull) individuals to those states.

Globalization has facilitated this process, by making individuals increasingly aware of more favourable conditions in other countries, which encourages migration: "the internet, easier international communication generally, and the rise of commercial agencies organizing health care staff migration have all greatly increased access to information about means, costs and consequences of migration" (Mensah 2005, 205-6).

The WHO estimates that the worldwide shortage of health professionals is 4.3 million workers (WHO 2006, 12). This unmet demand for health professionals is a major contributing factor to migration, as many developed countries including Canada, the United States, the United Kingdom and Australia have a shortage of health professionals and rely on immigration to maintain their healthcare systems. For example, the health plan for the United Kingdom released in 2000 required 10,000 more doctors and 20,000 more nurses to meet its needs and looked internationally for some of these professionals (Martineau, Decker and Bundred 2002, 3). The migration of health professionals has been analogized as an international "carousel" that moves health professionals from one country to another: a doctor from Tanzania, where there are two to three doctors per 100,000 people, may migrate to South Africa[1] to fill a vacancy left by a doctor who emigrated to the United Kingdom, which in turn was a result of the emigration of a British doctor to fill a vacancy in Canada that resulted from the loss of a Canadian doctor to the United States (Eastwood et al 2005, 1893). In recent years, there has been "a greater polarization [in migration] towards flows from poorer to richer countries," (Martineau, Decker and Bundred 2002, 7) and due to the more permanent nature of migration from developing countries, "the medical carousel unfortunately does not turn full circle, as it has in the past, so the poorest nations experience all drain but no gain" (Eastwood et al 2005, 1894).

HUMAN RIGHTS: THE RIGHT TO HEALTH

Reliance on the migration of health professionals to support domestic health systems results in "a serious ethical issue to be confronted," because it is clearly "inappropriate for nations as wealthy as Canada to solve [their] own domestic health human resources problems of undersupply and maldistribution by relying on the immigration of health professionals from developing countries" (McIntosh, Torgerson and Klassan 2007, 4). Although this normative argument is compelling, states relying on health professional migration may also incur a legal obligation to minimize the adverse effects of migration on developing countries in light of the human right to health that is recognized in the WHO Constitution. This right to health is further entrenched in international conventions, as "every country in the world is now party to at least one human rights treaty that addresses health-related rights, including the right to health" (WHO, 2007). In recognizing the right, "governments have an obligation to ensure that functioning public health and health-care facilities, goods and services, as well as programmes, are available in sufficient quantity to the population" (WHO 2003, 11). As a party to such conventions, Canada is bound by the obligations arising from these treaty regimes and by its membership in the WHO.

First reflected in the WHO Constitution of 1946, the right to health is implicit within the 1948 UN Universal Declaration of Human Rights in Article 25, which states that, "everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family" (UN 1948, Art. 25). The right was given further definition within the International Convention on Economic, Social and Cultural Rights (ICESCR), which states that all parties to the convention "recognize the right of everyone to the highest attainable standard of physical and mental health" (UN 1976, Art. 12(1)), and obliges states to take steps toward "the creation of conditions which would assure to all medical service and medical attention in the event of sickness" (Ibid., Art. 12(2)). The Committee on Economic, Social and Cultural Rights has adopted numerous General Comments clarifying the nature and content of the treaty and the obligations of states parties to the ICESCR (WHO 2002, 10). Adopted in May 2000, General Comment No. 14 identified the four essential elements of the right to health as availability, accessibility, acceptability and quality (Committee on Economic, Social and Cultural Rights 2000, Art. 12), while reiterating that, like all human rights, the right to health imposes the obligations to "respect", "protect" and "fulfil" [*sic*] on states parties (Ibid., Art. 33). Of particular importance, "the obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health" (Ibid.). International co-operation, originally noted in General Comment No. 3, is highlighted once again within General Comment No. 14, as "States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health" (Ibid., Art. 38). Furthermore, states that have the means to do so must "respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries" in order to comply with their obligations (Ibid, Art. 39). While exploring the customary status of the right to health is beyond the scope of this article, it is evident that states – including Canada – as parties to the WHO and the ICESCR, have the treaty-based obligation to recognize the right to health.

Given the widespread recognition of the right to health, this framework is useful in determining the legal obligation that may arise from the active recruitment of health professionals from developing countries experiencing a shortage of trained medical staff. Clearly, a normative dimension surrounds the recruitment of health professionals from other countries, as one is forced to ask if it is moral for a state to pursue policies or permit behaviours that undermine the health systems of other states. Framing the activity as a legal issue underscores the importance of the issue and provides an impetus for states to address the practice. The result of the legal obligation to respect other states' right to health is that state sovereignty cannot be used to shield domestic policies from scrutiny when they adversely affect other states, and "it is increasingly recognized that 'recruiting' countries should assess the impact of their policies on the fulfillment of human rights in other countries" (WHO 2003, 12).

The migration of health professionals clearly has the potential to undermine a state's ability to provide

health services. Poignant examples are Ethiopia, Nigeria and Uganda, as they have all "cited shortage of health professionals as the main constraint to mobilizing responses to health challenges" (Eastwood et al 2005, 1894). The costs of losing health professionals are substantial and present a potentially insurmountable challenge to developing countries. Lacking resources to invest in health care systems, the loss of trained professionals may have dire consequences in developing states. The United Nations Conference on Trade and Development has "estimated that each migrating African professional represents a loss of US$184,000 to Africa" (Ibid.), while the overall effect has been conceptualized as an annual subsidy of $500 million by Africa to North America, Western Europe and Asia (Mensah 2005, 210). Beyond directly affecting the quality of health services, emigration of health professionals may also result in inequitable access when individuals move from rural areas to fill urban vacancies. In-country migration can concentrate the lack of health professionals in rural areas, and since the poorest citizens are often located in these areas, they feel the loss most acutely. Ghana provides a clear example of unequal access: in 2000, not a single pediatrician was practicing in the northern two-thirds of the country due to in-country migration (Eastwood et al 2005, 1895).

Foreign trained health professionals represent a potentially enormous savings to developed countries, while acting as a drain on the resources of developing states that lack the financial ability to provide equitable health services. New Zealand, for example, is estimated to have saved $37 million by having six hundred South African trained doctors practicing in the country (Mensah 2005, 210), giving strength to the claim that, "by actively enticing medical graduates from the less-developed world…health planners are looking for an inexpensive solution to inadequate human resource planning" (Bundred and Levitt 2000, 246). The obligation that the right to health imposes is progressive, such that a state must provide its population with the highest level of health services for which it has the means to provide. As such, one may argue that states that have the means to meet their own health needs but rely, as a matter of acknowledged or unacknowledged policy, on the migration of health professionals to support their health systems, should be held accountable for the adverse effects of their policies on other populations.

HEALTH, DEVELOPMENT AND INEQUALITY

Beyond the right to health, the ability to provide health services has wide-reaching effects. Good health is central to development, as healthy individuals are more likely to lead productive and fulfilling lives. Successful development depends on functioning health systems because poor health leads to lower life expectancy and increased suffering among the most vulnerable segments of society worldwide. As the World Bank has noted, improving health outcomes may be justified on economic grounds, because it fuels economic growth: "It reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn; and it frees for alternative uses resources that would

otherwise be spent on treating illness" (World Bank 1993, 17). Investing in health services may also be a central means of combating poverty, while "the adverse effects of ill health are greatest for poor people, mainly because they are ill more often, but partly because their income depends exclusively on physical labour" (Ibid., 20). Good health is a "fundamental goal of development as well as a means of accelerating it;" therefore, "[t]argeting health as a part of development efforts is an effective way to improve welfare in low-income countries" (Ibid., 21). Sen, for example, views freedoms and capabilities as central to the enjoyment of some human rights (Sen 2005, 153-55). Through this framework, it is clear that health is necessary to achieve many human rights goals, as individuals suffering from the effects of poor health may be unable to meet or enjoy their other fundamental human rights due to a lack of capability.

Health professional migration has a disproportionate effect on the world's poor. Since developed countries are often the destination of health professionals, the benefits of migration are concentrated there, while the negative effects of migration are largely felt by developing countries. The result is that "losses are compounded in developing countries that contend with a disproportionate burden of disease with far fewer resources than developed countries" (McIntosh, Torgerson and Klassan 2007, 1). Given the link between health and development, the migration of health professionals may clearly undermine the development prospects for many states. The WHO confirms this linkage, as it has reported that, "the correlation between the availability of health workers and coverage of health interventions suggests that the public's health suffers when health workers are scarce" (WHO 2006, 10).

Just as human and financial resources are unequally divided worldwide, so too are health resources, as "countries with the lowest relative [health] need have the highest numbers of health workers, while those with the greatest burden of disease must make do with a much smaller health workforce" (Ibid., 8). Africa experiences this inequality acutely, as it "suffers more than 24 percent of the global burden of disease but has access to only 3 percent of health workers and less than 1 percent of the world's financial resources – even with loans and grants from abroad" (Ibid.). The WHO has identified fifty-seven countries with a critical shortage of health workers and estimates that 2.4 million additional health professionals would be required for these countries to reach the target level of health professionals (Ibid., 12). Given that thirty-six countries in SSA have a critical shortage and "an increase of almost 140 percent is necessary to meet the threshold [number of health workers]," the vulnerability of the region is difficult to overstate (Ibid.).

Struggling with being the centre of the HIV/AIDS pandemic, the loss of health professionals has dire consequences for the health systems in SSA. Beyond its drain on health resources, HIV/AIDS compounds poor working conditions for health workers in affected countries, through the "loss of staff due to illness, absenteeism, low staff morale…and through the increased burden of [HIV/AIDS] patient load" (Eastwood 2005, 1895). The Director-General of the WHO has noted that, "the brain drain from Africa is severely limiting the ability of health workers to combat the HIV/AIDS epidemic and achieve any substantial progress

towards the millennium development goals [MDGs]" (Mensah 2005, 203). Furthermore, "the dire shortage of health workers in many places is among the most significant constraints to achieving the three health-related [MDGs]: to reduce child mortality, improve maternal health, and combat HIV/AIDS and other diseases" (WHO 2006, 19). A 2005 study "estimated that an additional 1 million extra workers [would] be needed in [SSA] …to meet the [MDGs] by 2015" (Eastwood 2005, 1895). If the brain drain continues, very few of these extra workers will be realized, while development and the right to health will remain severely challenged.

The ability of developing countries to respond to the migration of health professionals is questionable, as migration often surpasses their capacity to train replacements. In SSA, twenty-four out of forty-seven countries have only one medical school, while eleven have none (Ibid., 1893). Ghana is a prime example of a country experiencing the negative effects of health professional migration: it requires 520 nurses annually, but is only able to enroll 375 students each year due to fiscal constraints (Mensah 2005, 207). Compounding the health crisis, it is estimated that 60 percent of doctors trained in Ghana in the 1980s have left (Eastwood 2005, 1893), while 90.3 percent of doctors trained between 1985-94 migrated to the United States or the United Kingdom and 90.8 percent of those trained between 1998-2002 have emigrated (Mensah 2005, 205). A similar situation is occurring in Zambia. The WHO has estimated that Zambia requires 1,500 doctors to meet its medical needs, but there are only eight hundred doctors registered in the country and only fifty of the six hundred Zambian graduates in the history of the medical school in Lusaka remained working in the Zambian public-health sector in 2000 (Bundred and Levitt, 245). With five thousand doctors trained in SSA working in the United States in 2002 and 3,199 SSA-trained nurses registered in the United Kingdom in 2002-3 (Mensah 2005, 207), it is highly unlikely that countries in the region will be able to provide adequate and equitable health services to their populations if the current migration trends continue.

THE EFFECTS OF HEALTH PROFESSIONAL MIGRATION

The issue of health professional migration is extremely complex, as no two source nor receiving countries are the same, and the issue is further complicated by the fact that it is ultimately an individual decision to emigrate. The interplay of influences on individuals contemplating migration is a complex mix of push- and pull-factors. Diallo has identified the main pull-factors for migration to be salaries and benefits, better working environments and improved quality of life for the worker and family (Diallo 2004, 602). For health professionals, the opportunity for professional development is also a major draw: "for highly skilled workers, continuous professional development is an integral component of individual career planning and progression," while the lack of opportunity for professional development at home "in contrast to the perceived opportunities abroad, reinforces the attractiveness of overseas employment" (Bach 2003, 11). This factor is confirmed by a 2002 survey of 1,119 foreign nurses working in the United Kingdom, in which pay

and professional development were cited as the most preferred aspects of their work (Mensah 2005, 204). Major push-factors can include the working environment, violence inside and outside of the workplace, and the toll of HIV/AIDS. The structural adjustment programs promoted by international lending institutions during the 1970s and 1980s have also been identified as a potential push-factor in states where the reform programs led to a deterioration of living and working conditions (Ibid.). Additionally, social networks can play a significant role in migration patterns, as migrants who communicate positive experiences to their colleagues and relatives at home encourage further migration and establish a potentially self-sustaining "migration pathway" between states (Bach 2003, 10).

The effect of migration is highly dependent on its nature – who is migrating, where they are coming from, where they are going and how long they will remain abroad. As mentioned above, the migration of health professionals represents a financial benefit to the receiving state. Although difficult to quantify, the benefit may be illustrated by the savings to the state by not having to train as many health professionals. It is estimated that every doctor trained in the United Kingdom costs £200,000 to £250,000 and takes five to six years to train; therefore, employing foreign-trained doctors is like importing "human capital at zero cost, with immediate effect" (Eastwood et al 2005, 1895). This loss of human capital and resources through migration is commonly referred to as 'brain drain.' The negative effects of such brain drain are further compounded when the individual migrant was involved – directly or indirectly – in training. Specific to the health sector, senior doctors are important because they act as a useful role model and source of information for new doctors (Ibid., 1894). When assessing the effects of migration, particular attention must be paid to *who* is migrating because the loss of an individual is difficult to quantify with merely the cost of training.

In contrast to brain drain, migration in highly skilled fields can also result in 'brain circulation' or 'brain exchange' through which temporary migration provides a long-term benefit for the source state because the migrant develops new skills through employment or educational experiences abroad that were not available in the source state (Bach 2003, 14). Given the unique circumstances within the health sector, brain drain is the more likely result of migration than brain exchange (Ibid., 12). Doctors emigrating from SSA also tend to migrate on a permanent basis therefore, the potential benefit of brain exchange to the region is limited (Eastwood et al 2005, 1894). Brain drain threatens the stability of the source state's health system, as the remaining workers "experience added stress and greater workloads," resulting in the staff being "ill-motivated, not only because of their workload, but also because they are poorly paid, poorly equipped, inadequately supervised and informed and have limited career opportunities" (Stilwell et al 2003, 5).

Even within developing countries, however, the effects of health professional migration may be quite different. One of the widely recognized benefits of migration is the potential for remittances, as money is sent back by those working abroad to support relatives remaining in the source country. Remittances are an important source of income for many developing countries, as it is "the second-largest source, behind FDI, of

external funding for developing countries," amounting to $72.3 billion in 2001 (Ibid., 6). The Philippines is a clear example of one of the few states that is known to benefit from the migration of its health professionals. Ten percent of the population in the Philippines lives or works abroad. As early as 1970, more Filipino nurses were registered in the United States and Canada alone than the Philippines (Martineau, Decker and Bundred 2002, 2), while the policy of sending workers overseas was recognized as being central to the country's economic growth in the *2001-2004 Medium Term Philippines Development Plan* (Bach 2003, 4). As the Secretary of Labour and Employment has stated, overseas employment is "an industry. It's not politically correct to say you are exporting people, but it's part of globalization, and…countries like [the Philippines], rich in human resources, have that to contribute to the rest of the world" (Ibid.) By training more health professionals than the country can employ, "remittances from physicians working abroad [are] estimated to compensate for the costs of training and emigration" (Diallo 2004, 602).

Although the Philippine experience shows that the international health carousel may be used to a state's benefit, the situation is much different in countries experiencing a health care crisis. Due to the fact that the funds "sent by health workers…are not directly reinvested in human capital for the health systems," there is a net loss of human capital within the healthcare system (Stilwell et al 2003, 6). As Eastwood *et al* have stated, "the idea that repatriated overseas earnings could make up for the deficiency [caused by the brain drain] is unrealistic, as there is no way of ensuring that repatriated income will find its way into investments in health care," a problem that is exacerbated when the state lacks professionals to champion the cause of investment in the health system (Eastwood 2005, 1894). Rather than hope for the potential indirect benefits of migration, "developing capable, motivated and supported health workers is essential for overcoming bottlenecks to achieve national and global health goals" (WHO 2006, xv).

RESPONDING TO THE CRISIS: INCOMPLETE INFORMATION AND CONFLICTING RIGHTS

A major challenge to addressing the health professional migration issue is incomplete information, as "the lack of reliable, up-to-date information greatly restricts the ability of policy-makers at national and international levels to develop evidence-based strategies to resolve the health workforce crisis, or to develop health systems to serve the needs of disadvantaged people" (Ibid., 15). Rather than being based on reliable evidence, most reports about the effects of migration are based on anecdotal information, or limited and inconsistent data (Stilwell et al 2003, 2). A major obstacle is the lack of international standards for measuring migration and the inability of many developing states to gather the information necessary to quantify the problem. Lacking concrete data on emigration from developing countries, studies largely rely on the health professional registers in developed states, which cannot provide all of the necessary information. This "reliance on incomplete data or incompatible data from different sources often means that it is not possible

even to have an accurate picture of the trend in outflow of health workers, let alone any assessment of the impact of this outflow on the health services" (Buchan and Dovlo 2004, 38). To overcome the problem of incomplete information, the WHO, the International Labour Organization and other international organizations are working toward the harmonization of methods for collecting and analyzing data specific to health personnel migration (Diallo 2004, 607). Although the lack of data "makes it difficult to empirically assess the impact of health worker migration on health systems" (Stilwell et al 2003, 8) and the effect of policies, it remains important for states to attempt to address the issue.

In order to minimize the negative effects of health professional migration, it is essential to develop ethical recruitment policies with the goal of successfully managing migration, rather than preventing its occurrence (Ibid., 2). Not only is prevention practically difficult, it raises ethical concerns, because there is an effective clash of individual rights at the heart of the process: the right to health and the right to mobility. Since "freedom of movement is a human right," it is unrealistic to view an outright ban on all health professional migration from countries with a health worker crisis as an effective response to the issue (Ibid., 12). However, an ethical compromise may be found in limiting or preventing active recruitment of healthcare workers from states with fragile health systems. South Africa adopted this approach in 1995, when it banned the recruitment of doctors from other Organization of African Unity countries in order to reduce the number of doctors migrating from poor countries to fill vacancies in its rural regions (Bundred and Levitt 2000, 245). As *The Lancet* has stressed, "what must be remembered [by policy-makers] is that the objective is not limitation of mobility but equity of health care as soon as possible" (The Lancet 2000, 177).

THE UNITED KINGDOM EXPERIENCE

Like many other developed countries, the United Kingdom faces its own shortage of health professionals and relies on migration as a partial solution to its problem. The government "views overseas recruitment as an integral component of government policy to increase [the National Health Service] workforce and combat staff shortages" (Bach 2003, 12). In 2004, thirty-one percent of doctors and thirteen percent of nurses practicing in the United Kingdom were born in another country, clearly illustrating the state's reliance on migration (Eastwood 2005, 1895). The health professional carousel also has a palpable effect in the United Kingdom, as many of its professionals are drawn to other countries like Ireland, Canada, Australia and the United States (Mensah 2005, 204). According to Mensah, the United Kingdom loses 15 percent of its doctors to foreign countries within three years of graduation, and 18 to 20 percent after ten to twenty years (Ibid.) Relying on migration to fill its vacancies, the United Kingdom acts as a drain on developing countries because "professional workers from developing countries are relatively unlikely to leave [the United Kingdom] after a few years of residence" (Bach 2003, 15). In response to this drain, Nelson Mandela criticized the United Kingdom in 1997 for actively recruiting South African nurses (Ibid., 21), providing a

high-profile impetus for the government to act.

In 2001, the United Kingdom became the first country in the world to address its obligation to not undermine the health systems of other countries by introducing a code of practice for the recruitment of health professionals. Revised in 2004, the key aim of the Code of Practice for the International Recruitment of Healthcare Professionals is "to promote high standards of practice in the international recruitment of healthcare professionals," which is "underpinned by the principle that any international recruitment…should not prejudice the healthcare systems of developing countries" (U.K. Department of Health 2004, 4). The revised Code places a greater emphasis on ensuring that recruitment activities do not adversely affect developing countries' healthcare systems by "preclud[ing] the active recruitment of healthcare professionals from developing countries, unless there exists a government-to-government agreement to support recruitment activities" (Ibid.). As a result of the revision, the Code applies to temporary as well as permanent staff, enables and encourages all healthcare organizations from both the public and "independent" sectors to sign on to its principles, and provides "best practice benchmarks" for recruitment activities (Ibid., 5). A central feature of the Code is that the Department of Health provides a list of developing countries "that should not be targeted [for recruitment] under any circumstances" (Ibid., 6). In recognition of the individual right to migrate, the Code only applies to active recruitment, so the National Health Service is not barred from employing individuals who applied for employment as a result of individual initiative without active solicitation.

A report for the U.K. Department for International Development "suggested that the [Code of 2001 had] very significant weaknesses and loopholes," some of which were addressed in the 2004 revision (Eastwood 2005, 1894). The principle problem cited with the Code was its failure to cover private employers and recruitment agencies and the ease with which indirect means could circumvent the active recruitment prohibitions (Ibid., 1895). Not being directly covered, the private sector has continued active recruitment directly from countries on the proscribed list (Buchan and Dovlo 2004, 17). In 2003, one quarter of nurse registrants in the United Kingdom were from the states on the proscribed list, while work permits for many health professionals from developing countries on the list were approved: 5,880 from South Africa, 2,825 from Zimbabwe, 1,510 from Nigeria and 850 from Ghana (Eastwood 2005, 1893). Despite the changes, concerns remain, largely due to the fact that adherence to the Code by private institutions and recruitment agencies is voluntary. For many analysts, the United Kingdom's demand for foreign health professionals is the greatest threat to developing countries' healthcare systems, which is not addressed by the Code; therefore, they find it "difficult to believe that strengthening the code on its own will overcome the demand from U.K. employers for more staff to run their hospitals," while "it is this demand that appears to be a principle cause of the drain of health professionals from English-speaking sub-Saharan Africa" (Ibid., 1895). Given that the Code is relatively new and there is a lack of reliable data available, it is difficult to make a definitive

statement about the Code's effect on developing states; however, it has been recognized to provide a "relatively weak regulatory mechanism" due to its lack of legal enforceability (Bach 2003, 22).

LESSONS FOR CANADA

The U.K. example can act as a useful comparison when determining what approach Canada should adopt to meet its obligation to ensure that Canadian recruitment of foreign health professionals does not adversely affect the healthcare systems of other countries. Like the United Kingdom, it has been recognized that foreign health professionals have "always played an important role in and formed a substantial portion of Canada's health system" (McIntosh, Torgerson and Klassan 2007, 1). Canada struggles with a brain drain of its own; an estimated eight thousand Canadian-trained physicians practice in the United States (Martineau, Decker and Bundred 2004, 3), representing a substantial loss of human capital, as the emigration of Canadian doctors is estimated to cost $100 million annually (McArthur 1999). Asia and Africa are the largest sources of physicians migrating to Canada; therefore, Canadian reliance on foreign healthcare professionals has the potential to adversely affect developing countries. Also similar to the U.K. experience, Canada was publicly rebuked in 2001 by the South African High Commissioner to Canada for recruiting South African doctors (McIntosh, Torgerson and Klassan 2007, 1). Although Canada cannot seek to comprehensively address the complex factors that influence international migration, it can most effectively meet its moral and legal obligations by ensuring that its domestic healthcare worker shortage does not have adverse effects on the sustainability of developing country health systems.

Canada has not effectively met its domestic demand for healthcare workers, as evidenced by the lack of physicians in many rural communities. Although the twenty-seven Organization for Economic Cooperation and Development countries increased total output from medical schools by an average of 26 percent between 1985 to 1994, Canada's output increased by only 18 percent (Bundred and Levitt 2000, 245). A major factor cited for Canada's lack of doctors is the 1991 Barer-Stoddard Report, which "predicted a future oversupply of physicians and recommended a 10 percent cut in medical residents…as a way of controlling costs" and led to training-restrictions (Ibid., 246). As a partial result of the insufficient training of doctors, foreign graduates accounted for 24 percent of all doctors practicing in Canada in 1999 (Martineau, Decker and Bundred 2002, 4). In an attempt to overcome a shortage in doctors, Ontario licenses many international medical graduates (IMGs). According to the president of the Ontario College of Physicians and Surgeons, the province is "quite dependent upon [IMGs] and they provide a great source of expertise that we need" (Mahoney 2007, A9). Of significance, the number of licences issued to IMGs in Ontario has tripled since 1995 to a record number of 1,247 in 2006, accounting for 42 percent of all licences issued in Ontario (College of Physicians and Surgeons of Ontario 2006, 4).

Examples of Canada's potential over-reliance on foreign professionals are readily available:

Saskatchewan is highly dependent on South African doctors, as 17 percent of its 1,530 doctors in 2001 earned their first medical degree in South Africa (McIntosh, Torgerson and Klassan 2007, 1); in 1997, a professional recruiter hired by the Alberta Health Ministry traveled to South Africa and recruited forty South African doctors to fill rural community vacancies (Bundred and Levitt 2000, 246); while the newly-opened Centre for Spinal Injuries in Boxburg, South Africa, which was intended to operate as the region's referral centre, was closed down indefinitely following the recruitment of two of its anesthetists by a Canadian medical institution in 2000 (Mensah 2005, 209). Compounding Canada's lack of health care workers is its ageing population, as 25 percent of Canadians will be over sixty years of age by 2020 (Martineau, Decker and Bundred 2002, 7). Without determined action to increase the output of Canadian medical schools in the face of an ageing population, the effect of Canada's lack of health professionals will be felt even more strongly in developing countries. Developed country healthcare systems need not suffer such sustained staffing shortages: Italy and Germany have an oversupply of doctors that results in minimal unemployment, while France and Germany both rely on less than 5 percent foreign-trained doctors (Eastwood 2005, 1895). In light of these numbers, it is logical for Canada to recognize that the best response to the issue is to work toward self-sufficiency in terms of health professionals, while managed recruitment from abroad is the second best policy (McIntosh, Torgerson and Klassan 2007, 6). To successfully address this issue, Canada must identify and deal with its own push-pull factors by determining what policies would best serve to meet Canadian staffing needs and prevent losses to the United States.

When recruiting foreign health professionals, a "managed migration" approach is preferred, as "it attempts to link international migration to the health policy goals of individual nation States, and tries to regulate the flows of health workers in a way that is beneficial to source and destination countries" (Bach 2003, 21). Concluding bilateral agreements like those envisioned within the U.K.'s Code of Practice may be an effective way of ensuring that migration is well managed, as it reduces the role for commercial recruiters and can provide a more transparent process that is more easily controlled by regulatory mechanisms (Ibid., 23). Monitoring of any recruitment policy is central to its efficacy; without monitoring recruitment activities and the maintenance of a "living list" of proscribed countries that responds to changes in developing countries, the goal of managed migration will be difficult to attain (McIntosh, Torgerson and Klassan 2007, 14). Legally binding guidelines also promise a much higher degree of compliance than merely voluntary codes; however, the political will and resources required for such an approach would undoubtedly be difficult to attain (Ibid., 17).

Any Canadian response to meet its international obligation will face challenges due to the division of power between the federal and provincial governments. Unlike the United Kingdom, Canada does not have a centralized system of healthcare provision, while in states like Canada where the central government "has less control over the actions of health-care providers…the impact of ethical codes of practice are likely to

prove much less effective" (Bach 2003, 23). The Federal Government has the authority to enter into international agreements, but the provision of healthcare services largely resides in provincial jurisdiction; therefore, future international agreements the Federal Government could enter into in order to address the issue of international recruitment may not be automatically binding upon the provinces. Since the right to mobility is enshrined in the Constitution through the Charter of Rights and Freedoms, this could undermine efforts taken by individual provinces because health professionals cannot be barred from migrating between provinces. Given these challenges, an effective solution requires a dialogue involving all interested stakeholders – professional associations, hospitals, regional health authorities and recruitment agencies – as well as the provincial and federal governments (McIntosh, Torgerson and Klassan 2007, 20).

Beyond addressing its pull-factors, Canada could help minimize push-factors, by focusing development assistance funds on developing and sustaining healthcare systems in developing countries, and help build capacity in states with weak healthcare systems by lending its expertise in the area (Eastwood 2005, 1897-99). A good example of an effective capacity-building effort is the Tropical Health and Education Trust, which provides teaching modules for medical undergraduate and masters programs in SSA (Ibid., 1898). There is also the possibility of compensation to foreign governments to offset the losses of human capital that arise from active healthcare professional recruitment. The Commonwealth Code of Practice for International Health Workers of 2002 places "a strong emphasis on mutuality of benefits for both countries, including compensation" (Bach 2003, 27). Compensation, however, may be politically unfeasible – it proved to be a primary obstacle to Canada, the United Kingdom and Australia signing the Commonwealth Code – while Canada's federal government would likely be unwilling to compensate for provincial-level recruitment of health professionals, and both the provincial and federal governments would undoubtedly be unwilling to pay compensation for the activities of private recruiting agencies (McIntosh, Torgerson and Klassan 2007, 10). Compensation may also be "poor pittance" because it "might temporarily assuage the guilty conscience of the receiving country, but does little to replace a doctor who has taken five years to train and is a teacher and a role model to students and junior doctors" (Eastwood 2005, 1894).

CONCLUSION: INTERNATIONAL MANAGEMENT OF THE CAROUSEL

Given the complex nature of the issue of healthcare professional migration, it would be unrealistic to believe that one state can solve the overall problem – or even its own problems – independently. There may always be the drain of professionals to other states because "modern medicine in the more-developed world creates an insatiable demand for doctors, and globalization offers easy solutions to the trade in physicians" (Bundred and Levitt 2000, 246). The lack of supply of healthcare professionals in developed countries presents a major pull-factor for migration; therefore, without international co-operation that achieves the identification and realization of "internationally agreed minimum training targets for developed countries, the most vulnerable

countries will continue to lose a large proportion of health workers" (Eastwood 2005, 1899). The pull from developed countries is expected to increase in the next ten to twenty years, as it is estimated that the US will require one million more nurses during this period (Martineau, Decker and Bundred 2004, 4), while the "graying" of the workforce presents its own challenges. Countries like Canada and the United States must address their practice of relying on foreign medical graduates, while turning away thousands of potentially qualified medical school applicants, or the negative effects of their healthcare policies will become more concentrated on developing countries like those in SSA (Martineau, Decker and Bundred 2002, 9).

In the end, codes of conduct will likely remain "only as strong as the will to conform to them" (McIntosh, Torgerson and Klassan 2007, 22). If Canada and other developed countries engage in active international recruitment, it "needs to be fair, transparent, consider mutuality of benefits and reciprocity and adhere to the principles of global justice and personal autonomy" (Ibid., 6). In developing a policy, attention should be paid to the push-factors in developing states, as the "rebuilding of source country health systems in order to provide a decent wage and working conditions represents a response that is ethically acceptable and also has a chance of working" (Mensah 2005, 214). In this sense, a moral obligation exists to "assist [developing countries] in achieving workforce self-sufficiency, maintaining educational institutions, and providing quality of care" (McIntosh, Torgerson and Klassan 2007, 7). Developed countries must recognize that they owe more than just a moral obligation to developing states. A legal obligation exists for states to ensure that their policies do not adversely affect the right to health in developing countries; therefore, states that rely too heavily on foreign health professionals must act to resolve their shortages of healthcare professionals and slow the international health professional carousel that is undermining the healthcare systems of many developing states.

NOTES

[1] With the introduction of South African policies, to be discussed below, the recruitment of health workers from poor states in the region is restricted.

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