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EDITORIAL

The ethics of international recruitment

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The ethics of international recruitment

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There are international recruitment pipelines for doctors[1]. Doctors from sub-Saharan Africa are recruited to South Africa. Doctors from South Africa are recruited to Canada or Australia. Doctors from Canada and Central America are recruited to the USA. Doctors from Australia, Europe, Africa and Asia are recruited to the United Kingdom. Similar patterns emerge in the global nursing workforce[2,3]. Whatever the example, it appears that the predictable flow of these pipelines is recruitment from the poor for the benefit of the rich.

This pipeline can be a major input into a country's medical workforce. For example, it was estimated that in January 2000, 6% of the US physician workforce was trained in Columbia[4]. Australian medical schools graduate 1200 doctors per annum, and the nation recruits more than 250 overseas trained doctors each year[5].

This situation is not new, and neither is the recognition that it is the rural areas of the poorer country that suffer the most. Mason, in commenting on the migration of Iranian doctors to the United States, pointed out that, despite this emigration, the urban areas of Teheran were still in fact over-doctored[6]. The entire negative impact was on the agrarian villages.

Neither is the problem confined to the health professions. The science literature is replete with commentaries on exactly the same problem[7-10] and with high profile attempts to entice productive scientists to stay in their home country [11,12]. As the initial description of the pipeline showed, many countries are both recruiters and suppliers [13,14]. Interestingly, the country's attitude towards this phenomenon may be determined by the balance between influx and efflux.

It seems very unfair that countries with a struggling economy that cannot afford to offer better deals for their doctors should lose out in this way to richer nations. It is doubly unfair when one realises that it is much cheaper to take a doctor from another country than it is to train one. Thus the rich save money at the expense of the poor. This is a moral issue! It has ethical similarities to the production of sports shoes or clothing in developing nation sweatshops for sale to affluent western consumers. In the words of Bundred and Levitt[1]:

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The migration of physicians from less-developed countries to more-developed countries is not a new phenomenon, but the ethics of national policies, which allow countries to recruit en-masse the most qualified physicians, at no cost or penalty to themselves, should now be challenged.

The principle is already established in international politics that the rights of national sovereignty must be balanced against a 'greater good' – but this has not been applied to the issue of health professional recruitment.

Two examples from Africa illustrate the problem. The Zambian public health service has only managed to retain about 50 of the more than 600 doctors that have been trained in the country since independence, and the doctor population ratio in Uganda is 1:24700[1]. One can argue that conditions in those countries, both in terms of employment conditions and general living conditions, are not conducive to retaining professionals, but that cannot hide the fact that Zambian and Ugandan doctors have been actively recruited to work in a number of richer countries – including South Africa.

A number of years ago, in 1996, South Africa took a problematic decision, viz. to declare a moratorium on the registration of foreign qualified doctors. The rationale for this was the fact that doctors from other countries in sub-Saharan Africa (such as Zambia and Uganda, but many others as well) were pouring into the newly liberated South Africa, with serious detrimental effects on those countries. The moratorium did cause serious difficulties however because doctors from developed countries were also excluded. That has now been lifted, so that potentially anyone may register with the Health Professions Council of South Africa. However, the government has maintained its principled stance and will not issue work visas to doctors from developing countries. This change in policy may have been influenced by the fact that South Africa now loses more 'home-grown' doctors to other continents than it recruits from its northern neighbours. It is estimated that a further 13% of its physicians plan to leave the country within the next 5 years[14].

The US Government has also recently changed its recruitment policy, although for different reasons. Underserved regions in the USA have come to depend on about 2600J-1 Visa Waiver doctors providing essential services. Despite being recruited to rural regions, these doctors do not tend to stay in these regions long term. This program was abruptly terminated last month as part of the Homeland Security Act. It will be interesting to assess the flow-on effects of this decision.

There are two ethical principles that stand in juxtaposition in our analysis. The one is the principle of autonomy, the right of the individual doctor to freedom of choice. The other is the principle of justice, particularly distributive justice, which speaks to the fair distribution of resources for the common good. Taking desperately needed doctors from other countries appears to be unjust, but restricting a doctor's career to their country of graduation denies those doctors freedom of choice.

What is behind this recruitment? It is very clearly the fact that every country, developing or developed, has a problem providing for the health-care needs of its poor, who, globally, are more likely to live in rural communities. And every country, in seeking to bring about distributive justice within their own jurisdiction, uses the recruitment of foreign doctors as one arm of its programme. The richer the country, the more that can be offered, and the more likely they are to attract foreign qualified doctors. Furthermore, by actively recruiting doctors from the developing world to work where local doctors will not work, health planners are looking for an inexpensive, quick-fix solution to their inadequate human-resource planning[1].

Doctors are mobile people. That has to be accepted as a given. However, the problem that arises from this freedom of movement is that better-resourced countries are able to recruit doctors from less well-developed countries, and the poorer the country, the most likely it is to lose its doctors – though that country arguably needs its doctors the most. How can a country like Kenya, which pays its doctors less

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than US$256 per month, compete with the salaries on offer in more affluent nations[15]?

One cannot blame doctors for seeking a better lifestyle, with better remuneration and better working conditions. Importantly, one can understand the concern for personal safety that now underpins the rationale of many doctors wishing to emigrate more than monetary issues[14]. The question is whether it is ethical for developed countries to recruit actively in developing countries, deliberately enticing doctors and other health professionals, as happens at the moment. This is a negative effect of globalisation.

What can be done about this? There are a number of strategies that we suggest need to be considered. The first alternative to foreign recruitment is for developed nations to train more doctors. Both Canada and the United Kingdom have recently dramatically increased their medical student numbers in an attempt to decrease their dependence on overseas trained doctors[16,17]. Australia has also increased its student numbers and tied them explicitly to meeting the rural medical workforce shortage[18]. The new places are linked to bonded scholarships, requiring the successful students to work in a rural area of need after they have completed their postgraduate training.

However, training more doctors, taken in isolation, can be problematic. The USA has tried this approach and found that more doctors trained does not necessarily mean more rural doctors. Each additional doctor who is trained and does not practice in targeted areas is very costly. The key is for this increase in medical student numbers to place an emphasis on rural origin students[19] and link this selection to appropriate rural-based education[20]. These students then return to the underserved communities by choice and bring with them an understanding of rural culture that is far more appropriate than that which is often brought by doctors recruited from an entirely different culture. The presence of the university in such rural regions also serves to increase the social and educational capital at all levels in these regions. These principles are exemplified in the successful community driven approaches such as the Rural Health Opportunity Program in Nebraska, USA[21].

Clearly, these responses are a responsible action that will benefit both the nation involved and the 'feeder' nations that have hitherto lost doctors to these destinations. In addition, the training of medical professionals in developing countries should be actively supported with both human and material resources, and active linkages between medial schools across the economic divide should be encouraged.

However, increasing medical student numbers is not the answer in itself. In Egypt, a country that produces far in excess of their physician requirements, the meagre remuneration for practicing in poorer rural regions leads doctors to choose to emigrate or change professions completely rather than accept the poor income provided[22]. Clearly, both developed and developing nations need to provide adequate financial incentives to doctors practicing in rural areas if they wish to change the direction of flow in 'the pipe', recognising at the same time the inability of developing countries to compete financially, so that the playing fields will never be level. Australia has arguably led the world in this aspect of providing financial incentives for rural practice[23], but no country can, at present, claim that it is providing sufficient resources to address this issue.

Second, at a government-to-government level, developed countries which recruit doctors from developing countries could pay compensation to that country for any doctors recruited. This could account for the training costs and the loss of service in the feeder nation. This was adopted as a resolution at the 4th World Rural Health Conference in Calgary, Canada in 2000.

Implementation of this resolution will require intervention by the WHO, and careful procedures would have to be worked out. The definition of the different groups of countries would need to be set out clearly, and a developing country should not be required to compensate for a doctor from a developed country. Ultimately it may be too difficult to apply the concept. For instance, when doctors go to

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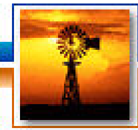

Australia as locums on short-term contracts, should compensation be paid? How will it be paid when the contract is simply extended? What happens if doctors decide to return to their home country? Perhaps a specific meeting or conference, under the auspices of the WHO, needs to be held on this issue.

Third, governments, and their recruiting agencies, could make a globally principled decision not to advertise in the journals of developed countries. This would not restrict the autonomy of doctors in those countries who, through the Internet or written enquiries, seek to take up such opportunities. The problem to be avoided is the situation where, for example, 10 pages of the *South African Medical Journal* are consistently taken up with advertisements for overseas posts, mostly rural positions in Canada, Australia and New Zealand.

This is, however, a complex area. We understand that the Commonwealth Health Ministers' Forum is working on a blanket agreement not to recruit in other Commonwealth countries. Such a decision may be detrimental to developing countries within the Commonwealth in the same way that 'free trade' often causes more problems for poorer countries. Such nations can never hope to offer financially attractive incentives to doctors, but should be allowed to publicise opportunities for exchanges as described in our fifth recommendation below. Regarding each country as being on a level playing field is clearly inappropriate at this stage, and governments of developed nations must ensure that they do not inadvertently disadvantage their poorer cousins with 'one size fits all' solutions.

Fourth, recruiters should not make visits to developing countries in order to lure their health professionals. Recruiting agents currently do the rounds of rural hospitals in South Africa. Thirteen radiographers were recruited during one such visit to a single region in South Africa! In addition, local South Africans are paid very handsomely to act on behalf of overseas agencies as recruiters.

Fifth, the WONCA Rural Working Party should take a clear stand on its position in regard to this issue, so that rural workforce agencies do not abuse the opportunity provided by international rural health conferences, or similar forums, to recruit health workers from poorer countries, while at the same time facilitating poorer countries wishing to seek help in terms of staffing.

The concept of international exchanges, or 'twinning programs', should be promoted by WONCA and its rural working party. Many doctors from developed countries have gone to developing countries over the years, and many will continue so to do. While most are short-termers, many are not. In this exchange process, doctors from over-burdened health care systems can be given a chance to have a break, reduce their sense of being trapped, and experience a different way of practicing in another country, for limited periods only, while doctors from developed countries are supported to take sabbaticals in areas of need. This can be part of the process of supporting medical education in developing countries. This needs facilitation, and support of the doctors concerned[24]. International funding agencies could be approached to assist with this.

In conclusion, there may be no easy answers to this issue. The ethical dilemmas exist at both a personal level for those doctors involved, and at a wider level for those actively involved in international recruitment or directing policy towards this end. The principles of autonomy, individual choice, family safety, national sovereignty, free trade and market forces conflict with those of equity of global distribution of medical services to poorly served rural communities. There is no doubt that the immigrant doctors provide an extremely valuable service in their adopted country, and they should not be singled out personally in this debate.

Whose responsibility is it to ensure adequate services to rural regions in developing nations? Although most will attribute this to the nation concerned, the international response to the sweatshop production of sports shoes and clothing shows that developed nations do at times argue that they have a

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responsibility to prevent exploitation and poverty in developing nations. In a similar manner, we would argue that those countries that are benefiting most from the globalisation of the medical workforce have an ethical responsibility to frame their own workforce policy in a manner that reflects global, not just domestic, need, and perhaps to compensate those countries at whose expense they have benefited.

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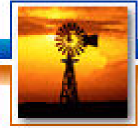

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