The ethics of recruiting foreign-trained healthcare workers

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Abstract
Canada’s active immigration policy includes thousands of internationally trained health workers arriving annually. The effective utilization of these workers represents an ethical issue relevant to the WHO’s Global Code of Practice on the International Recruitment of Health Personnel, to which Canada is a signatory. The ethical obligation for Canadian healthcare stakeholders is to continuously improve systems of credential evaluation and subsequent workplace integration to maximize immigrant health worker skills utilization and invest in better workforce data to meet Canada’s ethical obligations regarding health workforce sustainability.

Introduction
Canada’s health workforce includes internationally trained healthcare professionals, representing 29% of all nursing and healthcare support occupations,¹ and 26% of physicians.² The movement of these workers is subject to a voluntary code; The World Health Organizations’ (WHO) Global Code of Practice on the International Recruitment of Health Personnel (The WHO Code),³ to which Canada is a signatory. The Code aims to reduce the active recruitment of health workers from countries facing critical shortages, provides ethical principles regarding the international recruitment of health workers in a manner that strengthens the health systems of developing countries, and encourages high income receiving nations to commit to achieving health worker self-sufficiency.

This column considers how these ethical obligations apply in the Canadian context. First, the immigration system in Canada comprises various streams by which those with a regulated health profession might enter Canada. Their arrival is not necessarily because of their specific occupation, but nevertheless we need to understand the scope and nature of such mobility. Second, attracting but failing to effectively absorb immigrant health workers into the healthcare sector is an ethical issue that must be comprehensively addressed by mitigating skills underutilization through continuous improvement in current bridging and workforce integration programs. Third, achieving health worker self-sufficiency, as outlined in the WHO’s 2030 health worker strategy, requires assessment of domestic versus the international supply of healthcare workers, this is highly challenging to measure considering Canada’s current lack of national health workforce data.⁴ Each of these issues is examined in turn below after first considering the issue of ethics in health worker migration more closely.

The ethics of health worker migration
In the context of the global migration of healthcare workers, the issue of ethics focuses on state’s responsibility to not undermine other nation’s ability to secure their health systems by depleting their health worker resources, while also acknowledging the human right to mobility. Multiple migration drivers are involved in the out migration of health workers, including the underutilization and unemployment of workers in their home countries,⁵ deteriorating employment conditions at home, and active recruitment overseas where conditions of pay and employment are relatively better.⁶ In such contexts, active or passive recruitment of health workers rests on multiple discourses of what ethical recruitment means and demands.

Examples of promising practices in health worker migration have shown that ethical recruitment is possible, but that it rests with organizational commitment to continuous improvement and the ability to respond to dynamic process change (particularly immigration and workplace legislation).⁷ Examples of explicit compensation or mutuality between sending and receiving states, for example, through health worker mobility bilateral agreements, while encouraged in the WHO Code, are rare in practice.⁸ There are some Canadian examples where health worker recruitment has prioritized the ethical spirit of the WHO Code,⁹ but studies have suggested that addressing the ethical concerns surrounding health worker recruitment and migration rests on national and international multilateral cooperation and focused attention on the underlying drivers of migration (which includes improving health systems in the sending region and investing in health worker self-sufficiency everywhere).

Immigration to Canada and its contribution to the healthcare workforce
In the case of Canada, the ethics of health worker migration can not necessarily be regulated through oversight of recruitment agents, as it can in the United States where the majority of health

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immigrant workers arrive through these channels.\textsuperscript{10} Canada’s active immigration system incorporates internationally trained health workers through various migration streams, be it humanitarian (refugee or family class immigrants), economic (skilled immigrants and their families), or temporary (international students and temporary workers).\textsuperscript{11} Canada has an ethical and economic interest in facilitating the integration of these trained health workers into commensurate employment.

Immigrants already make a significant contribution to the Canadian health workforce. In 2019, 1,424,300 workers were employed in Canada’s health occupations,\textsuperscript{12} and immigrants comprised 1 in 4 of these workers.\textsuperscript{13} For example, nearly 60% of the country’s employment gains in 2017 were because of immigration, and this is particularly true for nursing and care related services.\textsuperscript{14} Foreign-trained pharmacists as a proportion of the total supply increased from 30.9% in 2010 to 49.7% in 2019. Of the total supply of doctors in Canada, 26% were foreign trained in 2019.\textsuperscript{15} For non-regulated professions such as nurse aides, orderlies, and patient service associates, in 2016, 36% of were foreign trained, representing an increase from 22% in 1996.\textsuperscript{16} The increased presence of immigrants in Canada’s health and care sector is marked by specific gendered and racialized intersectional inequities, including occupational segregation where women earn less money than men, hold fewer leadership roles, their work is perceived as holding less social value, and they face discrimination, sexual bias, and harassment.\textsuperscript{17} The devaluing of feminized skills is a key feature of international migration, and an important ethical concern, since women represent half of all international migrants and are increasingly embedded in global care services.\textsuperscript{18} Attending to immigrant health and care workers represents an ethical issue in terms of maximizing global health worker resources, and improving gendered labour market outcomes.

**Underutilization of immigrant healthcare workers**

Despite the significant contribution of immigrants to the healthcare sector skills underutilization is an important economic and ethical concern. Health professionals who enter Canada through any immigrant stream who wish to enter practice must have their foreign credentials recognized. Credential recognition is a complex process, managed by professional regulatory associations, subject to provincial oversight, and of interest to the Federal government.\textsuperscript{19} The complexity of this process is a major contributing factor to the underutilization of immigrants with a health-related education. Arthur Sweetman has detailed imbalances between the WHO Code on the International migration of health professionals, and the reality that in Canada we see a surplus in many health professions, with about 7,000 International Medical Graduates who cannot practice (immigrants as well as Canadians who have studied abroad).\textsuperscript{20} This represents a global health worker resource loss.

Foreign credential recognition has been targeted for sustained policy attention in Canada. For example, in Ontario, the “Fair Access to Regulated Professions” Act (2006) includes the creation of the Ontario Fairness Commissioner (OFC).\textsuperscript{21} The OFC assesses the processes used to evaluate the credentials of international applicants applying to practice in their profession. OFC stipulates that testing should be fair, transparent, and objective, and that fees charged to applicants should be only cost recovery. The 2018-2019 OFC annual report indicated that although improvements have been made over time, 40% of the professional regulatory bodies were still not meeting their legislated requirements, with 30% requiring some form of prior Canadian work experience for registration without explaining why this experience is necessary.\textsuperscript{22} The Ontario government has announced it will be introducing legislation to end the demand for Canadian experience for immigrants to get licensed in certain professions.\textsuperscript{23} While this legislation only applies to non-health related occupations, indications are that the Ministry of Labour, Training and Skills Development will work with the Ministry of Health to determine if the legislation can also be applied in health occupations.

Once international trained health professionals secure credential recognition, effective support in the workplace is also key. Research on Internationally Educated Nurses (IENs) suggests that supports during recruitment, transition and integration are “at best inconsistent and at worse nonexistent.”\textsuperscript{24} Lee and Wojtuk provide strategies for how health managers can begin to press for necessary system change, including building partnerships with settlement agencies, understanding why HR departments might screen out IENs, and recognizing the skills and experience IENs already possess. Also, IENs would benefit from more support at the unit level, including preceptorships or buddy/mentor assignments, more diverse orientation practices and more supportive structures.

**Meeting ethical obligations: Achieving health worker self-sufficiency**

The WHO adopted the Global Strategy on Human Resources for Health: Workforce 2030 in May 2016.\textsuperscript{25} The strategy includes milestones, one of which is that by 2020, member countries would make progress on developing a health workforce registry, and by 2030, they will make progress toward self-sufficiency by halving their dependency on foreign-trained health professionals.\textsuperscript{26} There is no universal registry of health workers in Canada recording stock, demand, and supply.\textsuperscript{27} This makes assessing the contribution of foreign-trained health workers difficult to assess, monitor and account for in terms of Canada’s responsibilities to the WHO Code.

Canada has neglected health workforce planning issues and lacks basic information about the supply and demand for health workers, including a lack of information about the diversity of the health workforce, including the immigrant and ethnic composition of the workforce. One solution is to improve the quality and co-ordination of data collection and utilization through enhanced Federal government oversight, replicating
better health workforce practices already evident in other countries. By understanding the composition and future projection of health workforce supply and demand, enhanced planning will allow for issues of sustainability to be addressed, reducing acute shortages, protecting health workers, and facilitating better planned integration and utilization of immigrant health workers into health systems.

**Conclusion**

Overall, the way to manage health worker migration and Canada’s commitment to the WHO code is to develop an effective system for health workforce planning that can incorporate and project potential supply through both domestic training and international migration. Such long-term planning will require the inclusion of multiple stakeholders (provincial health ministries, unions, professional colleges, and the higher education sector), and must also embed Canada’s ethical responsibility to create systems that will permit the effective and fair utilization of immigrant healthcare worker skills while recognizing the country’s ethical responsibility to work toward global health solidarity. The WHO 2030 healthcare strategy encourages countries to move to self-sufficiency. Canada’s active immigration policy means there will always be an inflow of internationally trained health workers in the annual immigration intake. Even though immigrants may be not actively recruited as health workers, their underutilization in Canada is consequential for the health systems of the developing countries from where they have moved, and this is core to the WHO Code. The negative consequences of health worker maldistribution and underutilization impacts all countries in achieving universal healthcare, and this makes the migration of health workers from lower income nations and their underutilization in the receiving country a transnational social justice matter.

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