IMAGINING PRAIRIE COMMUNITY: THE SETTLEMENT AND RETENTION OF SOUTH AFRICAN PHYSICIANS IN RURAL SASKATCHEWAN

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ABSTRACT

Saskatchewan is one of the few provinces in Canada where approximately one third of the population resides in rural communities. It has a longstanding shortage of medical personnel exacerbated by inconsistent Canadian physician supply. International Medical Graduates (IMGs) have been recruited and now account for more than 52% of practicing doctors in Saskatchewan. Many IMGs are white South Africans who feel disenfranchised by post-Apartheid reforms and are seeking greener pastures abroad. However, they tend to remain in rural communities only until their immigration requirements are met and then relocate to large urban centers. Ethnographic research that examined physicians' settlement choices and the influence of the host community was conducted in two rural communities in Saskatchewan for ten weeks. Interviews suggest that retention of these newcomers can be improved through inclusion in the "imagined community" which is achieved through the integration of family, quality of life factors including safety, lifestyle, job satisfaction, and continued feelings of community acceptance. These factors seem to mitigate the rigors of providing rural healthcare and compensate for limited amenities.

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Chapter 1-Introduction

The face of health care is changing. Large numbers of rural physicians are retiring and new graduates are taking their place. Yet Canadian medical schools are not training enough physicians to support desired doctor-to-patient ratios (approximately 190 physicians per 100,000 citizens) or to replace retirees. The solution thus far has been for provinces to recruit international medical graduates (IMGs) from other countries with comparable medical systems. The result is that 22% of practicing Canadian physicians are foreign-trained (derived from Southam Medical Database 2004). However immigration is notoriously unstable as is the settlement of skilled immigrants. Though they may initially be employed in any region in the country, many will migrate to a major urban centre shortly after their arrival in Canada (Grant 2004; Government Relations and Aboriginal Affairs [GRAA] 2002). This further exacerbates the shortage of skills in less populated areas while over representing them in cities.

Saskatchewan is one of the few provinces in Canada where more than one third of the provincial population resides in small rural communities. It also has a longstanding shortage of medical personnel in these communities. Numerous strategies have been employed to compensate for these lower doctor-to-patient ratios. Health services have recently been centralized by amalgamating 32 health districts (administrative bodies covering a specific area of the province) into 13 (much larger) health regions, new models of care delivery have been implemented (e.g., group practices), and extensive efforts have been made to recruit medical personnel from abroad. In fact, IMGs have

been recruited to such an extent that they are now the foundation of rural health services, accounting for over 52% of practicing doctors in the province (Grant 2004).

South African doctors are the majority of rural IMGs and represent 17% of overall migration to the province (Grant 2004). They have been recruited extensively because of the similarity of the South African medical system to Canada's, and the high calibre of doctors that South Africa produces (Bhorat, Meyer and Mlatsheni 2002). These doctors are also very mobile, and generally relocate after their initial placement contract in Saskatchewan has expired. In several interviews with community members, physicians, and health professionals it was also mentioned that some South African IMGs have earned a reputation for "getting rich and getting out." Some have been known to take on enormous workloads and/or use questionable billing practices to earn a great deal of money in a short time. They return to South Africa leaving patients and colleagues "in the lurch" and quintuple (or even septuple) their earnings on the exchange from Canadian dollars to South African rand. Canadian mortgages, car payments, and taxes are often left unsettled in these situations, prompting some car dealerships to refuse to sell new vehicles to South Africans.[1] As a result, the welcome in some communities has become rather ambiguous as they are grateful to have a doctor but unsure if she or he will remain in the community for very long.

Community retention strategies in the form of large bursaries, skill development opportunities, and accelerated credential recognition have been employed to reduce the outflow of IMGs (Saskatchewan Health 2004). However these programs are limited in scope and their effectiveness remains questionable since many immigrant doctors still

[1] One large car maker refused to finance the purchase of new vehicles by South African physicians in both communities in this study. Several South African physicians in this study commented that this was a common practice for this car company throughout Canada.

undertake a secondary migration to large urban centres. There is a need for further study of the social aspects of immigrant settlement and retention in these communities and since South African doctors are one of the largest groups of practicing IMGs in rural Saskatchewan they are the subject of this study.

Theoretical Framework

The theoretical orientation employed in this thesis is that of political economy. As the name implies, this is an approach focused on the interplay of politics and economics. In addition it is the study of the interaction between personal agency, historical conditions, and macro-level social, economic, and political forces:

> Political economists grapple with the tensions between structure and agency, between ideas and material conditions, between class and gender, class and race, and between the tendency to separate aspects of these for the purposes of analysis and the need to unite them in order to understand the whole (Armstrong, Armstrong, and Coburn 2001: ix).

In essence political economy is the study of larger political and economic structures and how they influence the settlement choices of international migrants. For present purposes this theoretical orientation will be employed to examine the settlement of South African immigrant physicians in small communities in Saskatchewan because it takes into consideration individual experiences and decisions within the context of politics, social issues/influences, and history at various levels (local, national, international).

Migration has historically been explained in binary, macro-level terms in the language of "pushes" and "pulls." Migrants were pushed by forces beyond their control such as famine, war, or poverty and/or pulled by the wealth, security and allure of life in 'developed' nations. Advocates of this explanation of migration pictured the invisible

hand of the market balancing supply and demand on a global scale (Kearney 1986). But this framework was overly simplistic as it ignored the unequal power relations inherent in migration. Western, or 'developed,' nations were the primary beneficiaries of these flows and perpetuated the dependence of developing nations on developed nations for their expertise, technology, and markets (Kearney 1996; Levitt and Glick Schiller 2004).

The ease and frequency of migration has been greatly increased by global economic and cultural integration (i.e., globalization). International bodies such as the International Monetary Fund (IMF) and the World Trade Organization (WTO) have increased the mobility of capital and investment. There is also a growing push towards internationalization of certain professions, most notably information technology (IT), to ensure transnational similarity in training, remuneration, and above all to ease international mobility and employability (Forcier, Simoens, and Giuffrida 2004; Iredale 2001; McAdams 2003). Consequently the possibility of skilled persons, such as physicians, moving between countries and being able to find employment in their profession at an income level that they would consider appropriate for their position has greatly increased.

International and bilateral trade agreements such as General Agreement on Trade in Services (GATS)[2] have further increased the transferability of labourers and "human capital" between nations so that the rapid (and often temporary) international transfer of skilled persons can sustain the economic growth of countries with specific skill shortages. In North America specifically, the North American Free Trade Agreement (NAFTA) has created numerous avenues for the movement of skilled persons between Canada, the

[2] The GATS was negotiated by WTO members in 1995 to liberalize the international trade in services including the health sector.

United States, and Mexico (Iredale 2001). Common recognition of credentials in the medical field enables, for example, the relatively simple relocation of Canadian physicians and nurses,[3] IT professionals, teachers, and social workers to the United States for the purposes of employment (Martineau, Decker and Bundred 2002).

While these agreements have removed many barriers to employment and settlement abroad, and are important to acknowledge, to have a fuller understanding of how agency interacts with these broader structures one must also address the formation of new interpersonal connections and how this affects the individual and the receiving community. When someone leaves a "homeland," they are no longer part of the 'local equation' and no longer include the homeland in their own cultural 'equations' because they are now part of a new homeland (Portes, Haller and Guarnizo 2002; Rouse 1995). However, in this new home they find themselves integrated into the larger society and new community in unexpected ways. For example, though they shared the same body, a young man of means in Kerala was also an exploited foreign labourer in the Persian Gulf (Osella and Osella 2000). The contradictions inherent in these types of situations need to be addressed (i.e., resolved, ignored, or simply acknowledged) in some way (Stoller 2002) and the means of doing this is often found in networks of family, friends, or members of the same ethnic group. These networks form communities that assist newcomers in the transition from their old home to their new one (Gardner 1993).

Stoller and McConatha (2001) and Stoller (2002) demonstrated such a community at work in their study of Nigerian traders in New York City. Upon arrival from Côte d'Ivoire, a trader was taken in by members of his kin or ethnic group. This same group

[3] As a professional group nurses have an exceptionally high rate of national and international mobility (Iredale 2001; Martineau, Decker and Bundred 2002).

helped the trader establish contacts with suppliers, offered advice on what merchandise was profitable and sold well, helped him find a location for his business on the streets of New York, and even provided informal emergency loans (Stoller and McConatha 2001; Stoller 2002). Newly arrived traders found a sense of identity within this group as well as the larger community of Islam as they observed the rituals of their faith (e.g., daily prayers, attending services at the mosque). Membership in these communities afforded West African traders some control over their lives while they remained "illegals" in American society (Stoller 2002).

Communities have been understood largely as the result of geographical proximity. "Imagined community" addresses a more abstract level of community, viewing it as a construct, a feeling of mutuality based on concrete interactions. As such, communities may exclude individuals or groups who live in close geographical proximity to community members. Conversely they may include members or individuals who do not live in the immediate area. The concept of the "imagined community" was originally defined by Benedict Anderson (1983) in a discussion of the formation of nationalism:

> [A nation] is *imagined* because the members of even the smallest nation will never know most of their fellow-members, meet them, or even hear of them, yet in the minds of each lives the image of their communion...In fact, all communities larger than primordial villages of face-to-face contact (and perhaps even these) are imagined...it is imagined as a *community*, because, regardless of the actual inequality and exploitation that may prevail...the nation is always conceived as a deep, horizontal comradeship (Anderson 1983: 15-16 emphasis in original)

In keeping with the work of Stoller (2002) and, at times, Chavez (1991; 1994), "imagined community" is used here to describe specific geographically-defined communities, not a national community as described by Anderson (1983). More specifically, the imagined communities of two towns in rural Saskatchewan, Easttown and Westtown (named for

their respective locations near the eastern and western provincial boundaries), are the subject of discussion. The imagined communities of these rural towns/communities are maintained through shared values (Stoller 2002), shared memories and histories (Ortner 1997) and through the interactions of community members (Chavez 1991; 1994; Tsuda 1999; Stoller and McConatha 2001). They are influenced by larger (hegemonic) provincial and national imagined communities but also have their own local nuances shaped by local histories, memories, and values. But how does one enter such a community?

Chavez (1991; 1994), Tsuda (1999), and Ong (1996) explain that entry is a bi-directional process. It is possible and not uncommon for outsiders to choose to remain in a community even if they are marginal to it because of a wealth of experiences and linkages that tie them to the (new) larger society.[4] They can be incorporated into the community in stages as they acquire "experiences, knowledge, and modes of behaviour that tie them to... society" (Chavez 1991: 259). However a migrant can only become a member of the receiving community if an avenue for incorporation exists. Receiving communities must have the capacity and willingness to absorb newcomers (Ong 1996; Tsuda 1999).

Each community contains implicit hegemonic or dominant assumptions about what is acceptable, what is deviant, and numerous gradations of what lies between. Communities may have attributes that influence (either by encouraging or inhibiting) the acceptance of, and accessibility to, those who are deemed outsiders, including certain kinds of international migrants. In the United States of America this is based on a racial duality. Newcomers are placed or incorporated into ethnicized categories based on the

[4] Others may also stay because they are desperate and have no other options.

idealized positive attributes of whites and the idealized negative attributes of blacks. According to Ong (1996: 739) the ethnicization in based largely on the proximity of immigrant groups to the ideal "white" standard of "human capital, self-discipline, and consumer power." Though they may not have "fit the bill" exactly, because of their middle-class backgrounds and staunch anti-communism, many Vietnamese refugees who entered the U.S.A. in the 1970s were incorporated as one of the "model minorities" along with Chinese immigrants from Hong Kong and Taiwan.[5] In contrast, due to the association of Cambodian refugees with the Khmer Rouge and their depiction as peasant farmers and fishers[6] they were (negatively) grouped with Laotians and poor refugees of colour such as Ethiopians and Afghans (Ong 1996). Though these outsiders were incorporated into the "imagined community" of American society they were not necessarily incorporated on their own terms but in a way that fit the social/ethnic/racial hierarchies of their new home country.

Underlying assumptions of group membership have been well summarized by Chavez (1991; 1994), who reasons that the settlement patterns of immigrants are predicated on a sense of belonging. In his study of undocumented Mexican and other Latin American immigrants in the southern United States, Chavez postulates that immigrants arrived in a community as either a "sojourner" or a "settler" (Chavez 1991; 1994). As sojourners, they constantly re-evaluate the benefits of staying in the host community versus the benefits of returning home. When they decided to stay, their

[5] The "model minorities" are generally characterized as highly educated, middle class, and relatively wealthy. Their children are equally seen as disciplined, dedicated to their education, and intelligent (Ong 1996).

[6] Though there were many peasants and fishers among the Vietnamese refugees, this fact was largely ignored. Vietnamese refugees were also frequently referred to as "immigrants" while Cambodian refugees were always referred as "refugees" (Ong 1996: 743).

mental orientation changed from a primary focus on their community of origin to the host community, and they changed their role to that of "settler." This did not mean that ties to the sending community were severed, only that they were considerably weakened and became less important than ties to the host community (Chavez 1994). If one felt that he or she had a "place" in the community, then he or she was more likely to remain in that community. Employment, social support, language and skills training, and perceptions of community friendliness are ways of developing these ties and the associated sense of belonging.

This depiction of identity, however, is not necessarily consistent with the reality on the ground. Chavez assumes migrants develop binary community attachments based on interactions with community members but admits that the construction of "settler" and "sojourner" exists more for the ease of the researcher than for the reflection of fact (1994: 55). He further emphasizes that settlement is bi-directional: not only must the sojourner want to become a part of the community but community members must also be able to "imagine" him or her as part of the community (Chavez 1991: 259) in a way that is acceptable to both (Ong 1996). Limiting the scope of possible community attachments to the sending and receiving community ignores the possibility of immigrants developing significant ties with numerous communities in which they sojourn and ignores the multidirectionality of social networks (Kearney 1996).

Tsuda (1999: 691) similarly takes issue with the notion of sojourner and settler because they are "artificially dichotomous" and "overly mechanistic." Though she recognizes that newcomers do, at some point, make a decision to settle in the host community, she observes that there is seldom a single point in time when a sojourner

becomes a settler, neither is the decision irreversible. The process of incorporation into the new community is gradual and often convoluted:

> Migrants can arrive in the host [community] with the intent to settle, but eventually become sojourners as they decide to return home or move on to another [community]. Even though many migrants do perceive themselves to be either temporary or permanent, such self-categorizations remain ambiguous and are sometimes poor indicators of future migrant behavior, which inevitably remains uncertain since self declared sojourners and settlers may eventually reverse their decisions. Nor are these categories mutually exclusive opposites. Indeed, many migrants are neither temporary nor permanent, but remain in a liminal state between the two extremes, uncertain about their futures and their ultimate [community] of residence (Tsuda 1999: 692).

Instead Tsuda (1999) proposes an analysis through the perspective of structural embeddedness. The focus is placed on the incorporation, over time, of newcomers or populations of newcomers into the host community to the point that they remain in the community even though the economic incentives that initiated their migration can be considerably weakened. They may remain marginal to the hegemonic imagined community, but they do choose to remain and perhaps find a more valued place within it.

However this does not clarify the decision to remain in the community; to become a "settler." Partially, this is a problem of scope. Tsuda (1999) is dealing with populations numbering in the thousands, not one or two hundred South Africans in Saskatchewan. Additionally, while newcomers do gradually settle or become embedded into a community until they decide to stay, when is a newcomer "embedded enough?" This is the same problem found in Chavez (1991; 1994). When is the decision to become a "settler" made? More importantly, when is the decision firm enough to withstand the pull of another opportunity somewhere else? If Tsuda (1999) is correct, then this final question may be impossible to answer since the immigrants themselves may not know.

What I propose is a compromise between the two. One must include the constructs of both settler and sojourner because some newcomers do choose to settle or take up long-term residence in a community, while others do not. Settlement, discussed in this way, must be addressed as a process or as a continuum rather than a binary choice between two exclusive options (i.e., either to "sojourn" or to "settle"). One must also address the notion of embedding as a process and examine the structures such as class, and employment-related hierarchies that encourage or discourage this process, albeit with the acknowledgement that these structures are often composed of people who interact on a regular basis. Thus embedding may not only include purchasing property, but also joining local associations and faith communities, talking to community members on the street, participating in community events, and going to work. Entering the "imagined community" of any scale is an abstract notion based on the concrete reality of value-laden human interaction.

Research Methodology

Research was conducted over a three month period in rural Saskatchewan in the summer of 2004. Information was gathered in the communities of Easttown and Westtown.[7] Both communities have populations over 5000 and are the largest centre within a 150 kilometre radius (or a commute of at least one and one half hours to a larger community). Research participants from both communities described them as "progressive" and "friendly." They also noted that for the most part, both communities are self-sufficient. Local economies are based primarily on commodity production and

[7] Community descriptions are based on common elements mentioned in participant interviews. This is to give the reader information participants deemed important. Specific names of local companies or community events have been omitted to maintain confidentiality.

processing, such as oilseed crushing and timber. There are also substantial tourism and sports industries focused on northern lakes and provincial parks. In fact, this connection to the lakes proved somewhat problematic to the research as it seemed that almost everyone was away at the lake during the field period.

Easttown is located near the eastern border of the province. When asked, respondents said that it is not a growing community, but it is "holding its own." The economy is based primarily on grain production and processing, livestock, honey, and tourism. There are three major grocery chain-stores in town as well as a bakery, several pharmacies, various small clothing shops, fast-food outlets such as Subway and A&W and several family restaurants. Amenities include a golf course, swimming pool, small movie theatre, arena and ball fields, and easy access to northern lakes. There are also several automotive dealerships, farm machinery dealerships, and a host of service and repair shops. Children have their choice of dance and music lessons and sports organizations. There are numerous community groups including the Lions, Elks, a hospital foundation, and others. A strong sense of community pride was evident in the interviews. All respondents noted that Easttown had recently won a competition for community beauty. Local sports organizations were not only doing well, many were the best in the province. It is a close community where "you can walk down the street and everyone knows you."

Westtown is a slightly larger community. Agriculture is still important locally but forestry and forestry products form a larger component of the economy. There are also several chain restaurants (e.g., A&W, Subway), large grocery stores, a few clothing stores, and several pharmacies. There are three car dealerships and several garages,

hardware stores and numerous restaurants, and a unique coffee shop. Local services include a golf course, a new indoor swimming pool, an arena and curling rink, and outdoor rodeo grounds. A new high-school was built recently in partnership with the local First Nation.

The population is growing, though it was noted several times that the middle class in Westtown is composed of "transients." There were also a large number of heavy transport trucks rumbling through town servicing local mills or on their way to northern communities. Some participants noted that it was difficult to make friends in the community because neighbours or co-workers came and went and local groups were composed of "people who have been here forever," making them very tight-knit and difficult to enter. However it was also common for participants to remark that "you always bump into people that you know or that recognize you from work when you're in the store or on the street."

The two rural communities in this study were somewhat unique in the range of services that were offered. Because they are the largest urban centres in the area, the clinics have contracts with several remote communities and native reserves to provide medical services in community clinics. In Westtown this involves a journey of several hours over rough, poorly maintained roads, to small communities two days a week. One physician also flies to even more remote communities to provide pre-natal care, including ultrasounds. In Easttown the local pharmacist and physicians from one clinic fly to a large reserve three times a week. Physicians from a second clinic provide satellite services at four other communities.

Hospitals in both locations are classified as district hospitals and provide 24 hour emergency service, some surgeries, deliveries, and radiography (see Appendix B). Again, because of their locations, these hospitals provide a wide range of care. In Westtown this included a large obstetrical practice that oversaw approximately 350 births per year. Many expectant mothers come in from more remote communities to give birth in Westtown. This is generally because the physician who oversaw their pregnancy is stationed in Westtown but also because it is the nearest centre that is able to perform ultrasounds and caesarean sections should the need arise. Easttown provides a slightly larger range of surgical services, again because of the qualifications of one or two physicians. Consequently these hospitals seem to perform more procedures and have a slightly wider range of medical services than other regional hospitals (see Appendix B) to meet the needs of these remote towns and villages. There are also a number of allied health professionals[8] in each community though both communities were in need of a speech-language pathologist and at least one other allied profession.

Each community has a local newspaper which was searched for references to healthcare, important local events, and South African physicians specifically. Relevant articles were used to construct a more accurate picture of the milieu in which these doctors are living and working. Informal and semi-structured interviews were conducted with South African doctors and several members of the hospital staff (nurses and support workers). I had originally intended to organize focus groups in both communities as well, but it was only possible to do so in Westtown. Attempts were made to recruit community members through posters displayed in public places. This failed dismally,

[8] These include a massage therapist, chiropractor, physiotherapists, occupational therapist, speech-language pathologist, and dentist.

but my landlady in Westtown was kind enough to organize a focus group at a local retirement home. The group consisted of 11 elderly females with an average age of 85, and lasted approximately 45 minutes. Questions addressed the perceived state of medical care in the community, the effects of foreign trained doctors on local health care delivery, and the specific impact of South African doctors on the larger community. These interviews were intended to establish the tenor of relations within the numerous social networks that exist in the larger community (e.g., Do community members consider South African doctors to be immigrants or "one of us"? Do South African doctors feel appreciated or alienated by the community or co-workers?).

The most important element of the research was participant interviews. Through the course of the summer various community members, recruiters, hospital staff, and physicians in particular participated. Participants were primarily recruited through "cold calling" and snowballing techniques. The questions with these participants addressed perceptions of the community, medical care, satisfaction with medical care and medical personnel, and experiences with immigration and settlement. This approach was intended to provide an accurate picture of immigrant physician settlement issues as they were understood by the physicians themselves, the local medical community, and the rural community in general and how/if these understandings played a role in physician retention.

In total, 30 people took part in this project not counting the focus group. Nine physicians participated in interviews (three women and six men) out of a possible total of nineteen, five from Westtown and four from Easttown.[9] Six of these physicians were

[9] Though this is a small number of physicians, considering their workloads and generally hectic lifestyle, the participation rate of 47% of active physicians is quite remarkable. During the fieldwork, it was

South African (one female and two males in Westtown and one female and two males in Easttown out of a possible seven South Africans in each community).[10] Two males and two female physicians were Afrikaner (white South Africans descended from Dutch, German, and French Huguenots), one male was English South African, and one was Indian.[11] All physicians, Canadian and South African, were married and spouses were interviewed together when possible.[12] Four physicians (one Canadian doctor and three South Africans) had small children. The South African physicians had lived in Canada from a minimum of six months to a maximum of four years. Three South Africans had left South Africa for Canada shortly after completing their medical training, and two came directly to Canada upon the receipt of their credentials. The other physician first worked in Britain for several months then immigrated to Canada. Five South African physicians had ties to family (e.g., parents, cousins) that were still living in South Africa and all had friends and/or relatives in Canada and abroad.

During the course of the fieldwork two South African physicians left the community to practice in other provinces. Through the interviews with other health professionals it became apparent that there were a number of physicians that had left both communities in previous years to practice medicine elsewhere (some relocated within Saskatchewan, but most relocated to Alberta, British Columbia, and to a lesser extent

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common for interviews to be scheduled around, pre-empted by, and/or interrupted by emergencies and other duties in the local hospital.

[10] Of the 19 physicians in these two communities, 14 (74%) were South African.

[11] Due to the small numbers of physicians living in both communities and the difficulty of maintaining anonymity in small communities, respondents will be referred to in gender-neutral terms whenever possible, or with terms such as "he or she," or "she or he."

[12] Four physicians (three South Africans and one Canadian physician), and two community members were interviewed with their spouse. All nurses were interviewed alone because they most often found time for the interview before or after their shift, or during breaks. In several other instances a physician/nurse/community member participated in an interview while his or her spouse took care of their children.

Ontario). This constitutes a major weakness in the discussion of factors encouraging and inhibiting retention because, despite the number of physicians who have chosen to leave Easttown and Westtown (at least half a dozen have left both communities in the last decade), most of the research is based on interviews and observations of physicians who have chosen to settle in rural Saskatchewan.

Twelve participants were employed in health care in the two communities; eleven had regular contact with all physicians throughout the course of their duties in the hospital. An additional seven community members and two hospital board members provided a great deal of information on the communities themselves, local perceptions of healthcare and physicians, and explained "the lay of the land" in the community at large and the local health community in specific.

Data analysis was based on an examination of the ways and feelings of belonging or "community" membership as discussed above. Primary focus was placed on social groups of international medical graduates (IMGs),[13] methods or avenues of inclusion into the host community, and socio-economic and cultural differences or similarities in the two communities. The influence of work on retention was also addressed. In keeping with the political economy of migration and embedding in the community, I looked for general trends in migration patterns (e.g., age, marital status, the age of any small children, destinations of choice), themes such as community friendliness, the "communities" that immigrant doctors created or interacted with, money/income, work environment(s), and motivations to migrate to Canada (see Appendix A for a guide of interview questions).

[13] See page 51.

The purpose of this research is two-fold. First, it is intended to provide a concrete tool to help communities improve their appeal to physicians. The analysis of key issues of one specific physician population, in this case South African IMGs, is intended to provide a mid-level resource that can be applied to South Africans specifically and new physicians more generally. The second goal is to contribute to the growing body of knowledge on immigration, settlement, and "community." While I acknowledge the inequity that I am promoting by encouraging the integration of South African physicians (who are desperately needed in their homeland) into Canadian communities, this research is intended to serve as a mid-level analysis of the retention of medical professionals in rural communities that can be applied to IMGs and more generally to Canadian physicians as well. Ultimately, if settlement and retention of existing physicians and Canadian medical graduates is improved in rural communities, the need for IMGs in rural healthcare will decrease, thereby reducing the 'brain drain' of foreign-trained doctors to rural Canada.[14]

The second and third chapters deal, through policy analysis and literature review, with the political economy of the migration of South African IMGs. Chapter two, "Out of Africa," is an analysis, through secondary literature, of the broader social and economic changes in South Africa that are precipitating the emigration of skilled persons. Chapter three, "Into Saskatchewan" is a discussion of the structure and politics of healthcare. Specific emphasis is placed on the issue of physician supply and demand in Canada and the structural importance of internationally trained medical professionals to

[14] This will also require changes to the politics of healthcare as well as the medical education system such as training a suitable (i.e., larger) number of Canadian physicians, changing the role of physicians in the medical system, and changing medical training to encourage more Canadian medical graduates to practice in rural communities. However an adequate, in-depth discussion of these issues is beyond the scope of this research.

the Canadian health system. This chapter concludes with the 'grass roots' experience of recent health care restructuring in the two field communities. Chapter four "Rural Life" is an ethnographic analysis of agency as exhibited by South African IMGs and community members as newcomers integrate and are allowed to integrate into their host communities. "Conclusions and Recommendations" is the fifth and final chapter. As the title suggests this is a summary of the research findings and recommendations for community-based retention strategies. The chapter concludes with recommendations to facilitate the integration or embedding of newcomers and thereby improve the retention of needed medical practitioners in these rural communities.

Chapter 2-Out of Africa

At the end of the apartheid era in 1994, South Africa was deeply in debt. After subsidizing the so-called independent homelands and enforcing population control laws, suffering the effects of international sanctions in the 1980s, large-scale military involvement in border wars and excursions into neighbouring nations (Angola in particular) the government had accumulated a national debt of over 50 billion rand.[15] When the Government of National Unity (GNU)[16] was formed as the first post-apartheid government in 1990, it immediately instituted a set of reforms, both social and economic, under the guidance of the International Monetary Fund. The GNU planned to create a more equitable society through rapid economic modernization. This was intended to promote rapid economic growth and the creation of employment for the formerly politically oppressed black majority. The theory was that resulting job opportunities could enable the poor to escape their poverty, and allow the GNU to repay the national debt as quickly as possible (McIntyre and Gibson 2002; Seekings and Nattrass 2002).

In practical terms the economic reforms resulted in a dramatic increase in capital intensity (i.e. automation and investment in information technology) and a corresponding increase in demand for *skilled* employees instead of unskilled labourers (Bhorat, Meyer, and Mlatsheni 2002; Seekings and Nattrass 2002). At the same time, some Southern

[15] This is a "narrow" definition of the debt as it excludes the debts of public authorities and public corporations. In its "wide" interpretation the debt was 86.7 billion Rand in 1993 (http://www.africaaction.org/docs99/dbt9903a.htm).

[16] The GNU was an amalgamation of three political parties, the African National Congress (ANC) of which Nelson Mandela was the president, the Inkatha Freedom Party (IFP), and the New Nationalist Party (NNP, formerly the Nationalist Party that had ruled South Africa for the better part of the last half-century) headed by former South African President F. W. de Klerk.

African Development Community (SADC)[17] countries were sending students to South Africa to access training that was not available in their own systems (Kahn *et al.* 2004). Many of these students chose to remain in South Africa because of the higher salaries (the highest salaries of any SADC nation) and greater opportunities for professional advancement (Matlapeng 2000). In this regard, South Africa was the beneficiary of a 'brain drain' of African intellectuals and professionals from all over the continent.

Though the southward migration of the continent's 'best and brightest' had begun in the 1970s it became a source of concern in the early 1990s as a surge of African immigrants preceded the free elections. Migration levels were so significant that the South African government revamped its immigration policy to limit the immigration of Africans from SADC nations and refused to certify some professionals altogether (Grant 2004; Williams and Crush 2002). The Immigration Act of 2002 attempted to limit the influx of unskilled labourers while streamlining the immigration process for select skilled persons deemed essential to the economy. These skilled persons were to be selected by market forces and the South African government would facilitate their incorporation into the economy. However market forces are difficult to discern and immigration continued to function on an impromptu basis. Immigration remained problematic for professionals and a "skills crisis" continued to impede economic development (Williams and Crush 2002).

While Africans travelled to South Africa, South Africans, especially white South Africans, moved abroad in growing numbers. Towards the end of the 1980s concern over

[17] The objectives of the SADC are to achieve economic growth and development and the alleviation of poverty in Southern Africa through increased regional integration and co-operation. (SADC website: http://www.sadc.int/index.php)
Member states are Angola, Botswana, the Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, United Republic of Tanzania, Zambia, and Zimbabwe.

the South African brain drain began to grow. Anxiety over migration was not new to South Africa but it did increase as the apartheid system was dismantled (Williams and Crush 2002). Spikes in emigration followed periods of civil unrest such as the Soweto uprising in 1976 and the state of emergency in 1984 (Bhorat, Meyer and Mlatsheni 2002; Møller 1998). Numerous white males emigrated to avoid conscription (Weiner, Mitchell, and Price 1998). Skilled flight increased sharply again in 1993 as all-race elections approached (Kaplan, Meyer, and Brown 1999). Since that time the number of skilled and professional emigrants has remained high.[18]

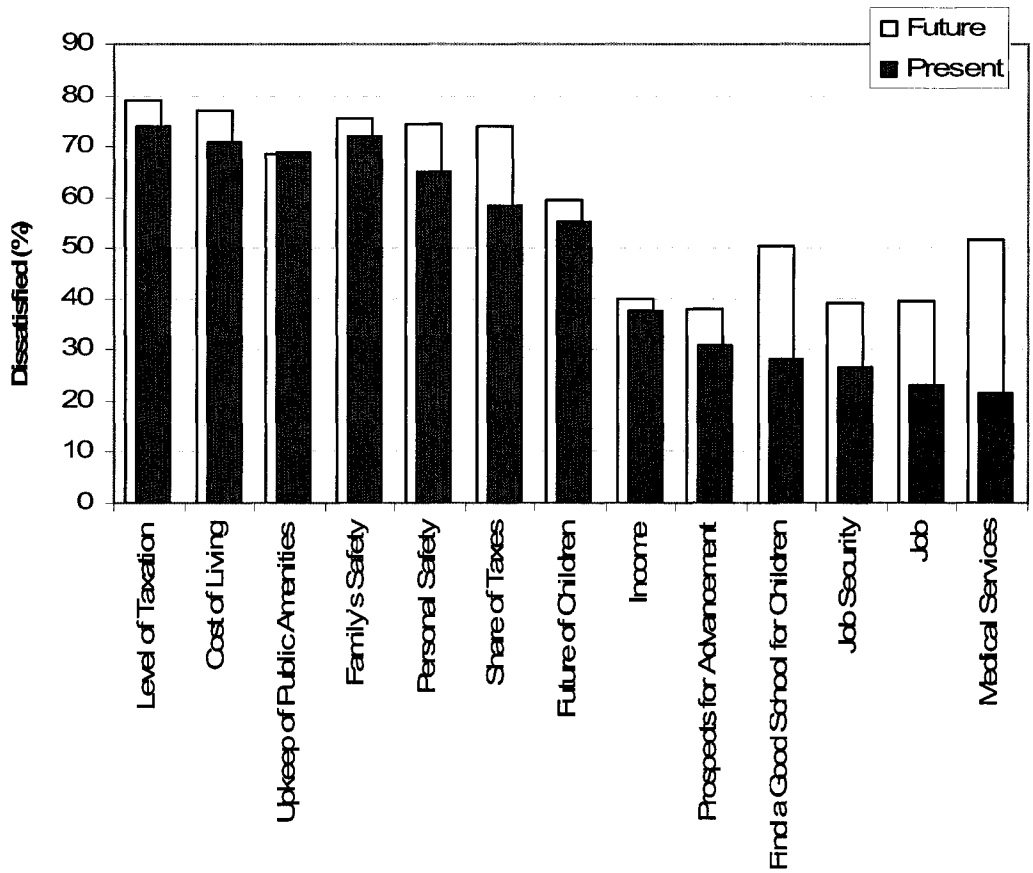
Pushes

Instability is one of the greatest drivers of migration. Increasing economic decline and loss of opportunity, career uncertainty, and fears for personal safety entice many to seek 'greener pastures' elsewhere. In South Africa this has been especially apparent among the highly skilled. A random probability survey of 725 skilled and professional South Africans (white and non-white) was conducted in 1998 by the Southern African Migration Project (SAMP).[19] Over two thirds of the sample had given some thought to emigration and 38% had considered it a great deal (Bhorat *et al.* 2002). Findings suggest that the most important issues driving the brain drain were safety and security, quality of life and levels of taxation, and future opportunities for children (Figure 2.1). Forty per-cent of male and 33% of female participants indicated that fears for safety and security were the most important issues that would cause them to leave South Africa. The second most important push was the level of crime (indicated by 10%

[18] See page 39.
[19] The website of the Southern African Migration Project can be found at http://www.queensu.ca/samp/

of men and 14% of women) followed by economic concerns and anxiety about their children's future (Dodson 2002: 19).

Figure 2.1 Perceptions of Quality of Life in South Africa



(Derived from Dodson 2002: 15-16)

Møller (1998) found similar concerns for safety. She combined the results of four South African quality of life surveys conducted both before and after apartheid (1983, 1988, 1994, and 1995) "to observe whether the new political dispensation of the post-apartheid era had raised levels of subjective well-being among the formerly disadvantaged and narrowed the gap between white and black levels of perceived well-

being" (Møller 1998: 28). White[20] perceptions of "security against crime" dropped from 76% in 1983 to 41% in 1995, and Indian confidence in security was halved from 50% in 1983 to 25% in 1995. When the survey sample was divided by income regardless of race, only 21% of high income earners and 29% of medium income felt secure against crime in 1995 (Møller 1998).[21]

National crime rates suggest that their concern is justified. South Africa remains the "crime capital of the world" (Lebone 2004). According to data from the South African Police Service (SAPS), the number of murders decreased (down to 42.7 per 100,000 in 2003 from a high of 67.9 in 1994) but attempted murders increased by 12.2% over the same time period (SAPS 2004, n.pag). Carjacking decreased 6.1% from 2002 to 2003 to 13,793 reported cases (29.7 per 100 000). However property crimes rose considerably. In 1994, 218.5 aggravated robberies were reported per 100,000. That total increased to 288.10 per 100,000 in 2004, or 57.6% over ten years. Residential burglary (596.2 per 100,000 in 1994) rose 29.4% from 1994 to 2003 (SAPS 2004). In general violent crimes (including political killings) decreased after a spike in 1995, while property crimes increased dramatically in the late 1990s and continue to rise.[22]

In addition to anxiety over crime and safety, the second most significant emigration push was dissatisfaction with economic circumstances. Dodson (2002) records dissatisfaction with the cost of living and levels of taxation at 71% and 74% respectively. Møller (1998) indicates that whites felt that job opportunities were

[20] The results are derived from the original quality of life surveys conducted by the South African government which employed the apartheid racial categories of Black, Coloured, Indian (also known as Asian), and White.

[21] It should be noted that this was only a slight decline from 1983 where 31% of middle income earners and 29% of high income earners felt secure.

[22] Special consideration should be given to statistics on sexual assault and rape as these crimes are often unreported. While SAPS statistics showed a 17.8% increase in incidences of rape between 1994 and 2003 the actual numbers may be significantly higher (Mistry 2003).

drastically reduced after the end of apartheid. Overall satisfaction with employment opportunities peaked in 1988 at 74% before plummeting to 36% in 1995, one year after majority rule. Indian job satisfaction declined slightly to 30%, Coloureds' satisfaction fell from 48% during apartheid to 27% in 1995, and Black job satisfaction fell from 18% in 1988 to a mere 10% in 1995. According to income levels, high income earners' job satisfaction was 29% in 1983, rose to 34% in 1988 and then fell to 17% in 1995. Middle income earners' job satisfaction fell to 10% in 1995 from 17% in 1983. Only 17% of low income earners were satisfied with their employment in 1983. This declined to 13% in 1988 and plummeted to 7% in 1995 (Møller 1998).

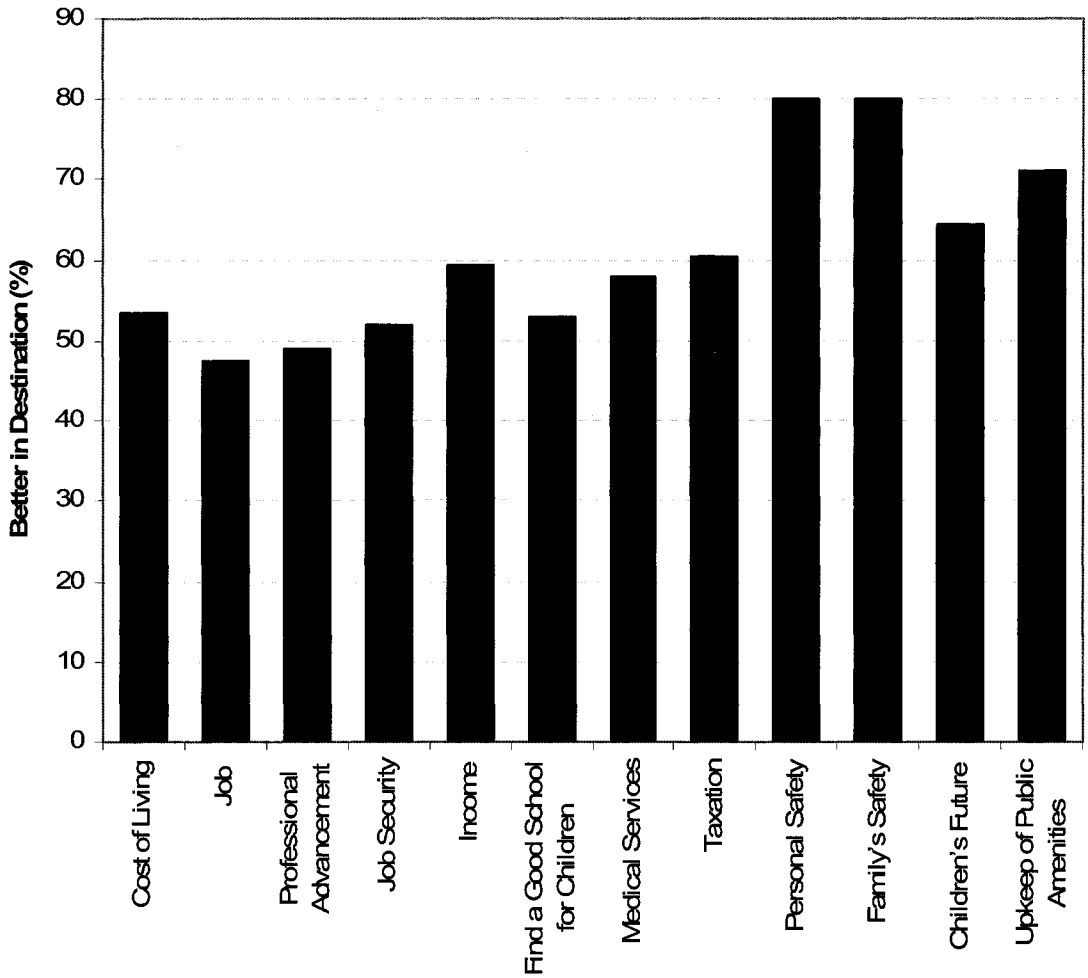
When asked about future economic expectations respondents also showed a degree of pessimism, especially in relation to taxes and the cost of living. Present circumstances were economically discouraging and there was some expectation for conditions to worsen (an additional 5.5 % of respondents expected the future economic situation to be worse) (Dodson 2002). Despite a 15% increase in real incomes among white households between 1995 and 2000 and a decrease in household incomes of all other groups, these responses indicated continuing (economic) uncertainty among high and middle income earners who are the majority of trained and/or experienced professionals in South Africa (Bond 2004; Seekings and Nattras 2002).

The third push to emigrate was found in perceived decline of social institutions for whites. As the economy was reformed post 1994, so too were South African social institutions. Education, the medical system, and public spaces were all designed to reinforce the dominance of whites over the other 'races.' For example, white teachers were better-educated, better paid, and had ready access to quality reading and teaching

materials. Their black counterparts, many of whom had little or no training, were generally unmotivated, underpaid, and unable to access even the most basic of materials. In this way, racially segregated job markets were maintained because whites were the only social group able to pursue professional careers (Seekings and Nattrass 2002). Post 1994 reforms have attempted to remedy this inequality through increased funding for non-white education, and (affirmative action) programs to mitigate the lingering effects of the apartheid education structure. Some whites (and other formerly privileged groups) have accused the government of reverse discrimination, encouraging "token" promotions of unqualified blacks to prestigious positions at the expense of qualified whites (Bond 2000).

Outlooks on the availability of quality schooling for children, upkeep of public amenities, and healthcare were not dramatic when compared to concern for safety and economic wellbeing. Dissatisfaction with the maintenance of public amenities was high at 69% while dissatisfaction with availability of quality schooling was 28% and dissatisfaction with healthcare registered the lowest score of all survey categories at 21.5%. However, while disenchantment with public amenities remained stable (future dissatisfaction actually decreasing 0.5%) assessments of future trends in healthcare and education were the most negative. Fifty per cent of participants expected their children's access to quality education to decline in the next five years and 51.5% expected the quality of health care to deteriorate within five years. While current circumstances were acceptable for most survey participants, over half expected key social institutions to be unacceptable within the next five years.

Figure 2.2 Perceptions of Preferred Destination Compared to South Africa



(Derived from Dodson 2002: 18)

When compared to perceptions of a preferred country of destination, it is not difficult to understand why so many South African professionals have considered migration (Figure 2.2). According to Dodson (2002) it is the social factors that most heavily influence the decision to emigrate. Møller (1998) demonstrates that key quality of life indicators of middle and upper income earners plummeted post-apartheid. For example, 80% of respondents felt that their preferred country of destination was safer than South Africa. Dodson (2002) shows that responses indicating an expected

improvement in quality of life after migration are all equal to, or higher than, the percentage of responses expecting these same indicators to decline in South Africa. Improved quality of education in the preferred destination was approximately equal to the expected decline of education in South Africa. Expectations of improved personal safety were 10% higher for the preferred destination than those expecting future deterioration in safety in South Africa. On all of these major issues South Africa was considered inferior to other nations. The choice to migrate is often a matter of 'wait and see' and those who migrated were tired of waiting when they could improve their situation (especially their safety and their children's future) through migration.[23]

Medical Crisis.

The quality of medical services is an especially relevant push factor when considering skilled migration. Past research has demonstrated that the greatest degree of pessimism is associated with health care. Expectations of future medical degradation were more than double the score of present dissatisfaction (21.5% present dissatisfaction but 51.5% expected future dissatisfaction) (Dodson 2002).

In keeping with apartheid ideology, the South African health system had consisted of two separate entities. In 1948 the National Party came to power and imposed apartheid, or the separation of the 'races.' All hospital facilities were segregated and facilities were generally divided into two sections, one for whites, and the other for

[23] Crapanzano (1986) develops this theme of 'waiting' as the underlying anxiety during apartheid of being a tiny white minority ruling a huge black majority in apartheid South Africa, knowing that time is running out but unable to act or react: "Waiting for something, anything, to happen" (Crapanzano 1986: 42).

Coloureds, Asians/Indians, and Blacks.[24] The government focused primarily on meeting the needs of the white population and provided vastly greater resources in terms of equipment, medicine, space, and training (South African Department of Health [DoH] 2002). The system that served whites was largely urban and focused on advanced curative treatments in acute care hospitals.[25] Though initially a public enterprise, this system was almost entirely private by the 1960s. Services were paid through insurance or through non-profit medical schemes that were subsidized by the South African government. Though servicing only 21% of the national population, this system accounted for 61% of total health expenditures by 1995 (Wadee, Gilson, Thiede *et al.* 2003; Bloom and McIntyre 1998).

Racism also held sway in the medical training system. South African medical students continued to receive exceptional training within the public system, but only 3% of graduates between 1968 and 1977 were black,[26] a tiny minority (Williams 2000: 1167). Further, the bulk of medical graduates promptly entered the private sector where they could earn significantly more than in the public sector. In essence the public sector was subsidizing private healthcare for the cost of training new doctors and receiving very little in return. In 1990 only 38 % of general practitioners remained in a public sector that provided care to 78% of the population (approximately 30 million people) (DoH 2002).

The remaining public system was poorly funded and inequitable. The least funded province, Mpulamanga (with the highest population of black Africans) spent 3.6

[24] These were the four categories under apartheid. The most privileged racial class was the white class. Japanese were "honorary whites" and were given all the rights afforded to this racial class. Asians/Indian refers generally to the descendants of Chinese or Indian indentured labourers. Coloureds were of mixed descent, and Blacks were the largest and poorest racial group (see Crapanzano 1985: xiv-xv).
[25] South African physicians performed the world's first heart transplant in Groote Schuur Hospital in Cape Town in 1967.
[26] This amounted to seven graduates in 1966, 11 in 1967, and 10 graduates in 1968 (Hoffenberg, 1997).

times less funding on services than the province with the highest funding (Bloom and McIntyre 1998). Moreover, the system was understaffed and horridly inefficient. Multiple levels of administration (national, provincial, 'homeland', and a host of local governments) duplicated or overlapped services and were poorly coordinated. Like the private system, emphasis was placed on acute care which did not meet the needs of poor, largely rural Africans. Only 11% of total funding was allotted to primary care programs, compared to 76% spent on acute care hospitals (DoH 2002; McIntyre, Bloom, Doherty *et al.* 1995).

Disparities in health services had the concrete effect of drastically increased infant mortality for the (black) poor. In 1998, Africans had an infant mortality rate of 47 per 1000 live births. The infant mortality rate for Coloureds was 18.8 in 1998 but was only 11.4 per 1 000 for whites (Day and Gray 2001).[27] These rates increased for all groups except whites by 2002 (67 deaths per 1 000 for Africans, 24 per 1 000 for Coloureds, 11 per 1 000 among Indian/Asian). White infant mortality, while at 11.4 per 1 000 in 1998 dropped to 7 per 1 000 in 2002 (Ntuli and Day 2004). Life expectancy was also significantly lower for non-whites (55.5 years for Africans compared to 65.5 for Whites in 1996) (Day and Gray 2001) and the most common causes of death were injuries and infectious diseases. The notification rate for TB was 35 times higher for Coloureds than for Whites.[28] Measles was another major cause of disability and death though 63% of children had been immunized by 1990 (this did not include former homelands) (McIntyre

[27] There was no data available for Indians/Asians in 1998.

[28] Disease carriers are notified if they have been tested for, and found to carry the disease. As many South Africans do not get tested, it is estimated that between one third and one half of all cases of TB were unreported (McIntyre *et al.* 1995).

et al. 1995). All of these conditions were aggravated by conditions of endemic poverty and increasingly by HIV/AIDS (to be discussed in greater depth in the next section).

Health reforms from the 1970s until 1989 compelled medical schemes to apply "community rates" and guarantee minimum coverage and minimum benefits.[29] After 1989 regulations were relaxed and for-profit medical insurers and medical schemes were allowed to enter the health sector. Patient coverage decreased and insurers and schemes were allowed to risk-rate,[30] refuse coverage to more applicants and increase membership fees (Figure 2.3). In 1994 minimum benefit requirements and guaranteed payments for claims were removed altogether (DoH 2002). By 1999 fees had skyrocketed[31] and only the healthy, young, and employed could afford insurance (DoH 2002). All others were forced to rely on poorer medical schemes, which offered fewer benefits, and the anaemic public system. By this time, government support of the public system, as a percentage of the GDP, had almost doubled but failed to stave off the decline in services, staff, and facilities (Wadee *et al.* 2003).

The issue of billing for medical services was consistently a point of contention in the private system. For their part, private physicians and other professionals (such as

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[29] These schemes are properly known as Medical Savings Accounts (MSAs). Members pay a monthly sum into their account, which goes into a general pool. When scheme members require medical attention the cost of their treatment is taken from the general pool. Membership is often a condition of employment, where both employee and employer pay into the scheme. Employers are then given a tax deduction for approximately two thirds of their contributions. Community rates are a flat rate charged to everyone of a given community regardless of age or condition, as opposed to discretionary rates which vary according to age, conditions, gender, income and other factors. Depending on the scheme there may be a maximum out-payment per year or fixed payments per procedure, premiums for each claim, and limitations on eligibility (McIntyre *et al.* 1995; see DoH 2002 for regulations after 1994).

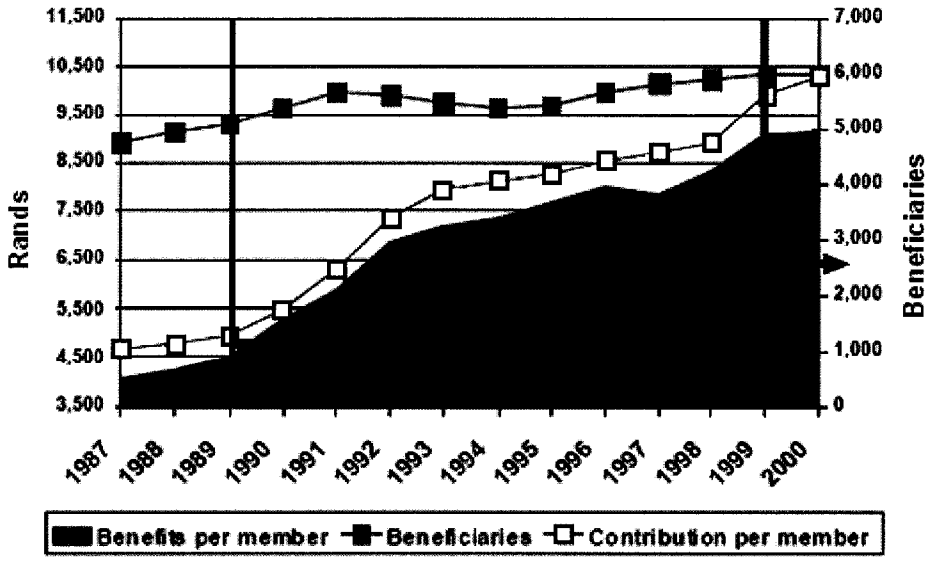
[30] Risk rating is the practice of charging different premiums to different scheme members based on certain "risk factors" such as age, pre-existing medical conditions, type of employment, number of dependants, etc.

[31] Average membership fees more than doubled from 7% of the average salary in 1982 to 15% of the average salary in 1992 (McIntyre *et al.* 1995). GSA (2002) contends that a large part of fee hikes was the result of various questionable practices such as insurance companies using medical schemes as fronts and then taking members' contributions as profits instead of contributions to the general pool. Very little of the fee hike was the result of rising medical costs.

physiotherapists, dentists, and pharmacists), unless employed by the medical schemes, negotiated the cost of services with the schemes. In 1960 physicians billed the patient a set fee for their services. The patient sent the bill to their medical scheme and the physician was paid by the scheme if he or she was "contracted-in" to the fee schedule. Health professionals could also "contract-out" and bill the patient directly, or work in the public system. Contracting-out was also used by physicians to maintain some control over fee levels and methods of payment. Between 1960 and 1978, 3 941 of 14 000 physicians had contracted out to protest low fees and tardy payment from insurance or medical schemes (DoH 2002).

Several amendments changed the method of setting fees to reduce tension between medical schemes and service providers but in 1984 the option of contracting-"in" or "out" was effectively removed. Fees were set after the Representative Association of Medical Schemes consulted with representatives of service providers. A scheme was required to pay a provider directly for a service, provided that the bill did not exceed the agreed-upon fee and the medical scheme offered that benefit (DoH 2002). Finally in 1994, guaranteed minimum benefits were removed as was guaranteed payment for claims. This was meant to reduce "supply induced demand" (unnecessary referrals, medical procedures, and hospital stays for which the service provider is paid) and so reduce the cost of health care (McIntyre *et al.* 1995). However medical costs continued to rise and fewer and fewer South Africans could afford or were eligible for coverage. The strain on public health resources increased to the point where community rates were reinstated in 1999 (See Figure 2.3).

Figure 2.3 Medical Scheme Real Cost per Beneficiary and Benefit Trends 1993-2000



(Source: DoH 2002: 32)

In essence health coverage in 1999 returned to where it had begun almost two decades earlier, all members of a given scheme paying rates differentiated only by family size and receiving the same benefits. Only now rates had more than doubled in real terms, and while the amount of benefits paid per claim had increased, actual benefits had declined because of the inflation of health care costs. Additionally health service providers were no longer guaranteed payment for any service under any scheme if the scheme determined that it was not necessary. Finally, the proportion of the population with medical insurance decreased slightly to 16.2% in 2000 and the number of poor without any medical coverage had increased to nearly 81% (36.3 million in the total population of 45 million) (Health Systems Trust, n.d.).

HIV/AIDS.

One of the most discouraging factors discussed by participating South African physicians was the spread of HIV/AIDS. HIV/AIDS entered the South African consciousness in approximately 1982 when the first two cases were reported (Jochelson, Mothibeli, and Leger 1991). At the time it was largely confined to homosexual men and migrant labourers. In 1986, 2.6 million labourers were registered as migrants from areas within South Africa and a further 440,000 labourers originated from outside the country, with Lesotho, Mozambique, and Malawi accounting for nearly half of the migrants (Jochelson *et al.* 1991). Initially the public believed migrants were bringing the virus to South Africa from their homelands. It was only later that they were found to be more susceptible to the disease because of the migrant lifestyle (Brummer, 2002). Proliferation of the virus was aided by high levels of poverty, a high prevalence of sexually transmitted diseases, especially genital ulcers, and the presence of tuberculosis, malaria, and cholera. In such a setting, victims' immune responses were hindered by malnutrition and other diseases.

Some estimates placed the number of AIDS-related deaths at 40% of all mortalities in 2002 and others expect this number to reach 55% of total reported deaths in 2005 (Doherty and Calvin 2004; HST n.d.). The South African Department of Health estimates that 27.9% of adult South Africans were already infected in 2003 (DoH 2003). In terms of cost, treating AIDS patients could consume up to 75% of total health care expenditure by 2010 using current treatment methods (McIntyre *et al.* 1995). Without a large increase in health expenditure this would effectively bankrupt the health system.

In terms of economic reforms the AIDS pandemic poses a huge problem. As the number of infected and dying South Africans increases, so too does the drain on public resources. Skilled persons die in their most economically productive years,[32] depriving the country of the initial investment in their education, their labour, and the cost of their care. Economic output is further reduced by increased absenteeism when relatives exit the work force to care for the ill. The downward spiral is exacerbated among the (mostly black) poor when former caregivers exhaust their own resources caring for the ill (Whiteside 2001). Many turn to prostitution and other illicit activities to subsist and contract HIV themselves (Equinet 2003; Poku 2002). Growing numbers of AIDS victims contribute to the growing cost of healthcare and the increasing difficulty in paying for it.

At the same time, services that can prevent the spread of HIV/AIDS are under strain. The Growth Employment and Redistribution (GEAR) policy instituted by the African National Congress in 1996, essentially a neo-liberal structural adjustment program, intensifies factors that facilitate the spread of disease. It curtails social spending on health and welfare programs, reduces the amount of money available for community development, and often reduces the capacity of existing programs. GEAR also encourages devaluing of currency to stimulate exports (Schneider 2003). For the poor this raises the prices of staples out of their grasp, and for AIDS victims in particular, the cost of antiretroviral drugs becomes an insurmountable barrier to treatment that is compounded by a government that has shown little inclination to support pharmaceutical interventions and has questioned the diagnosis of HIV/AIDS itself (see Martinson,

[32] The age group that experienced the most dramatic increase in mortality due to AIDS is the 26-40 year age grouping which is also the most economically productive (Whiteside 2001: 77)

Radebe, Mntambo *et al.* 2002; Bond 2004; 2000). As a whole, HIV/AIDS and economic restructuring created a self-perpetuating cycle of disease and decline.

That's It, I'm Outta Here

The onset of HIV/AIDS and the post-apartheid upheaval made the delivery of medical services increasingly difficult. Physicians experienced a decline in their standard of living as medical schemes were deregulated. Changes to medical training programs increased disaffection with the medical system and the South African government in general. HIV/AIDS increased the danger of their work significantly. The situation did not seem likely to improve and many physicians began to explore options abroad.

In the past, mostly white physicians had serviced affluent predominantly white communities in urban centres. Reforms in the administration of medical schemes reduced the ranks of insured patients and the certainty of payment for services provided. If a physician deemed a procedure necessary but the scheme did not, the physician was left with three options: bill patients directly, take the scheme to court, or 'eat' the loss. One physician living in Saskatchewan noted that it was not uncommon for a practice to write off substantial amounts owed them as uncollectible: "I was earning the same in South Africa that I do now in Canada, but I was actually being *paid* only one third of my earnings. The medical schemes have gotten very good at delaying, reducing, and refusing payment." Medical schemes could afford lengthy litigation while physicians could not.

In addition to reduced numbers of insured clients, private-practice physicians (all but two physicians in this study were members of private practices in South Africa) were also faced with growing numbers of patients with minimal or "poor" medical scheme

coverage. The ballooning cost of scheme membership in the early 1990s forced many South Africans to join schemes that offered only limited coverage. Several practicing physicians described their situation in the following way:

Physician 1: You have times when patients that are your patients come to see you and their medical aid is done so they don't have money to pay you. You're faced with a dilemma. Should you see them? Should you send them away? You know you're not going to get paid, or if you do get paid it might take two years, seriously two years. You can't do that for everyone. You have to pay your staff, your bills, clothe your kids...

Physician 2: You might examine a patient and they need an x-ray or blood work but there's no money for that. They only had enough money to pay you. So now you either don't do the tests and make do with what you know or you send them in for the tests and they have to pay it off somehow. You're always caught in the middle. You try to limit the tests and x-rays to save money but in the process you lose some of your diagnostic ability. Too often you end up winging it.

The alternative to private practice was to work in the public system. All physicians that participated in this research shared the same opinion: the public system was a shambles. Resources were woefully inadequate, facilities were swamped, and staff were overwhelmed.

Physician 3: All day the emergency is full of people. So you would take 100 people and ask who has a cough. For the ones that put up their hands you would prescribe antibiotic cough medicine. Then you would ask who has stomach pains and you would give them ulcer medication. Who has an earache? You would give them antibiotics, and on and on. It was never ending.

Physician 2: You can't do proper medicine in the public system. Get them in, get them out and bring in the next group. It's just numbers. You never treat the patient. You just dispense drugs.

Physician 4: Three quarters of the cost of health care is self inflicted [due to the violence in South Africa]. You spend your time in theatre sewing together intestines, putting lungs together, and putting tubes into chests. As a doctor you're supposed to be preventing disease but that falls by

the wayside because you spend most of your time patching people together.

Job satisfaction was almost non-existent. Physicians spent the bulk of their time treating as many patients as possible as fast as they could with little hope of respite.

Work in the public sector was further exacerbated by labour shortages and HIV/AIDS. Though South Africa trains large numbers of nurses, physicians, and other medical specialists there are shortages in all positions in the public sector (Reid 2002). Workloads increased with no hope of respite. Doctors treated patients knowing that they would continue to return in worse condition than before until they died (Joint Learning Initiative 2004). The situation becomes even more grim with the resource shortages in the public health system.

Physician 1: If someone came to the hospital with AIDS we were not allowed to treat them. We sent them home to die. When an AIDS patient was admitted it was because nobody knew that they had AIDS at the time.

Physician 2: In public hospital wards at least 70% of the patients have AIDS...sometimes 100% of patients are AIDS patients in the more remote areas.

Despite these drastic measures the prevalence of HIV/AIDS was estimated by some physicians to be in excess of 70% of hospital patients.[33]

Physician 4: If you start to think that every third person that you operate on has AIDS you really start to worry about yourself.

The high prevalence of HIV/AIDS patients placed additional stress on hospital staff due to the risk of infection (Bach 2003). In Botswana for example five per cent of health workers will have AIDS by 2005 (Equinet 2003). In South Africa 15.7% of health

[33] This figure seems high when compared to the finding of Doherty and Calvin (2004) who place the occurrence of HIV/AIDS at 46.2% of patients in public hospitals and 36.6% of private hospital patients (Doherty and Calvin 2004: 208).

workers are estimated to have contracted the virus in 2004, primarily through heterosexual intercourse (Doherty and Calvin 2004). Though a government decision in 2003 to provide antiretroviral therapy through the public system may moderate the impact of HIV/AIDS somewhat, the full impact of these infection rates will only be felt in five to seven years when infected workers develop the illness (Doherty and Calvin 2004).

As with many other nations South Africa has recruited abroad to fill vacant positions (Liese, Blanchet, and Dussault 2003; SAPA 2004 n.pag.) In 1998 at least 27% of all practicing physicians in South Africa and Botswana were non-citizens (Dovlo 2003). These physicians were overwhelmingly employed in rural posts shunned by South African physicians.[34] However these foreign recruits do not come close to meeting the need. In 2003, 31% or 52 574 positions for health professionals in South Africa were vacant (Padarath, Ntuli, and Berthiaume 2004). While this is a dismal state of affairs it is a substantial improvement from a vacancy rate of 57% in 2001.[35] Additionally the national vacancy rate hides poignant regional inequalities. The provinces of Limpopo and the Western Cape have vacancy rates of approximately 13% while 67% of all positions in Mpulamanga remained unoccupied in 2003 (Padarath, Ntuli and Berthiaume 2004).

The actual number of medical professionals emigrating from South Africa is difficult to determine. Statistics South Africa bases emigration statistics solely on exit forms filled out voluntarily by emigrants and only places these forms in international

[34] Approximately 78% of practicing rural physicians in South Africa came from abroad (Liese, Blanchet, and Dussault 2003).
[35] The authors note, however, that at least some of the reduction in the number of vacant positions is due to the removal of "non-functioning posts and clean[ing] up the data" (Padarath, Ntuli and Berthiaume 2004: 304).

airports. Since many who emigrate may be intending to leave temporarily or do not wish to 'burn any bridges' should they desire to return, and others take overland routes out of the country, the numbers have been substantially underreported. To find a more reliable data source, Brown, Kaplan, and Meyer (2002) used the data available from five major recipient nations[36] to calculate the total number of South African professionals living abroad. They estimated that between 1989 and 1997 approximately 41 496 skilled South Africans settled in these five countries, while Statistics South Africa reported a total of 11 255 emigrants leaving for these same nations. In essence, Statistics South Africa has a capture rate of only 27% of total skilled emigrants.

Pertaining specifically to emigrant physicians, Hagopian, Thompson, Fordyce *et al.* (2004: n. pag) suggest that in 2002 at least 14% of South African-trained physicians were residing in Canada and the United States alone. In absolute numbers 1 943 South Africans were practicing medicine in the United States and 1 845 in Canada while 23 844 remained in South Africa. The study does not address the South African physicians in the United Kingdom specifically, but does note that at least 3 451 doctors from Southern Africa[37] were practicing in the UK in 2002, 5 334 in the United States, and 2 151 in Canada. In total 10 936 Southern African physicians, or 12% of all physicians trained in Southern Africa, are working in these three countries. This does not include Australia and New Zealand, though the immigrant records system in New Zealand does report that 26% of skilled South African immigrants (approximately 836 immigrants from 1989 to 1997)[38] were in the health field (Brown, Kaplan, and Meyer 2002).

[36] The countries included in their study were the United Kingdom, New Zealand, Australia, the United States of America, and Canada.
[37] A term that generally refers to the southern part of the African continent.
[38] Based on the estimation methods used in the same study (Brown, Kaplan, and Meyer 2002).

To cope with the shortage of physicians, the government of South Africa focused on medical students to help reduce shortages. In 1998 a community service (CS) requirement was added to the medical curriculum. Upon completion of their formal training, students are now required to perform an additional year of CS. Placements were spread throughout South Africa, though most were in urban or semi-urban facilities.[39]

CS candidates are placed through a three-round process. They are initially asked to list five preferred locations, and approximately 85% of the placements are filled through this round. The remaining 15% indicate their next five preferred postings, and any who are not placed in the second round are assigned to the remaining open posts. However not all students register for CS or report once assigned. Reid (2002) comments that 6-8% of candidates do not register for their CS or fail to report to their CS posting. Needless to say, those posts that remain vacant are mostly in rural hospitals with the fewest resources and supervisors. The majority of "no-shows" chose to travel overseas instead of working in rural hospitals (Reid 2002).

Of the physicians in this study, only two completed their medical training after the institution of CS. One was assigned a post in a rural hospital while the other was placed in an urban hospital. Though the first physician had previously considered emigrating, being placed in a rural hospital in what was perceived to be a very dangerous community solidified the physician's resolve to leave South Africa immediately after completion of the medical program.

> **Physician 5**: I put in my five choices and I didn't get any, so I reapplied for what was left. I reapplied and I didn't get that, and then I was *issued* a placement in the Eastern Cape. I would probably be the only white person in the

[39] Only 25% of placements were in hospitals classified as rural (Reid 2002).

> whole city, and when I thought about safety? There was no way I was going.
>
> ...You can't just drive home from work in South Africa. You phone ahead before you leave and then you sneak through the night as fast as you can. You don't stop for traffic lights or anything or you're dead. They put boulders on the roads to stop you so they can rob you and steal your car, and if you're a woman?... That was the big push for us. We decided to leave as soon as I was registered.

This physician is not alone. According to Reid (2002) 20-45% of CS physicians planned to work abroad after their community service was complete.

A multitude of factors conspired to make the practice of medicine in South Africa unpalatable for many South African trained doctors. Perceptions of growing white and Afrikaner marginalization in the new South African "Rainbow Nation" (Moodley and Adam 2000: 51) and a lost sense of security in the upper classes made the idea of migration attractive to many skilled South Africans. Physicians became increasingly disenchanted by growing violence and fear of violence, the decline of the medical system, and the ravages of an AIDS epidemic. For many it was too much. As one South African physician summarized, "There came a point where it was a matter of our own survival. Nothing was getting better, and nothing has gotten better since. We had to leave for our own sake and for our kids. What future did they have?"

The general failure of post-apartheid reforms led to disillusionment and widespread poverty. Economic development did stimulate growth but at the expense of unskilled labour, and the vast majority of South Africans experienced a decrease, slight or drastic, in their standard of living. Social dysfunction, as evidenced through crime and violence, exacerbated post-apartheid social transformation and increased the need for spending on public services while the GEAR policy demanded the reverse. Specifically,

the strain on the medical system increased immensely and health professionals began to look for a way to avoid a cataclysm that seemed to be fast approaching. Coercive attempts to compensate for public-sector staffing shortages only increased the drive for physicians to emigrate. They (and many other health professionals) looked abroad and found that their skills were highly valued in numerous (relatively speaking) safe, developed, affluent nations.

Chapter 3-Into Saskatchewan

The Canadian healthcare system is a complex blend of technology, personnel, institutions and expectations. It is both publicly funded and open-ended, meaning that a patient is given access, free of charge, to all hospital and medical care that is 'medically necessary.'[40] However patient demands are not static: "[d]emand for medical services depends on factors such as the size of the population, prevalence of disease and public expectations. The latter two, in turn, are influenced by factors such as the age and gender of the population, education level and socioeconomic status" (Chan 2002: 4). The resources required to administer all medically necessary services change constantly as political agendas, funding, patient needs and expectations change (Marchal and Kegels 2003). Further complicating health care delivery is increased patient pressures for specific services and procedures, blurring the line between needed and demanded services (Canadian Labour and Business Centre [CLBC] 2003). There are also interprovincial variations in the interpretation of medical necessity. For example, chiropractic care is a provincially funded medical necessity in Saskatchewan but not in most other provinces (personal communication with a rural physician). This makes the provision of healthcare difficult as planners attempt to predict future needs, assuage public concerns, and maintain a reasonable cost limit.

Many Western nations are experiencing a troubling demographic shift. Birth rates are dropping, often below the level needed to sustain the population (the so-called

[40] The term "medically necessary" is used, though not defined in the Canada Health Act. In practice what constitutes a medical necessity is left to the discretion of the physician within the limitations of what the province will cover under the public insurance plan. These 'listed services' also differ between provinces (CHSRF 2002: 3).

'replacement threshold'), and 'baby boomers' are aging.[41] This has resulted in a population where the number of persons nearing retirement (age 65) is growing faster than the number of economically active adults.[42] Work force growth is beginning to stagnate and the demand for public services is increasing (Halliwell, Shamian, and Shearer 2004). This aging trend is most keenly felt in the health sector since almost 16% of the current physician workforce is eligible for retirement (over the age of 60) (Hawley 2004). Aging physicians (and other health care workers) are generally less productive than younger (i.e., mid 30s) male physicians. They tend to work reduced hours and/or at a lower intensity.[43] Further, female physicians now form one half of the physician stock and also see fewer patients, especially during child rearing years (Canadian Policy Research Network 2002; CLBC 2003; Zurn, Dal Poz, Stilwell *et al.* 2002). Since the use of medical services increases with age, rising dramatically after age 65,[44] the need for health services is increasing and a shrinking physician work force is providing more services to each patient with the net result of a reduction in the overall number of patients served.

The supply of physicians is equally difficult to manage. Policy change, economic pressures, and changes in education programs have, in part, caused large oscillations in the number of physicians graduating from Canadian medical schools. The number of

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[41] Hogan and Hogan (2000) note that the oldest 'baby boomers' will begin retiring in 2011, so while there is talk of an 'aging crisis' in Western nations it is not precisely the present that is being discussed but the very near future.

[42] Fourteen per cent of the Canadian population will be senior citizens (65 or older) by 2010 and in the years following the percentage of seniors will increase rapidly (CLBC 2003: 27).

[43] There is also a contrary trend for new physicians to work fewer hours than their older counterparts did when they were young. This is in part a result of dual career households, sharing childcare more equally between spouses, and different expectations for quality of life (personal communication with a rural physician).

[44] The health expenditure for persons 65 years of age or older is three times the amount spent on all other groups combined (CFHC 2002: 22).

doctors needed to provide services to a growing population has continually increased but the supply of Canadian graduates has, at various times exceeded or fallen short of national demand, to say nothing of chronic understaffing in rural areas. Federal and provincial governments have looked to international medical graduates to ensure the continued operation of Canadian healthcare. They have become an integral safety valve that ensures a ready supply of qualified physicians is available to compensate for domestic shortfalls.

Supply and Demand

Since the creation of the Canadian Medicare program there has been a constant struggle to balance the 'supply' of services with the 'demand.' In an open-ended health system, such as the one in Canada, there is a phenomenon known as 'supply-induced demand' where the utilization of health services grows as physician numbers increase (Barer, Lomas, and Sanmartin 1996; Evans 1976; Zurn *et al.* 2002). This invariably translates into ever-rising costs which are passed on to the insurers, who in this case, are the provincial and federal governments. Medicare is funded through the tax base, meaning that governments constantly find themselves balancing healthcare costs against other needs (e.g., education, public works) with limited revenues. It was in the recession(s) of the late 1970s and 1980s that both levels of government ended the unsustainable growth of health care. Major reviews were undertaken (and many more reviews have been conducted since) to find savings within the system. By 1991 there were spending cuts to acute care hospitals (some cuts began in the late 1980s). Health facilities received their yearly operating budgets as lump sums and a cap was placed on

physician expenditure (Barer and Evans 2001). In both instances the care provider was responsible for any additional expenses that exceeded the budget.[45] These measures increased the predictability of costs for both levels of government and placed strong incentives within the system to reduce the growth of spending.

One of the primary drivers of the cost increases was the growing number of practicing physicians. The medical system is unique in that the regular laws of supply and demand do not apply, nor do population health priorities (Evans 1976; CPRN 2002). Between the 1960s and 1980s it was commonly believed that there was a shortage of physicians in Canada. Governments acted to remedy the problem and the number of physicians grew 3.7% per year, more than double the national population growth rate of 1.5% (ACMC 2001). Medical training capacity was doubled (See Figure 3.1) and the physician to population ratio[46] rose from 1.3 per 1 000 in 1964 to 1.9 per 1 000 in 1981(Evans 1976; Grant and Oertel 1997).[47] As the number of physicians increased, so did health spending because of supply-induced demand. More physicians provided services to the same (or marginally larger) patient population. Patient loads shrank with a corresponding reduction in income. Doctors negotiated higher fees for their services to regain lost income. Since physicians also had more time they were able to increase appointments and perform more services for their remaining patients. The result was more physicians helping fewer patients (albeit helping them more often) at greater cost to the taxpayer.

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[45] Barer and Evans (2001) note that no province imposed a complete cap on cost overruns and usually had some method of sharing cost overruns with the service providers.

[46] This ratio is usually reported as number of physicians per thousand or per 100 000. Though it is a gross oversimplification of the overall size of the healthcare workforce it is still used as one of the primary indicators of the size and adequacy of the healthcare system in a given region (Chan 2002).

[47] The actual number of physicians peaked in the 1993 at 37 612 active physicians (Chan 2002).

Most physicians practicing in Canada (73% in 2001) operate on a fee-for-service basis (Commission on the Future of Health Care in Canada [CFHC] 2002). Physicians are private contractors selling services to the province in private-practice clinics or not-for-profit facilities (e.g., hospitals, clinics, and other centres that operated under the supervision of a board of trustees). They bill the province for each interaction with a patient and are paid according to a prearranged fee schedule. In this flexible framework a physician's desire to maintain a specific income and lifestyle can easily influence the way he or she directs his or her practice (hence supply-induced demand) (Zurn *et al.* 2002). Consultations are generally remunerated at a fixed rate per interaction not on time spent with each patient. Physicians who participated in this project placed the desirable number of patient interactions at approximately 30-35 per day (this averaged out to 12-15 minutes per patient). This allowed them to maintain a "decent" income while spending enough time with each patient to provide proper treatment.[48]

However the system in this form is easily manipulated for maximum financial gain. Common methods are maintaining heavy patient loads, reducing the scope of services to those that garner higher fees (e.g., emergency medicine), pre-selecting patients for those that need less time in consultation or repeat consultations, and focusing on treatment of illness instead of prevention (Barer and Evans 2001; Chan and Barer 2000; CFHC 2002). This has the added effect of increasing the number of physicians needed to provide services as additional physicians are needed to care for the less desirable patients in the coverage area. In Saskatchewan, some respondents mentioned

[48] Several physicians mentioned that proper treatment entailed treating the *patient* as opposed to treating the *symptoms*. Every interaction with a patient was divided between visiting with the patient (i.e., chatting about children, local events, or the weekend at the lake) and discussing the specific reasons for that particular appointment with the doctor.

one or two physicians (who no longer lived in the community) broke up consultations so that a patient was seen several times for a few minutes instead of once for a long consultation. In other instances they insisted on officially admitting patients to the emergency ward for minor injuries because of the higher fees allowed for treatment after regular hospital hours. Even completely ethical physicians can utilize the health system in a less than frugal way as they "do everything possible" for their patients (Evans 1976: 152). The possibility of lawsuits is a final (and strong) incentive for many physicians to order numerous tests for their patients so that, should the unfortunate happen, they are able to prove that they used every available means at their disposal to treat the patient.[49]

Global fee limits ensured that the total expenditure of all physicians would not rise above the budgeted amount because all fees were paid out of a common pool.[50] The fee budget was set provincially and implemented in the form of billing thresholds with "claw-back" clauses to recoup medical costs incurred above the threshold. Claw-back methods varied from province to province. Some recovered overpayments from one year by reducing fees for the next year while others demanded lump sum repayments at the end of each year (Barer and Evans 2001; Barer, Lomas, and Sanmartin 1996). High volume physicians (who would have high billing totals) were subject to threshold reductions and penalties for exceeding the threshold (Chan 2002). The ensuing 'zero sum' situation would also encourage self regulation among physicians since the high income of one doctor was at the expense of another.

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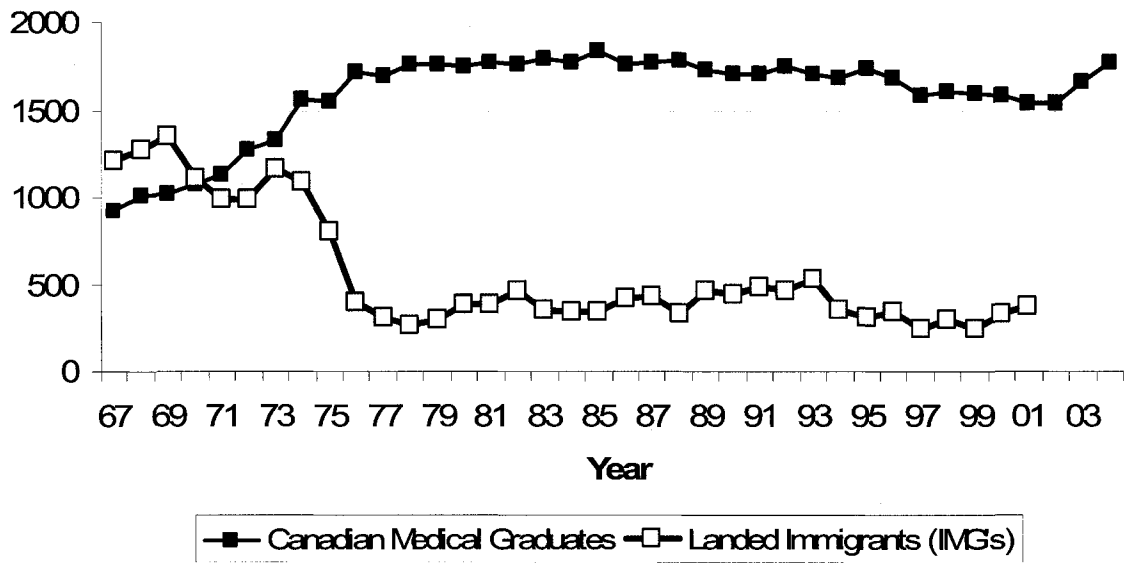
[49] Personal correspondence with a rural physician outside the field communities.

[50] It should also be noted that the 'height' of the budget ceiling is the ultimate determinant of cost reduction but is very difficult to set. A high ceiling will allow a predictability of cost but not necessarily any cost reduction or efficiency gains because it does not create an incentive for caregivers to provide only necessary services. Conversely a low ceiling may discourage effective care delivery. For further discussion of different types of income caps and their effects, see Barer, Lomas, and Sanmartin 1996.

There were several side effects from the fee caps. Most notably (and predictably) was a desire of physicians to limit the number of new doctors setting up practice. Disincentives were implemented to deter new physicians such as reducing fees paid to new graduates or IMGs, restricting access to billing numbers for physicians immigrating from another province, and other measures that varied from province to province.[51] Whereas physicians and governments had once believed there was a physician shortage, the opposing view (a physician surplus) began to take hold in British Columbia, and due to intensive lobbying by professional and provincial groups spread throughout the country. In 1993, the number of medical students was reduced by 10% to 1577 students to eliminate the surplus of doctors in Canada.[52]

Figure 3.1 Landed Immigrants Indicating Medicine as Their Intended Occupation (IMGs) and Graduates of Canadian Medical Schools



Source: Derived from Tyrrell and Dauphinee 1999: 6; and medical graduates after 1997, CMA 2004; CIHI 2001.

[51] See Barer and Evans (2001) for more discussion of disincentives. Many of these restrictions have since been removed because of legal challenges or to prevent challenges based on the Charter of Rights, specifically the right to freedom of movement (Barer and Evans 2001).

[52] The effects of this reduction were felt from 1997 onwards when the reduced cohort graduated (see Figure 3.1).

International Medical Graduates (IMGs)

One significant sector of the medical workforce that has only briefly been mentioned thus far is the graduates of foreign medical schools.[53] In the 1960s the number of IMGs (mostly from Commonwealth nations and Ireland) granted medical licenses was greater than the number of Canadian medical graduates. The large numbers of immigrating physicians were the greatest source of growth in the expanding physician pool. Until the early 1970s at least one quarter of new physicians each year were internationally trained (Association of International Physicians and Surgeons of Ontario 2002: 3). During this time influential groups continued to pressure the government to adopt a policy of national self-sufficiency in physician education (Forcier, Simoens, and Giuffrida 2004). The National Committee on Physician Manpower of 1975 reiterated the need for national self sufficiency in physician education[54] and the federal government of the day agreed. The inflow of IMGs was curtailed in 1975 (Chan 2002) and fell by more than two thirds from 1 090 immigrant physicians in 1974 to 261 in 1978 (see Figure 3.1). In 1991 the entrance of IMGs was further reduced by toughening (and enforcing) student visas that allowed foreign medical students to train in Canada and then return to their home country, emphasizing to immigrating doctors that they were not guaranteed work upon arrival,[55] and closing overseas testing facilities (Chan 2003).[56] These actions had

[53] Refer to page 1.
[54] The Hall Commission of 1964 had already recommended the doubling of medical school training which occurred in the 1970s as mentioned earlier.
[55] New IMGs were asked to sign a declaration stating that they were aware that no government institution was responsible for ensuring that they would find employment as physicians upon their entry into Canada (Chan 2003).
[56] This recommendation was made in the Barer and Stoddart (1991) report which made numerous recommendations to reduce overall physician supply not just IMGs (by 1991 common wisdom held that there was an excess of physicians in Canada). The only other recommendations of note that were acted

the desired effect. Practicing IMGs were reduced from 30% of active physicians in the mid 1970s to 23% in 2000 (Dauphinee 2003).

However, this is not to suggest that IMGs no longer play an important role in Canadian medicine. As a group, IMGs are overrepresented in training programs and practice locations (especially rural and remote communities) that are avoided by Canadian medical students (Barer and Stoddart 1999). Though the physician pool increased significantly, rural and remote communities remained short of physicians. It was in these rural posts that many immigrant physicians filled a vital role in local health service delivery. In Saskatchewan specifically IMGs accounted for 53% of rural practicing physicians in 2004 (Saskatchewan Health 2004). Numerous sources suggest that internationally trained physicians are no more likely to live in rural areas than Canadian graduates but their settlement patterns are determined in part by the way they entered Canada (Chan and Barer 2000; Tyrrell and Dauphinee 1999). Immigration regulations were such that accepting posts undesirable to Canadian graduates was the only or most expedient way to practice medicine in Canada.

The Canadian immigration system operates on a point system. Immigration applicants are assessed on a host of traits such as age, education, financial means, and intended occupation and are awarded points in each category.[57] Categories are given different point limits based on immigration goals (such as allotting 25 possible points to the education category and 24 points in the official languages category but only 10 in the

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upon were the reduction in training capacity in Canadian medical schools and greater restriction on the number of IMGs allowed to enter Canada as discussed earlier. Both measures were implemented in 1993 (Barer and Stoddart 1991; Chan 2002; Editorial [CMAJ] 2004).

[57] For a closer examination of the current points system the Citizenship and Immigration Canada [CIC] Website displays the current categories, weighting of points, and "passing score" at www.cic.gchttp://www.cic.gc.ca/english/skilled/qual-1.html.

age category) for an accumulated score out of a possible 100 points. If they are awarded more than 67 points they are eligible to apply for landed status. If their points are below the cut-off (66 or less) they are not able to apply. In 2002 the point system was altered to focus more on skill base and education than employment-specific skills.

The points system was first introduced in 1967 and assessed potential immigrants in nine categories out of a total 100 points. Initially immigrants needed at least 50 points to be accepted into Canada. Most important for this discussion is that the system focused on supplying labour for the Canadian economy through immigration. Professionals in high demand in the Canadian economy were awarded maximum points and those in low demand were awarded few or no points at all. Some changes to the point system were made in 1976 Immigration Act but the overall focus remained on the labour needs of the economy (Knowles 2000: Ch. 6).

Under the Immigration Act of 1976 it was very difficult for IMGs to enter Canada as skilled workers. If they stated "physician" as their occupation they would earn zero points towards their application score. In the weighting system at the time this would almost certainly guarantee that their score did not pass the cut off (since virtually no other category would be given full points either). Many IMGs applied under the refugee or family reunification provisions which were not subject to the points system. These immigrants account for a large number of immigrant physicians living in urban areas, and unfortunately are now many of the IMGs in Canada that are unable to find employment as doctors.[58] (Chan 2002; Task Force on the Licensure of International Medical

[58] This is largely due to the limited spaces for training IMGs who do not meet all the requirements for licensure in Canada and the inflexibility of the system. Essentially, if an IMG does not enter Canada intending to work as a physician there is almost no way to enter the profession after the fact (AIPSO 2002; TLIMG 2004).

Graduates [TLIMG] 2004). IMGs who entered Canada in the 1980s and 1990s and were employed as physicians did so through temporary work visas and temporary licenses.

In Saskatchewan this temporary license is initially a locum license. A locum is a physician who is a graduate of a recognized medical training facility[59] who temporarily fills posts for a physician who has retired, moved away, or needs time off for training or recuperation, or assists a physician for a short period of time. Locum licenses are issued to a qualified physician for a specific placement in a specific community for a specific duration. Several short term locum permits can be issued to a physician (or one permit renewed) to a cumulative maximum of one year.[60] At this point the physician must either write and pass the MCCEE (Medical Council of Canada Evaluating Exam) and qualify for a provisional license or return to his or her country of origin.

Those who also applied for landed status while employed in Canada applied as skilled workers under the points system. As such their chances of acceptance were subject to the goals of legislators and medical workforce planners (see above). Those who applied for landed status after 1998 were allowed to do so under a joint federal and provincial/territorial program known as the Provincial Nominee Program. This program was designed to solve several immigration-related problems that were emerging as Canada's dependence on immigration increased.

[59] These may be located in any one of a number of countries. See the bylaws of The College of Physicians and Surgeons of Saskatchewan for further clarification: http://www.quadrant.net/cpss/labqa.html.
[60] The bylaws of The College of Physicians and Surgeons of Saskatchewan also explain exceptions to this one year maximum such as for teaching or training purposes.

The Provincial Nominee Program

The Provincial Nominee Program is primarily a strategy to match skilled persons to employment outside of large metropolitan areas in a more flexible way than existing legislation allows. Currently the bulk of Canadian immigrants gravitate to three major urban areas. Toronto (44%), Montreal (15%), and Vancouver (14%) cumulatively accounted for 73% of all Canadian immigrants in 2003 (CIC 2003: web page). Through the nominee program skilled immigrants can be settled outside these three cities and utilize their expertise (to the benefit of other regions) throughout the country. The Canadian government devolves some responsibilities for immigration (such as providing settlement services and language training) to the province/territory.[61] Provinces/territories that have signed an agreement are permitted to sponsor selected immigrants with desired skills or professions, and if they pass the necessary federal health and security examinations their nominations are generally accepted.

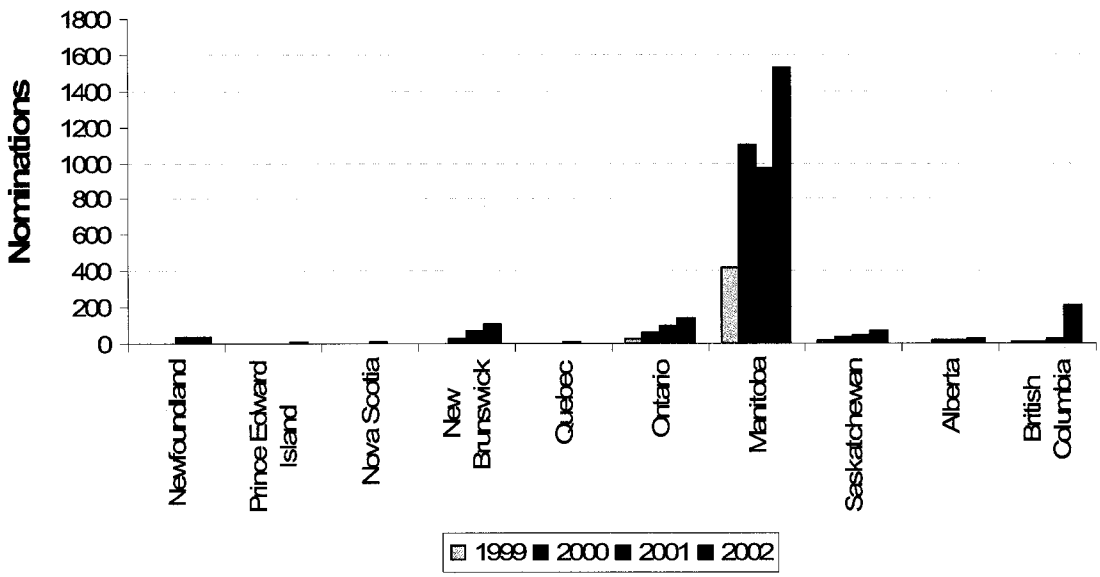
IMGs are allowed directly into the province/territory of sponsorship on temporary work permits, and enter into a contract stating that they will remain employed in a specific region for a specific employer for a specified period (usually three to five years). After this time has elapsed they are granted permanent resident status, and if they have completed the required certification examinations from the Medical Council of Canada (there are two qualifying exams that must be written after the MCCEE), they are also granted Canadian medical licenses (Government Relations and Aboriginal Affairs [GRAA] 2002). This is the manner in which most physicians from Commonwealth

[61] The responsibilities contained in the agreements vary somewhat between provinces/territories. British Columbia and Manitoba are responsible for providing more settlement services than most other provinces. Quebec signed a separate accord with the same goals as the Provincial Nominee Program in 1991 but with sole responsibility for selecting immigrants to import into their province (Papillon 2002).

nations, including those from South Africa, have arrived in their current communities of residence (CIC 1998; Grant 2004).

Provincial governments make nominations based on policy goals with input from employers and public service institutions and may employ a point system similar to the national system for skilled workers (Papillon 2002). To date British Columbia, Alberta, Saskatchewan, Manitoba, Newfoundland and Labrador, New Brunswick, Prince Edward Island, Nova Scotia, and the Yukon have nominee agreements with the Government of Canada (Quebec selects all of its own skilled immigrants under the Canada-Quebec Accord). The largest program remains in Manitoba, accounting for 75% of provincial nominees, or 1527 nominees in 2002 (CIC 2002; Standing Committee on Citizenship and Immigration [SCCI] 2003: 4) (see Figure 3.2).

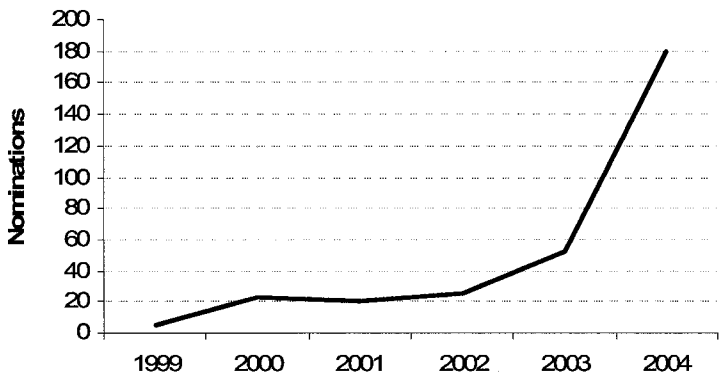
Figure 3.2 Provincial/Territorial Nominees by Province (Principal and Dependants)



Source: CIC Provincial Nominees by Province 2001: n. pag.; Provincial Nominees by Province 2002 webpage.

Saskatchewan first initiated the Saskatchewan Immigrant Nominee Program (SINP) as a two year pilot program in 1998 and five immigrants were nominated. The pilot was limited to 150 nominees over two years and expired in 2001 after which time it was enlarged and extended to 2002.[62] In its current incarnation the SINP expires in 2005 and has four major categories (skilled worker, health professional, business person, and farmer). Since 1998, the number of provincial nominees increased to 73 in 2002 and as of March 2004, 180 nominees had entered Saskatchewan, 63 of whom were physicians (CIC 2001; 2002; GRAA 2004: 20; Saskatchewan Government Relations [SGR] 2005: 17) (see Figure 3.3). However there is also a trend among nominees to leave the province once they have completed their contractual obligations. Benarroch and Grant (2004) note that physicians are a highly mobile group and will exercise their mobility to find more suitable (professional and personal) locations to live and work. IMGs are no exception.

Figure 3.3 SINP Nominations Per Fiscal Year



Source: GRAA 2002

Consequently the government of Saskatchewan, in partnership with the department of health and the SMA also offer a series of incentives to encourage

[62] The procedure for application under the pilot program is outlined at the following website: http://www.quadrant.net/cpss/registration/mlpimg/mlpimg.html (Accessed May 2005).

physicians to relocate to, or maintain practices in rural areas. The first incentive is the nomination itself. The province only nominates a physician after he or she has been working in the province/community for six months. Though it is a recruitment and retention program, the Saskatchewan government does not actively recruit immigrants.[63] That is left to the industry. In this case it is the purview of the Regional Health Authority (RHA) to recruit physicians, though clinics and/or individual physicians were recruiting new physicians themselves.[64]

The second significant incentive is a Rural Practice Establishment Grant funded by the government and distributed by the SMA. This is a grant of $25 000 for physicians who are setting up practice in a rural community. For IMGs the grant is paid out in three instalments beginning with $15 000 after 18 months of rural practice have been completed. The remaining $10 000 is paid out in two equal sums after 27 and 36 months of satisfactory community service (SMA 2003a). For Canadian medical graduates, a grant of the same size ($25 000) is paid to physicians who establish a rural practice for at least 18 months. The sums of $15 000 is paid immediately upon establishing the rural practice in a rural community and $5 000 is given to the physician after nine months and 18 months of practice (SMA 2003b).

The third incentive is loans given in multiples of $10 000. The loans are administered by the health region upon request of the incoming physician and are generally forgiven after a period of time has been spent working in the community.

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[63] Canada became a signatory to the Commonwealth Code of Practice for the International Recruitment of Health Workers in 2003. This code of practice is intended to limit/prevent recruitment of physicians from other Commonwealth nations (most notably poor nations) and calls for compensation to the host country for the loss of physicians that are recruited to another nation. The code can be accessed at the website of the Commonwealth Secretariat: http://www.thecommonwealth.org/Templates/Colour.asp?NodeID=34044

[64] Physicians have always been the most common (and arguably effective) recruiters of other physicians. Easttown and Westtown are located in different health regions which were developing recruitment strategies but were not fully functional at the time of the fieldwork.

Travel expenses, the rental of a home for the first six months of residence, and the use of care are covered by these loans as are the membership fees for numerous professional associations.

Additionally the SMA provides several subsidies and bursaries for re-entry of rural physicians into specialist training. There are funds available for increased medical training, extended leave from a rural practice, and locums who will fill in for physicians that need time away from their practice. A subsidy also helps rural doctors defray the costs of providing services in rural communities other than the one in which they live. [65]

Thus far the success of the Provincial Nominee Program and other retention initiatives seems debatable in that the retention rate of physicians in Saskatchewan is negligible.[66] Grant (2004) explains that, "many immigrant physicians, originally recruited by one province to address a shortage of physician services in remote and rural communities...relocate to large urban centres in another province" (Grant 2004: 2). To counter these tendencies the Saskatchewan government has partnered with health districts and other municipal groups to increase social support programs, career development and credential recognition programs, quality of life assistance, and place a greater emphasis on the promotion of community hospitality (Basran and Zong 1998: GRAA 2002). It has been assumed thus far that these measures, in the right mixture and concentration, are the most practical and plausible means of maintaining skilled immigrants in smaller communities (Cook and Pruegger 2003). The expansion of the SINP and the retention of

[65] A complete list of support, education, and retention programs can be found at: http://www.sma.sk.ca/programs/

[66] Atlantic Canada, Manitoba, Saskatchewan, Northern territories, and Quebec all experience a net out-migration of physicians to Alberta, Ontario, and British Columbia (Benarroch and Grant 2004).

immigrants is key to any future provincial initiatives to boost the workforce and population in general (Lorje 2003; Peykov 2004).

Recruiting in South Africa

Though programs such as the SINP have been created to ease the process of immigration to Canada (for specific types of immigrants) it remains arduous. When a physician in another country accepts a job offer in rural Canada the ensuing immigration process is highly stressful, expensive, and time consuming for both recruited and recruiter. The IMG must navigate the myriad of federal, provincial, and professional regulations in order to practice medicine.[67] There is also a great deal of effort that goes into recruiting physicians to fill rural vacancies as the recruiting party must also meet certain guidelines in order to "import" physicians. The following is a composite recounting of the recruitment and nomination process from four South Africans who have been recruited and nominated as well as two persons involved in recruiting physicians for their community:

> We have a lot of CVs on file from fellows in South Africa who are looking for a job. Maybe they've seen our ad or they heard from a friend or whatever. Some just send CVs to us out of the blue. We go through them and choose the ones that seem best-suited to our practice and which ones are most likely to get the approval of the College.[68] We've been doing this so often I can almost tell you by looking at them which CVs will make it through the College. Once we have a short-list we begin calling them back to see if they're still interested and call their

[67] South African IMGs are given a three year (recently lengthened to a five year) provisional license upon their arrival in Saskatchewan. They are allowed to practice medicine with the understanding that they will write and pass the three Canadian standard medical examinations (which all Canadian graduates must also write and pass) within the allotted time and earn a permanent Canadian license. If they do not pass the exams they must apply to re-write them and are subject to quotas for re-writes. Some physicians who did not pass the exams before their provisional licenses expired had no choice but to return to South Africa and reapply for immigration Canada.

[68] This refers to the College of Physicians and Surgeons of Saskatchewan, the provincial regulating body for physicians.

instructors if we know where they are....and hopefully in the meantime they haven't taken a job in the States or in Britain.

We try to make sure they're not going to pull one over on us. It has happened a time or two. Everything is fine, the College okay's them and the visas are being processed and then they're gone. They had another better offer or got tired of waiting or were never serious in the first place, I don't know, but they're gone. So we have to go to the second choice and so on and hopefully these guys are still looking to come here too.

After we find a candidate we have to advertise for the position nationally to satisfy the HRDC (Human Resources and Development Canada) that we're not taking a job away from any Canadian doctors, which we obviously aren't or we wouldn't be doing this in the first place. After that we make a formal job offer to the doctor and submit his CV to the College so they can assess his credentials and training. When the College is happy that he qualifies for a provisional license we go back to HRDC, and with their approval we get permission for the doctor to apply for a Canadian work permit. If they accept him and we get the okay from HRDC and from the College the doctor can go and apply to the High Commission in Pretoria.

If everything runs smoothly at the High Commission it will take another six weeks until he gets a file number. Once he has a file number, within a week the high commission sends the papers for a physical which can only be performed by a few doctors that have been hired by the Canadian High Commission to do them. If the doctor is married then the spouse must also have a physical. Everyone also needs to have x-rays taken to check for Tuberculosis except for children under the age of ten, and they will often ask for a urinalysis and check for syphilis.

The medicals are quite expensive in Africa, it's equivalent to $360 Canadian for an uncomplicated one but if there was a problem like TB as a child, he basically has to prove to the doctors before he goes in for his medical that the problem has been sorted out, or not bother applying because it's a waste of time.

The medicals are sent to Nairobi[69] which takes at least six weeks, and then the queries start coming. So if he has a condition and he knows what they will want as proof that it has been dealt with, he should send all of it along with his physical before they ask for it. If he's lucky and has a nice guy for the medical then it is best to ask him what else they will ask for in Nairobi, and then think of anything else they might want and get it done right away because they don't ask again. Then he either gets it or he doesn't.

If he is cleared, he is given a work permit and a visa. The visa is dependant on the work permit and the permit on the visa. The permit and visa last for a year for the first time around and after that, if he's still in Canada, he can reapply. If there's nothing outstanding against him, no criminal charges or anything, he'll get the permit and visa again. IMGs used to have to go back to South Africa to reapply but now you only have to go to Buffalo, New York and apply for a new work permit.

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[69] Nairobi is the central processing centre for the Canadian government in Africa. The results of the physical are sent to the Canadian Medical Attaché.

> The physician must provide a job offer again; he can't come here and then apply for a work permit afterward. He will need a new certificate of status from the medical college in South Africa to make sure nothing is outstanding against him, and they fingerprint him to make sure that there are no criminal proceedings or security concerns. If it all checks out he will get the work permit.
>
> Once he gets here and he has been nominated (under the SINP) he can apply for landed status. It used to be possible get landed status within nine months but they've changed things around now and you can wait for over two years now, which is quite a bother because you have to continue to renew the work permit each year.

The entire process from initial job offering to approval for a work permit can take six months or more, and can be refused at any time. In the interim physicians must inform their partners that they are leaving and find new placements for their staff. Many physicians may sell their practices or close them down for want of buyers.[70] They have sold their cars and houses, or made arrangements to have them looked after, and by the end there is little left to do but wait. The stress is immense. One couple that had experienced a severe mishap during the application process said that they did not fully expect to be allowed to enter Canada until they boarded the airplane.

When South African physicians arrive in Canada and begin to practice medicine they must routinely re-apply for permission to remain in Canada until they are granted permanent resident status. So while the recruitment process may be stressful, they are not entirely 'in the clear' until three to five years after their arrival in Canada when they have passed the MCC exams and their residency application has made its way through the immigration bureaucracy. Until that time has passed, IMGs must apply for temporary visas every time they want to leave Canada, and must annually reapply for permission to remain in Canada while they are settling into their communities.

[70] Because the private medical system is in decline it can be quite difficult to sell a practice and/or medical equipment. Some physicians are unwilling to make such a substantial purchase when the possibility of earning a living from the practice is in doubt.

Restructuring Health Care in Saskatchewan

Internationally trained physicians who arrived in Saskatchewan at the turn of the twenty-first century entered a provincial health system that was itself in transition. The federal preoccupation with health care was reflected in many provincial governments including the governments of Saskatchewan. The most recent changes to the provincial health delivery system were based on two reports that dealt with three themes central to health care: demographic change, effective delivery of care, and cost control.

The first report is The Directions in Health Care Commission, known as the Murray Commission (after the chairperson Dr. Robert F. Murray) which issued a report in 1990 entitled *Future Directions for Health Care in Saskatchewan.* Having been commissioned amidst the fiscal crisis of the late 1980s, the Murray report contained 46 recommendations for health services reform, many of which focused on increasing efficiency and cost reduction. Included among these was the proposal to transfer some resources from underused or partially empty rural hospitals to urban hospitals,[71] and shift the focus of the health program from acute care to a community health or "wellness" model including a health services telephone line (Saskatchewan Commission on Directions in Health Care [SCDH] 1990). The assumption was that this proactive model would reduce the usage of acute care hospitals and resource intensive treatment by implementing preventative care from a coordinated group of community health personnel.[72]

[71] The Murray Report notes that in the smallest (rural) hospitals 40% of hospital beds were never used while the need for beds in urban hospitals was skyrocketing (SCDH 1990).
[72] A rural physician not in the field communities observed that the HealthLine telephone service actually increased the usage of emergency services since patients were advised to visit emergency rooms rather than speak with a general practitioner who had a more detailed knowledge of their problem(s).

A second key proposal sought to replace over 400 boards administering selected services throughout the province with 15 regional divisions delivering the complete range of services (i.e., home care, community-based health care, mental health care, and acute and long-term care in institutions) under the direction of a board with some elected members (SCDH 1990). Regions would service a minimum population base (12 000 persons) and would organize services around regional hospitals that could provide the most intensive care while surrounding facilities would provide fewer acute services. This second recommendation was acted upon albeit in a less dramatic fashion, and the provincial administration of health services was divided between 32 districts and one health authority in the northern extremity of the province (see Figure 3.4).[73]

The second and most recent provincial commission (The Fyke Commission) presented its report *Caring for Medicare: Sustaining a Quality System* in 2001. Like the Murray commission, the Fyke report stressed the need for further centralization of acute care. The report notes that since the creation of districts in 1992 rural populations had shrunk considerably:

> Four districts now serve populations of less than the 12,000 originally established as the minimum number for a district. In another 16 districts, the population served is less than 20,000. Moreover, the number of people living in some districts will continue to decline... by 2015 seven districts will serve fewer than 12,000 residents, and another 16 districts will have populations of less than 20,000 (Saskatchewan Commission on Medicare [SCM] 2001: 56).

As a result the report proposed three major cities (Regina, Saskatoon, and Prince Albert) provide the most comprehensive services, the closures of some 50 rural hospitals, and the need for fewer health districts (between nine and eleven regions were suggested). There

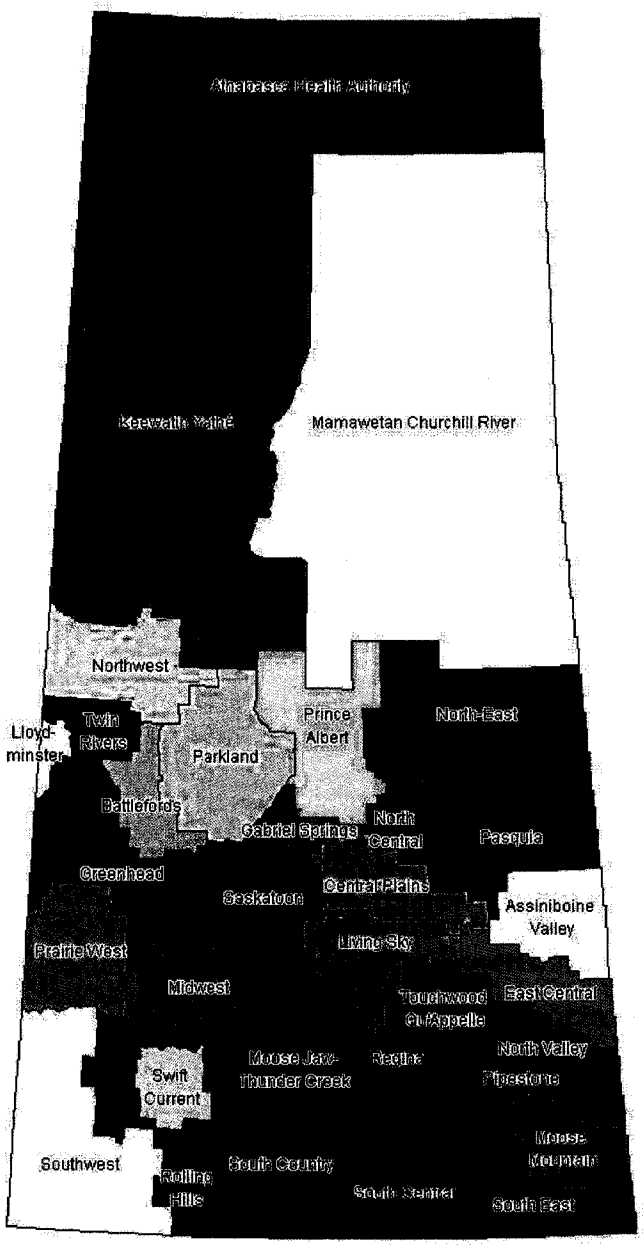
[73] A recommendation for a small number of health regions had been made as early as 1944 but was ignored (Sigerist 1944).

were further calls for physicians to enter group practices with other health service providers, and a change from elected district boards to appointed boards due to extremely low voter turnout (10% or less) and the high number of board seats won by acclamation (SCM 2001).

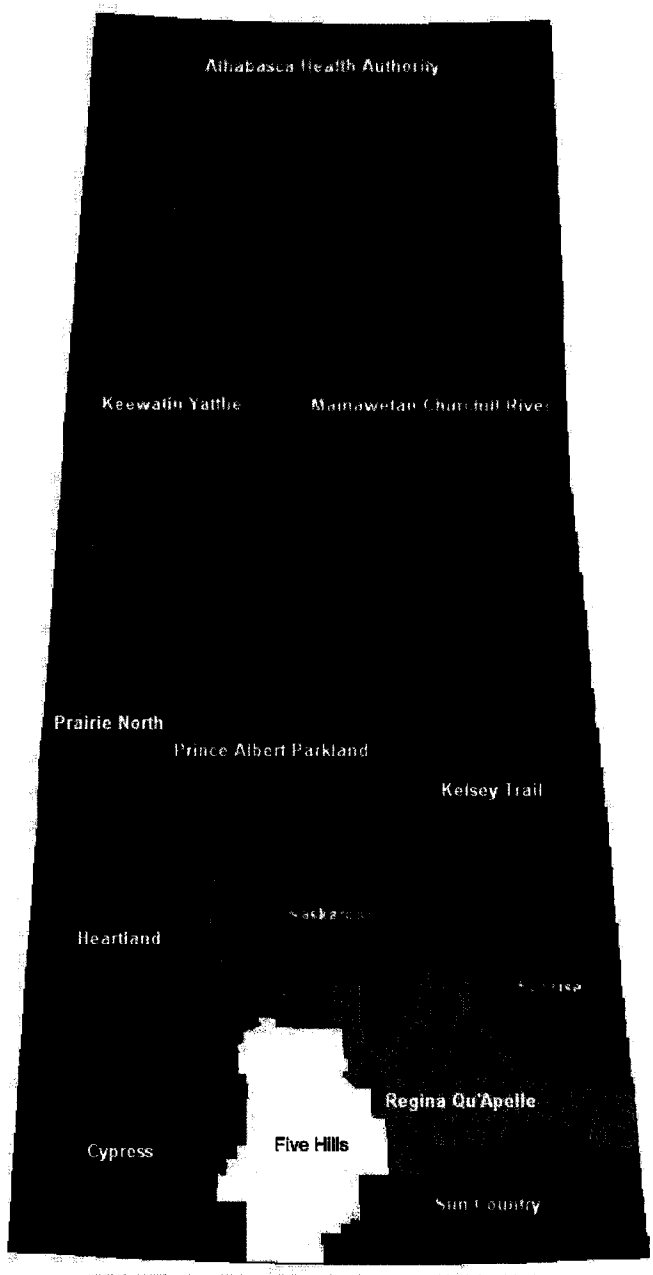
Again these recommendations have been acted upon, thus far, in a slightly less dramatic fashion. Health districts were amalgamated into 12 regions in 2002-2003 (see Figure 3.4) with boards appointed from local community members and overseen by a chief executive officer. Hospitals have been divided into four levels of service provision based on size of the population they serve and their proximity to other hospitals of higher or lower raking.[74] A 24 hour toll-free "HealthLine" health advice call service was created along with improved support of rural physicians through such things as telephone access to specialists in central hospitals (GoS 2003).

[74] The services offered in each category are listed in Appendix 1 of the Action Plan for Saskatchewan Health Care (Saskatchewan Government 2001) and have also been in this thesis as Appendix B.

Figure 3.4 Transition From District Health Authorities to Regional Health Authorities in Saskatchewan



Map of Saskatchewan Health Districts in 2000



Map of Saskatchewan Health Regions in 2002

Source: Saskatchewan Health website http://www.health.gov.sk.ca/mc_publications.html

Local Effects

In the two field communities, the restructuring and centralization of the health system fostered a sense of alienation of staff and community from the local hospital and the health region. Community members felt that the hospital was no longer "their" hospital. Board members were no longer elected,[75] and decisions concerning the hospital and service delivery were made by the CEO of the region who was based in a city over two hours away. Further, when the health districts were amalgamated into regions, the funds of the local hospital association were incorporated into the global budget for the region despite the fact that this money raised locally (through donations and charity events) to improve the local hospital.[76] A community member explained that "money was donated by people in town to improve our hospital....The region took it...and put it in the global budget. By rights it should have gone back to the community but now our money paid for equipment or filled the budget deficit of another hospital [somewhere else] instead of going back to the community here." Community members and several nurses in Westtown observed that since regionalization, fundraising focused more on the purchase of smaller equipment that can be given directly to the local hospital, and less on larger projects (such as larger diagnostic machines or improvements to local hospital rooms) since capital expenditures are now funded from a common pool in the health region. As such, local investment in the hospital building would lead to a reduction in the amount of capital funds they received from the health region.

Medical staff also expressed feelings of alienation and resentment. Nurses, physicians, and technicians felt that, though they were the primary care givers, they no

[75] Though even when board members were elected, the vast majority of seats were won by acclamation.
[76] In the past these funds had been used to furnish a room for palliative patients and their families.

longer had any meaningful input into important decisions about patient care. Rigid adherence to the budget meant that hospital staff were now required to pay for coffee and condiments when they had never had to before. In another instance, when a nurse's car was broken into during a night shift, requests to upgrade the parking lot surveillance system in the Westtown hospital were disregarded. In its current state, the lighting of the parking lot is too poor for security cameras to be effective. Worse, the cameras are only monitors. No recording device is connected to them. Several medical personnel thought that "a thousand dollars for better lights and a recording device" is a small price to pay to prevent an attack late at night, but "the administration [is] content to be part of the problem, rather than the solution" and is "not interested in being part of the solution" either. Hospital administration, especially in Westtown, was felt to be too inflexible and, at times, antagonistic.

Several nurses and physicians also noted the change of hospital care into a business model where "patients" became "clients" and "consumers" of healthcare. Some older nurses were particularly uncomfortable with this change in focus because they felt that it impeded proper care of their "patients." They were further disappointed (and unsettled) by some co-workers who responded to the changing relationship with decision-makers by adopting a "someone else's problem" attitude and limiting the tasks they performed to those that were specifically assigned, rather than lending extra help wherever and whenever it was needed.[77] For these older nurses, healthcare was not a business but a service, and nursing was not just a job, it was a vocation or a calling.

[77] This feeling was expressed to me, to various degrees, by several younger nurses. If the hospital would not go the extra mile to help the nurses, nurses would not go out of their way to accommodate the hospital administration, though they tried to do this in ways that did not affect patient care and prevented their fellow nurses from bearing any additional burden.

In both communities, negative comments about the management of the hospital were tempered with the acknowledgement that the administration was largely dictated by the CEO of the region. Local administrators were following orders and/or adhering to budgets as best they could. As such they received the blame for things over which they had little or no control. However these statements were also interspersed with jokes about the large salaries of the CEO and the administrative staff.

Conclusion

Health sector human resource planning is a highly political, controversial, and volatile Canadian institution. Shifts in public opinion and policy have had dramatic effects on the supply of health personnel, particularly physicians. Provinces and governments have attempted to remedy shortages of personnel and resources through various restructuring and cost containment measures, all with limited success as provincial and regional shortages/surpluses of physicians have not significantly changed. Thus far, the shortcomings of the medical system have been mitigated by the ready supply of foreign-trained physicians, particularly from South Africa, who are more than willing to leave their own troubled health system for under-serviced areas of Canada such as rural Saskatchewan.

Chapter 4-Rural Life

Research has shown that immigrants who have lived in Canada for less than 10 years are a highly mobile group and the majority relocate to large cities within two years of their arrival in Canada (Abu-Laban, Derwing, Krahn, *et al.* 1999). This is especially the case in Saskatchewan. As a portion of the national intake of immigrants and refugees, Saskatchewan accepted 1 670, or 0.8% of new immigrants to Canada in 2003 (CIC 2003). At least 50% of the newcomers that enter Saskatchewan leave the province within one year (GRAA 2002). As Lorjé (2003) has noted, the future growth of the province is tied to increasing immigration, but it is a futile effort if high rates of secondary migration continue. This begs the question of how to stem the outflow of newcomers, such as IMGs, and foster their integration into their host communities.

There are a number of interrelated factors responsible for the poor retention of newcomers in Saskatchewan and the high rate of secondary migration. The first factor relates to the small and scattered population. The three largest cities are Saskatoon, Regina, and Prince Albert with populations[78] of 225 927, 192 800, and 41 460 respectively. Combined they account for nearly 50% of the provincial population of 978 935 (StatsCan website, 2001 Census). Secondly, despite rapid urbanization, the agricultural legacy of the province remains to the extent that 35% of the provincial population continues to reside in small rural communities. Though there may be numerous ethnicities represented in rural communities throughout the province, they are generally "one of's," that is to say that a Sikh or El Salvadorian family in a rural community is probably the only one in the area. The small and decentralized nature of the

[78] These are populations of the Census Metropolitan Areas around each city based on the 2001 census. They include the city and surrounding communities that form the core of the urban economy.

provincial population makes it difficult if not impossible to adequately provide needed services for immigrants, refugees, and ethnic minorities. McIsaac (2003) states that low retention rates are endemic to rural areas because:

> the conditions for economic growth and immigrant settlement in smaller, more remote communities are fundamentally different from larger census metropolitan areas (CMAs), and arguably not as conducive to receiving and integrating immigrants. Smaller communities often do not have the institutional and community infrastructure to offer the necessary supports for effective economic integration. It is not so much a question of population size as it is of capacity. (McIsaac 2003: 3).

The nature of life in Saskatchewan renders the province unsatisfactory for some or simply too big a change of pace for city dwellers who move to more agreeable surroundings in Calgary, Edmonton, Vancouver, Kelowna, and Winnipeg.

Settlement is dependant on the successful navigation of community dynamics in the form of social tensions, class conflicts, and the local effects of larger (provincial or national) trends that impact on the community and/or newcomers. It is an exchange where communities allow social 'space' for newcomers to enter, and newcomers in turn choose to enter that 'space' (Ong 1996; Tsuda 1999). In the hopes of fostering more effective incorporation and retention of immigrants and refugees, the Government of Saskatchewan commissioned a study, *The Saskatchewan Immigrant and Refugee Settlement Needs and Retention Study*, in 2000. As the name implies the study dealt with two key issues, namely addressing the unmet needs of immigrants and refugees in Saskatchewan, and the underlying causes of the high rate of secondary migration out of the province. The study recommended increasing career opportunities and the availability of skills and language training in a flexible, client-centered framework. Additionally the study concluded that for the successful settlement and integration of

newcomers the host community must be welcoming (GRAA 2002). This final conclusion is especially pertinent for the retention of skilled immigrants because they are highly educated, more likely to speak English or French, an important category in the points system,[79] and so are generally less dependant than a refugee family on the help of their host communities to become established.

These conclusions apply to the internationally trained physicians, arriving as immigrants, in Saskatchewan. Unlike many refugees and some immigrants, IMGs are arriving in their host communities with assured employment and a measure of social status. Under the requirements of Citizenship and Immigration Canada, to qualify as a skilled immigrant one must also be financially solvent. As a result there is little need for any form of government or community aid when a physician is establishing his or her household in Saskatchewan, and what need exists is taken care of by the Health Regions.[80] South African physicians have the added benefits of fluency in English (the dominant language on the Prairies) and medical training similar to their Canadian counterparts. These physicians have the human and cultural capital (training, status, language proficiency, and financial resources) to settle wherever they wish, however they choose, at least initially, to live in rural Saskatchewan. Embedding in the community may be encouraged because they have fewer obstacles to overcome due to their increased human and cultural capital (when compared to many other newcomers) and they are filling a role that has a unique place in rural communities.

The settlement and integration of South African doctors and their families seems to progress through several stages. There is an initial period of arrival and establishment

[79] Refer to page 53.
[80] Refer to page 58.

where physicians are initially welcomed to the community by fellow physicians and their families, other co-workers, and by members of the community at large, but remain peripheral to varying degrees. The reception by the community figures largely in this early stage. If they choose to stay, newcomers begin the process of integrating into the community and finding their 'place' in it (Chavez 1994; Ong 1996; Stoller and McConatha 2001). Key determinants of further embedding seem to be the integration of spouses, quality of life factors including feelings of safety and an acceptable standard of living, lifestyle, and continued feelings of community acceptance and openness. Job satisfaction, which is both rooted in structures outside the purview of the community and is influenced by relationships with co-workers (who are co-community members), also plays a pivotal role in the integration process. As such the retention and embedding of physicians is dependant on both internal and external forces at work in rural communities in Saskatchewan.

Reception

When IMGs arrive in Canada to practice medicine they do so with temporary work permits. The permits expire after one year at which time the physician can apply for a provisional license and a work permit lasting three years. However some physicians choose to return to their country of origin. The possibility of return places a great deal of importance on the ability of communities to make their newly-arrived physicians feel welcome so that they choose to stay past the first day, the first week, and past the first year. "Putting down roots" (i.e., embedding) in the community is a bi-directional

process. Newcomers do not only signal the intent and desire to enter a community; community members must also indicate a willingness to accept the newcomers.

In both Easttown and Westtown the reception of South African IMGs begins almost immediately upon their arrival in Saskatoon. The trip from South Africa to Saskatchewan takes the better part of two days[81] and there is an eight hour time difference that IMGs must deal with upon arrival. Physicians are received by someone from the community (travel arrangements in Saskatchewan are usually made by the clinic) at the Saskatoon airport or picked up from a hotel and taken to their new community. IMGs and their families are provided with a house (usually one side of a duplex) to live in for up to six months.[82] In Easttown physicians are given a resource package by the physician in charge of recruitment and/or the hospital administrator. The package outlines the services in the community, local schools, activities and lessons for children, and local arts and cultural events. They also receive a detailed relocation guide which describes the process of immigrating to Canada, includes advice on helpful and necessary documentation for immigration and settlement in Canada, and helpful tips on national/international travel arrangements and the transportation of household goods. A few days after arrival, the new doctor is formally introduced to the members of the clinic where he or she will be working and is given a tour of the hospital. After that, the new doctor begins to see patients and takes his or her turn in the call rotation in the local emergency room.[83]

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[81] Times spent in transit ranged between 30 and 36 hours with short layovers at several airports. One couple had the misfortune to travel for 36 hours non-stop.
[82] This same service is provided to new nurses, interns, and other health professionals.
[83] The call schedule is the schedule of which doctors will be "on call" in the emergency room of the local hospital. Physicians are private contractors who provide call services, through a contract with the clinic in which they are a partner, to the local hospital.

The community-based welcome and processes of integration begin rapidly and almost immediately as well. Physicians generally made informal contact with members of the community through their co-workers. They were invited to barbecues at a doctor's home where they met other physicians, nurses, and their spouses, and others in the medical field. These initial connections led to further ones as new acquaintances introduced IMGs to more of their friends in the community.

South African Physician:

> We had barely arrived and we were being invited to barbecues and parties. We felt like we were in the party capital of Canada. That was how we met people, and how we were introduced to two of our very closest friends.

To a certain extent they also announced their presence to members of the community at large through their practices.

South African Physician:

> Being a doctor in a small town makes it very easy to meet people because they want to meet you. For the first six months that we were here we were basically eating out every other night just because people wanted to invite us. Without being mean you know we have a *position* in town and people wanted to invite the new doctor over (emphasis in original).

Community Member:

> People are used to international doctors by now. We've had them forever I guess. As soon as a new one comes to town, [the information] makes its way down to coffee row and then everyone knows.

A more formal welcome from the community at large is the local welcome wagon.

South African Physician:

> A lady came and visited us with a basket of goodies from every store and business in town and a bunch of vouchers, mostly the buy one and get one free type. It's part advertisement and part genuine welcome but it really is a clever idea since you have to go around town and find this place because you have this voucher.

At the time of the research only the welcome wagon in Easttown was functioning. Physicians there were very appreciative of the gesture and the way that it gave them a reason to become acquainted with their surroundings. A similar welcoming program had existed in Westtown but it had fallen into disuse some time prior to the summer of 2004.

The welcomes that made new international doctors feel "really at home" in the community were primarily the actions of individuals. In Easttown physicians said that a central figure in their welcome and integration experience was an administrator in the health system. Respondents noted that the administrator is very determined to make new physicians "feel at home." The administrator invites the new doctors to numerous formal and informal community events, is readily available to medical personnel for assistance in whatever needs (personal or professional) may arise, and has a certain charisma or charm that simply makes people feel comfortable and at home. Several interviewees noted that the most memorable/thoughtful part of the welcome to Easttown were groceries (milk, butter, eggs and a few other necessities) waiting in the refrigerator when new physicians arrived.

The administrator is proactive in encouraging the community at large to do more to integrate physicians and other professionals into the community:

> ...How long can we get along without [IMGs]?....
>
> We have to welcome these doctors and integrate them as quickly as possible. That means their spouses and children too. We've had one couple leave and then return a year later because their son was so integrated into the community and wanted to play hockey with his friends in Canada.

The administrator is also one of the central, or anchor figures, in the social network of South African IMGs in Easttown.

In Westtown the personal welcome to the community can largely be attributed to the initiative of an elderly couple. In 1996 there were only three physicians remaining in Westtown. Others had left because of the immense workload and burnout and they were unable to recruit and retain replacements. One physician published an article in the local newspaper explaining to the townspeople how to make new physicians feel at home. The couple took this message to heart and when a newly arrived South African physician moved into the community they brought him a large pot of soup. This began a very close relationship with the physician who came to consider them his or her adoptive parents (and they considered him or her an adopted child), and grew to include other South African physicians in their adoptive family as they arrived in the community. The couple also created a small community group to try to improve the welcome that new physicians receive.

Physicians were very appreciative of their reception, the openness of the community, and the "relaxed" hospitality of Canadians. This was particularly phrased in opposition to more formal British culture.

South African Physician:

> We find people very relaxed here...I think it has a lot to do with the immigrant culture you know? Everyone is from somewhere else or their grandparents are immigrants so society is very young you know. People in Britain have been there since forever and it's much more difficult to fit in. Here you are immediately a part of things.

Others in the community who had traveled to, or lived in Britain agreed with this assessment.

Community Member:

> If you came to my home in England we would give you nice tea in a cup and saucer and all this garbage and you can have a mug here. You don't have to phone ahead and come at 2:00 sort of thing you know. I think Canadians are

> much more relaxed and I just love it compared to the British route...I've had family come and visit from Britain and they *all* say the same thing.

Some newcomers already knew established IMGs from attending the same medical schools or training in the same hospitals.

Several doctors mentioned that friends who were a visible minority did have some difficulty adjusting to rural life, but this was attributed more to religion than racial discrimination. It is difficult for a family to fit into a community when they are the only Hindu or Muslim family in the town (and the immediate area).[84] This does not seem to be an insurmountable obstacle since these families have lived in their communities for several years and are good friends with several physicians (and assumedly other community members who did not participate in this project). Physicians were themselves aware of their foreignness, such as the darker skin of the Indian physician, or when Afrikaner IMGs spoke Afrikaans in public, but did not feel that it hindered their acceptance by the community or that they were treated any differently because of their differences.[85] As such, physicians not only found their new communities welcoming but also found it relatively easy to become involved, or find a "place" in their host communities. They felt as though they were immediately welcomed in a friendly, informal, and personal way.

Spousal Integration

When deciding whether or not to put down roots in their host community, the integration of spouses and family members remains equally as important to retention as

[84] Refer to the general discussion of rural Saskatchewan on page 70.
[85] This is also discussed on pages 108-109.

the integration of physicians. Settlement choices were not based on the decisions of physicians alone; they were also influenced to a large degree by spouses. In Westtown at least one IMG left because his wife was homesick and did not feel connected to the community despite his attachment to the community. Conversely an immigrant physician in Easttown may have left the community but for his or her spouse. A community member recalled that "we did a really good job of getting [the doctor's spouse] involved in things that [he or she] liked, and [he or she] is so comfortable here that I think you might have to move heaven and earth to get [him or her] to leave." This IMG has remained primarily because of the strong community attachment of the spouse.

While the physician is able to integrate through his or her professional position (as discussed in the previous section) the spouse must find other points of entry into the community. In the interviews, some of these avenues are employment (which will be discussed in greater detail below), learning sports (such as curling, ice hockey) that are not widely played in South Africa,[86] teaching lessons or classes in the fine arts (music, dance), involvement in church and community groups, and if they are parents of young children, involvement in school activities. In the sample of South African physicians in this study a gender bias was not pronounced. Both male and female spouses of physicians were embedding through other means, particularly involvement in sports, through their spouse's relationships with fellow health workers, and through their children's involvement in the community (e.g., school, parent's groups, sports). Several community members were adamant that their towns needed to do more to retain the spouses of new physicians:

[86] All the South African IMGs also mentioned taking up golf in Canada. Though golf is played in South Africa, it is exceptionally expensive and much less accessible to middle-class and upper middle-class than in Canada.

> small communities have to be actively involved in physician recruitment...And by that I also mean putting a little money where your mouth is. What's wrong with giving them a pass to the regional park for a year, or giving them 10 rounds of golf, or whatever? There are all kinds of things in the community that could be done....

Several participants thought that efforts to integrate spouses could be extended to giving them preferential treatment if they apply for jobs in town (i.e., giving the spouse of an IMG the job if he or she applies for it and if he or she is as qualified as all other applicants).

Employment is one of the most difficult aspects of incorporating the spouses of South African physicians in particular. Many of the physicians are married to professionals[87] that have left behind fulfilling jobs to move with their spouse to rural Canada. It can be quite difficult for these professionals to find work in rural communities where the industrial or commercial infrastructure is limited and employment for some professions is nonexistent. One IMG couple stated that though they loved the town that they lived in, and had become part of an "adoptive family" in the community, the one thing that would drive them away was if the IMGs spouse was able to find suitable and fulfilling work elsewhere. The spouse has explored various avenues of employment including taking up a trade and several entrepreneurial ventures. If the spouse is able to find a suitable and fulfilling career they are quite certain that they will remain in the community.

Additional barriers to professional employment are the differences in education and a lack of evaluating services in Saskatchewan (and Canada for that matter) for other professionals. Though South African IMGs are quite easily employed as physicians in

[87] In this instance, five South African physicians were married to spouses who were professionals in their own right.

Canada this is largely due to the political focus on the shortage of doctors. Other professionals in health and related fields can have great difficulty gaining certification. For example, one of the South African physicians is married to a South African nurse. Though the nurse has been attempting to become accredited in Canada, he or she has thus far been unsuccessful, and the future does not look promising. The physician said that his or her spouse really loved his or her job as a nurse and was having trouble coping with not being able to work in his or her chosen profession. In a situation such as this, there is little that can be done by the local community to assist the spouse in gaining accreditation. Alternative employment may be available but it is the choice of the spouse to take advantage of it.

Quality of Life

In addition to finding fulfilling employment, physicians and their spouses placed a high priority on maintaining an acceptable quality of life in their host communities. Quality of life was discussed by South African participants in terms of four important factors including a sense of safety and security, status, a suitable or "interesting" lifestyle, and supporting the community. Satisfaction at work, while a quality of life issue, was also discussed in terms of much larger forces at play in the rural system of health delivery and their effect on the desire to integrate or pull up roots and move elsewhere.

Safety

Safety was the greatest single factor that served to push physicians out of South Africa. Physicians feared for their safety, the safety of their families, and especially the safety of their children.

South African Physician:

> There is a lot of violence. If you don't know someone who has been killed then you know someone who has been crippled for life. I mean just within the circle of your family. You don't even need to consider your friends because there are even more of them. You can't go out at 9:00 at night for a walk. You'll be killed. You can't go out at night unless you're in a big group and if you're a woman forget about it entirely. There's just no way. Women can't even drive alone at night.

As such it was also an important consideration in settlement. All South African participants thought that, while Easttown and Westtown had problems with crime, these were minuscule compared to what they had left behind in South Africa and for all intents and purposes they felt completely safe.

South African Physician:

> A few months ago they found a skeleton on an island in one of the lakes and it was in the news for weeks. We were just amazed you know. In South Africa stuff like that doesn't even get reported. The papers just mention the number of people killed during the night. They don't bother to list their names, nothing you just get a number, like "140 people were killed over the weekend." So you can see how the crime out here is really a matter of perspective.

All IMGs felt that their community was a very good place to raise children: "I can let my daughter ride her bike or play in the back yard or go to her friend's house without any worries. In South Africa we were afraid to send them to school because the bus might be hijacked. It's happened." A similar sense of safety was shared by members of the focus group who noted that though there had been one or two minor thefts and assaults of

elderly people in the past year, they still felt completely safe. Saskatchewan has the most murders per capita of any province but all the physicians considered this to be trivial. Though there had been a number of murders in Westtown in 2003 and numerous burglaries as well, some physicians did not regularly lock their doors at night. The most telling image of trust in personal safety, however, was seeing a physician jog along the poorly lit main street at 11:30 in the evening while cars drove by, when he or she had been hesitant to go out in large groups after dark in South Africa.

Status

In the hierarchy of rural communities, doctors are located very near the top. The average yearly income of a general practitioner in Saskatchewan, based solely on income from billing for services, was $207 000 in 2004,[88] though the average billing of physicians in Easttown and Westtown was at least 10% above this average (Sask Health 2004).[89] This compares to an average yearly income of $32 000 in Easttown and $41 000 in Westtown (StatsCan website).[90] As such these physicians are significantly wealthier than their fellow townspeople and are able to afford more luxury items such as sport utility vehicles or luxury cars,[91] exotic vacations and trips abroad (such as yearly trips home to South Africa or flying relatives to Canada), cabins at the lake. Many physicians

[88] One must keep in mind that a physician pays operating expenses (e.g., salaries of staff, clinical equipment, utilities) with billing fee revenues. Total billing fees are the gross income for a business, not for the individual doctor.
[89] Billing payments made to physicians are reported as the average billing payment in each health region in 2003-2004. Easttown and Westtown are in different health regions with different average incomes from billing (the region in which Easttown is located billed $10 000 more per year than the region in which Westtown is located) (Sask Health 2004).
[90] This total is based on full-time year-round employment earnings in 2000.
[91] Whether they can buy them is another matter. One South African IMG was unable to purchase a vehicle until two friends (also South African physicians) who had been living in Canada for several years assured the dealer that the new IMG would not "take off" in six months.

also owned larger and/or more expensive houses located in areas of town with senior managers, members of the judiciary, and other health professionals, or on acreages near town. Physicians tended to live in newer or larger houses on bigger lots in recently developed areas of town, or areas that were recently developed when they arrived. They were also more likely to be near recreational facilities, particularly the local golf course, and within a few minutes' drive of the hospital, though close proximity to the hospital is a requirement of being a health professional.[92]

One physician and his or her spouse went to great lengths to enforce their status in the community. While renovating their home, carpet layers were refused entry through the front door of the house despite the fact that this door opened into the room that was being recarpeted. Instead they were ordered to enter through the back door where "the help" entered, even though they had to cut the carpet in half so it could be carried through the house to the front room. However this couple returned to South Africa after only a year or two in rural Saskatchewan.[93] When community members spoke about this couple, their departure was attributed to their self-imposed isolation. The wife in particular had little to no contact with other community members outside of South African physicians and was disliked because she was "arrogant" and "stuffy" in comparison to other South African physicians who were "real," "friendly" and not preoccupied with their status.

Status is not reflected solely in assets however. Physicians are also afforded special treatment in rural communities. A Canadian physician gave an example of how physicians are treated differently than other community members:

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[92] There is a limit on the response time of physicians and other health service professionals to an emergency call at the hospital so whether they live in town or on acreages, they are generally within 10 minutes travel of the hospital.

[93] Refer to page 79.

> There's not a store in town that wouldn't trust me to leave with my purchases and come back to pay for them later if I forgot my wallet.
>
> When I phone and I need my car serviced and they move appointments around to make sure that I can get my car in when it's convenient for me. I doubt that the lawyer in town would have appointments juggled to get his car in a bit faster. That's part of how you are treated in a small town.
>
> Your patients are loyal, in a way. I mean that they respect the commitment that you are making to them... That doesn't happen in a city where the doctor locks the door at five and if you need something [you have to] go to an emergency room or call in the morning.

Local merchants and service persons go out of their way to accommodate physicians.[94] A respondent believed that this is, in part, due to the chronic shortage of doctors in rural areas, so when one arrives "everyone is in a hurry to make them feel as welcome as possible." Canadian doctors believed that this treatment is a sign of respect for their profession and a form of repayment or reciprocity for their commitment to the community. Consequently physicians are insulated, to a degree, from the rest of the community by their relative affluence, the deference of local businesspeople, and the overtures of townspeople who want them to stay in the community.

Lifestyle

Interviews with physicians revealed that a number of factors are considered to contribute to a comfortable lifestyle. These include options for recreation and entertainment, an active and satisfying social environment, and contributing to the community. Though a rural community does not offer as wide a selection of lifestyle 'perks,' responses from IMGs and other new arrivals in Easttown and Westtown suggest

[94] A physician who has just arrived in the community would be less likely to receive this sort of freedom than a physician who has been in the community for a few months or several years. In the author's own experience growing up in a small prairie town, though this privilege may be extended to prominent persons in the community sooner than to "nobodies" it was still dependant on a level of trust built over time.

that a full range of lifestyle options, as would be available in a large city, is not necessary. Certain aspects of small town life, such as a sense of personal connection unavailable in cities, can compensate for numerous shortcomings.

Respondents from urban backgrounds (including the majority of South African IMGs)[95] commented on the positive and negative qualities of rural life. Those from larger cities in particular were aware of the availability of almost anything in a city to the comparatively limited or (more accurately) mundane options in a town of a few thousand inhabitants. However respondents were quick to note that Easttown and Westtown are more or less able to provide anything one might need.

Canadian Physician:

> You rarely need to leave town to get anything...There's a book store, bakery, three or four grocery stores including one big chain store. You can get every essential service and a few non essential ones, like Belgian chocolates, almost any aesthetic treatment, a movie theatre and a very nice coffee shop. One of the benefits of being a merchant in a small town is the distance from other competitors so you can make a go if it here when you couldn't in a city.

South African Physician:

> There are the lakes and the natural attractions are really good if you like the outdoor lifestyle. The schools are good, so you know, it's not bad. I wouldn't go smaller than this but it's a nice-sized town. It's nice not being more than five minutes away from anything. You're never late for anything, no traffic. It has its advantages....

South African Physician:

> Once in a while we'll go into Saskatoon and maybe spend the weekend, you know just for a change, but a day or two is enough and we're glad to be back when we're back.

Though it is not always possible, newcomers said they try to purchase from local businesses as a way of supporting or investing in the community. For example, while one is able to buy clothing in either town, there are only two or three clothing stores and the selection is rather limited. Families find it difficult to buy suitable clothing for their

[95] See OECD 2003 for further discussion of the characteristics of South African IMGs.

children in local stores and footwear in general is quite limited. However for long-term town residents and IMGs who had lived locally for more than a few years, mail-order (such as the Sears Catalogue) and on-line shopping made up, in part, for local shortcomings.

Entertainment options are also thought to be quite good for a rural community though somewhat lacking on the whole. Of special note are the natural attractions such as nearby lakes and forest.[96] Easttown and Westtown are both very close to a number of lakes and forests and have a large tourism industry that caters to outdoors enthusiasts of all types. In Easttown especially there are numerous fishing derbies, and both towns are home base for hunting outfitters.

Community Member:

> There are a lot of things to keep people busy all year 'round. We have fishing derbies, golf tournaments, there are quite a few Americans that come to town to hunt. We have some really beautiful lakes and people in town have cabins or you can go camping. It's a very beautiful place to live.

South African Physician:

> There is a strong feeling of the nearness of nature. Town life is still very much dependant on the rhythm of nature. Everyone watches the sky and they're in a rush to plant their crops in the spring even if they only have a small bit of land....

There are also numerous social events sponsored by community and church-based groups, or on the whim of a local person who takes the initiative.

South African Physician:

> What you miss is when it's late on Friday night and you go out for coffee. That's when we used to go to the mall or watch a movie or go have coffee or whatever. Places here in town close very early, like 9:00PM. It's still bright

[96] The focus on nature has specific appeal to South African whites, or Afrikaners, who are the majority of IMGs in the two field communities. In broad terms the identity of Afrikaners is heavily tied to nature and agriculture. It is based on notions of trekking across, and conquering, the rugged South African wilderness and turning it into productive agricultural land. For further discussion see Crapanzano 1985, Coetzee 1988, and Moodley and Adam 2000.

outside so you don't feel like retiring yet and you want to go out and do something but there's nowhere to go. So that's when you invite friends over.

South African Physician:

There aren't many restaurants here and people tend do more social things at their homes. We find that a lot of the stuff that we're involved in is happening because a local person was interested in something and started calling other people to come over get involved. It's nice because it's not like the official leagues in the city where you go and do your stuff and then go home. You get to know people much better...you meet the whole family and watch the kids growing up...That's how we met our closest friends here. They have really taken us under their wing and treated us like family. They have become our adoptive family. Now we have two sets of parents, you know?

Many participants attributed the large number of informal events to the limited options for other forms of entertainment such as restaurants or movie theatres. However this does not seem to be a shortfall. If one is willing to become involved informal social interactions enhance newcomers' feelings of connection to their coworkers and other community members as it allows for more personal relationships that can take the place of absent kin.

South African Couple:

There are people, Canadians, that in the short time we've been here, have become like a brother and sister to us.... At the hospital you start developing very strong relationships...You back each other up, you go out of your way to help each other. We have developed relationships that have carried us a lot.

Though they had only been in the community for less than two years the South African couple had developed very strong ties with several townspeople.

A final, and powerful contributor to integration and long-term settlement in rural communities is support of the host community. In the eyes of many IMGs the ability to give back, through organization of, and/or involvement in community events, helps to cement feelings of community membership (i.e., feelings of having become Westtowners or Easttowners). The purchase of a house, vehicles from the local dealership, and buying

a cabin at the lake were all ways of investing in the community. In the summer of 2004 only one IMG was living in a rented home.[97] The remaining South African physicians had all purchased homes within a few months (usually within two months) of their arrival. One IMG couple also explained that buying a home is based on the belief that the town will continue to grow and prosper, that it is a "progressive" town.

South African Physician:

> It's a progressive town. They just built a new mill; there are a lot of jobs.... We know that rural Saskatchewan is dying. A lot of smaller communities in the area are withering away and the people are moving here, so it's nice to know that this town is going to do well.

South African Physician:

> We try to buy as much as we can locally, you know, to support the businesses in town. We want them to do well so we support them by giving them our business whenever we can.

As such it is at least partially a signal of faith in the community. Respondents from the community at large understood home ownership as a statement of a physician's intention to become part of the community: "The Pietersens[98] said they were here to stay, and they just bought a house. They're putting down roots so I guess it says something about the people and the community because they've chosen to live here." Purchasing a home is also seen to be a sign of community support.

Finally newcomers organized and/or supported events that they thought would improve the community. In Westtown several physicians and their spouses organized a community triathlon to raise fitness awareness and encourage healthier lifestyle choices. In Easttown golf tournaments have been organized for charity. Physicians also take time to talk to high school classes about health issues and one who participated in this study

[97] The physician explained that this was due to circumstances beyond the physician's control and did not indicate a desire to leave the community.
[98] This is a pseudonym.

also sponsored a local charity for the less fortunate. "Putting down roots" (i.e., long-term settlement) is not only living in community, it is also investing resources, time, and ideas into improving the community. It is putting their own mark on the community (Chavez 1991; Stoller 2002).

Rural Medicine

The final factor in the settlement and integration of IMGs is the demands of their job. As mentioned earlier in the chapter, physicians are given a special place in rural communities because of the nature of their work. "Doctoring" in a rural community influences many other aspects of physicians' lives. Physicians not only provide clinical services, they also provide on-call services at the hospital, and satellite services to neighbouring small communities. They also fill numerous administrative roles in hospital and community associations. Relationship with co-workers, job satisfaction, and time off from work are just as important to retention and integration as social interactions in the community.

Time Off

The most contentious issue discussed by research participants was time off from work. As mentioned in the previous chapter fee-for-service physicians in rural Canada work at least 80 hours a week. In the summer of 2004 both hospitals were short staffed. This placed extra stress on the remaining physicians to make up for the lack of personnel by increasing their patient loads and increasing or changing the call schedule.

The call is the most gruelling part of the job of a rural physician.[99] Many city hospitals have salaried doctors who work specifically in the emergency room on a regular shift rotation (usually 12 hours). When the shift is over the doctor goes home. This is not the case in rural hospitals. Rural physicians do not staff an emergency room for a specified period of time. Instead they are on call for a 24 hour period every few days in a rotation with all the other physicians in their clinic or, if there is more than one clinic, all the physicians in the community.[100] The call is further broken up into doctors on call for surgery, obstetrics, anaesthesia, and emergency with a backup for each doctor if the primary is not available. A physician does not need to stay at the hospital for the entire 24 hours but is responsible for any emergency cases that come to the hospital regardless of any plans he or she may have made. After a 24 hour call is over, most physicians still went to their office for the day to see a full docket of patients. If a physician had a busy call he or she may not get any sleep or spend time with his or her family for up to 34 hours.

Regardless of age or origin, physicians disliked the way that the emergency ward was used by people in the community. Though they were paid significantly more for emergency calls, three young physicians (mid 30s with young children) in Westtown and one in Easttown wished for a reduced on-call workload. The call was most keenly disliked by doctors with young families, and the general consensus was that while they appreciated the additional remuneration for emergency services, money could not replace time spent with their children.

South African Physician:

[99] This is a contentious issue in almost every hospital where physicians share emergency responsibilities.
[100] Fee-for-service doctors are also paid significantly more for on-call services than during regular hours.

> I've always been in favour of the fee-for-service system, but for quality of life issues I wish we were salaried... [because] it lets you have a life. When the day is over you turn off the lights and go home to your kids. If there is an emergency it is someone else's problem.

Canadian Physician:

> People don't realize that it is an after hours service for emergencies only, and they need to treat it as such. Their taxes paid for it so the should get it whenever they want it. When they come in for a sore toe or a headache late at night they are taking doctors away from their families.

Hospital staff were also aware of, and tried to discourage, abuse of emergency services but were more likely to explain some emergency room misuse as the result of a lack of access to care. Only a handful of respondents (doctors, nurses, administrators) in each community (all Canadian) gave this same assessment. Physicians in Westtown were, perhaps more justifiably, aggravated by misuse of the emergency room because they offered an after-hours walk-in clinic. This, they stated, had the desired effect of reducing the number of non-emergencies at the emergency room but did not eliminate them entirely.[101]

Though the call seems to have always been an area of contention, the difficulty of staffing what some physicians see as excessive time on call is increasing with the new generation of physicians. A regional employee explained that:[102]

> There was a time when physicians were just always on call and they worked like beggars all the time. I find that the younger physicians, wisely, expect to have a life outside their practice...The community expected them to be on deck all the time. If they were shopping in the grocery store or whatever, they were always expected to be *the local doctor*. That's something that dies hard in rural areas and the smaller the town the harder it dies. The new generation of doctors want to have a life too and a lot more people need to recognize that.

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[101] Three nurses noted a similar reduction in the number of non-emergency visits to the emergency room and visits for things that were urgent but not necessarily emergencies. However the emergency room remained quite busy.

[102] Similar statements were made by several nurses as well.

Nurses noted that the older doctors were much more willing to come into the hospital when on call. They were also more likely to sacrifice time with their family if they were needed at the hospital even when not on call. They viewed being a doctor as a "calling," not a job. Younger doctors from Canada and South Africa were much more protective of their time away from the hospital and less willing to come into the emergency room for a "maybe."

The demands of the call schedule are mitigated somewhat by the co-operation of physicians in the community. In Easttown co-operation between the two large clinics was also quite common. For example, if one doctor wanted to go to a child's soccer game or a graduation, other physicians were generally willing to trade calls with him or her.

Relationships

In such a stressful environment the support of co-workers is very important. In the field communities relationships between physicians and other hospital staff were quite positive. All the physicians who participated in the interviews reported that they had good or excellent relationships with the rest of the doctors in their clinic.

South African Physician:

> The people at work are terrific. I have a very good relationship with the rest of the doctors in the community. We're not all best friends of course but that's because you can only have one or two best friends but it's great to go to work with your friends every day.

South African Physician:

> The nurses in Canada are superb. They're much better than the nurses in South Africa....

Hospital staff were quite positive about their relationships with South African IMGs. There were physicians that the nurses in general seemed to prefer more than others, and also some that were disliked or resented.

Nurse:

> When they (South Africans) first arrive they are very controlling. The first few months get pretty tense but once they've adjusted everything is fine and they are basically the same as the Canadian doctors...There is one who is still, well, we call [the doctor] "God." [The doctor] treats patients very well but is really hard on the nurses. I think [the doctor] preferred it the way it was in South Africa where [the doctor]'s word is law and that's it.

Personalities played a large role in the general tone of the work environment. Nurses and technicians were very appreciative of physicians who were competent and who were willing to admit that other members of the health care team also had expertise to contribute to the treatment of their patients.

Health professionals noted that there was a transition period when South African IMGs first arrived often characterized by tension and sometimes hostility between staff.

Canadian Physician:

> The South African (medical) model is based on the British system. It is much more autocratic. The doctor is in charge and his decisions are final. Here we do a lot more consensus medicine, so the nurses and the pharmacist have input and will make suggestions or question orders if they feel there is a better option. It takes the South Africans a while to get used to it.

Nurse:

> Right when they get here they are pretty tense. I mean they have to adapt to a lot. It's a different system, so they are pretty much unsure of everything at the beginning. So you try to make them feel at ease but you are all pretty much on the same level at that time.

Nurse:

> We get quite a mix of personalities. Some South Africans, when they start at the hospital, are very intimidated I think. They are trying to prove that they are still competent doctors and it can really interfere with patient care. I mean I've watched new physicians fumble around with equipment that they obviously don't know how to use and they'll never ask the nurses. We're just "the help" and if you try to help they get very angry. Others are terrific and if

they don't know something they'll ask right away. The patient comes first, not their ego.

IMGs were keenly aware of the stress and difficulties of adjusting to a new country, a new community, and a new job at the same time. Most had several anecdotes about confusion regarding various medications known by one name in South Africa that is unknown in Canada, or prescribing an application method that was not used in Canada.[103] For instance one physician prescribed a certain antibiotic to be administered orally but it is only administered intravenously in Canada. After the initial period of adjustment, all IMGs preferred the team approach to medicine in the Canadian system, and Canadian counterparts found IMGs, with the exception of the demanding doctor mentioned above, to fit into the Canadian structure of medicine very well.

Job Satisfaction

In addition to appreciating the Canadian approach to medicine, quality of care was also considered. In general, South African physicians expressed a high degree of satisfaction with the quality of care and the calibre of medicine practiced in their community.

South African Physician:

I had to complete certain courses before coming to Canada like the ACLS (Advanced Cardiac Life Support). It is like CPR (Cardio Pulmonary Resuscitation) but it's not just ABC and compressions, the drugs get involved. It's the same manual in South Africa (it's standardized). You need to memorize the drugs in the book so that when "x" happens you give this drug, or this drug, or that one. There are ranked choices of drugs: first, second, and third best, but they're not always available. Now all of the sudden the first choice is right there on the shelf.... In South Africa the first one's not available, the second one *maybe*, but you usually get like the third one in the

[103] Or being unaware of common over-the-counter drugs in Canada that have different names in South Africa.

public hospitals, which will still work, but here it's like in the private system, the first choice is consistently available.

Official:

Most of the South Africans are amazed with what we have here. Many of them think of rural Canada as much more outdated in terms of the quality of the medicine that we have here and the kinds of diagnostic equipment available. When they see what is available here and in our lab they're extremely impressed. It isn't like working in a bush station in Namibia. I think they like that part.

South African Physician:

I really enjoy the type of medicine that we practice in town. You get to use a much broader range of skills in a smaller hospital like this, and you learn more every day. Practicing medicine in a small town like this forces you to become a better doctor....

One physician went so far as to say that the medicine practiced in the community would probably be on par with the best in the world. The wide range of problems and conditions encountered on a daily basis ensured that physicians were using a wide range of knowledge and skills.

However, in keeping with the general Canadian trend of pessimism about the health care system, many respondents, both Canadian and South African, doubted the sustainability of the local delivery of care. All IMGs who participated in the study phrased responses about health services delivery in terms of a public/private or First World/Third World dichotomy. Certain features of the Canadian system were "like the private system in South Africa" such as the thoroughness of diagnostic tests and the use, in general, of advanced diagnostic procedures. Universal access to care was also agreed to be a very positive or "First World" trait. However other aspects of the system were decidedly "public" or "Third World" especially the long waiting lists for joint

replacements and certain types of scans.[104] When questioned about the sustainability of care in their community, physicians (Canadian and South African) in Easttown acknowledged that the situation was not ideal but were otherwise generally optimistic. Physicians in Westtown were decidedly more pessimistic.

The unfortunate fact of rural care is that the services available at a hospital are directly dependant on each member of the staff. The removal or retirement of one physician can have disastrous effects on the entire range of services available at the hospital. In Westtown the departure of one doctor required the reorganization of the call schedule and an overall reduction in the emergency services offered in the hospital. The problem is that "you can't temporarily suspend a service in a rural hospital, like closing the intensive care unit for a few months to wait for staffing, because once you lose a service in a rural hospital it's gone. You almost never get it back." If a service is maintained while the hospital is short-staffed, there is the ever present risk of burnout, creating a 'domino effect' where more physicians leave because of the heavier workload, increasing the burden on remaining physicians who may also leave (for further discussion see Chan and Barer 2000).

South African physicians are highly sought for rural medical posts because the graduates that are trained as General Practitioners (GPs) most often have an additional diploma in a specialty (e.g., anaesthesiology, surgery) so they qualify in Saskatchewan as a GP anaesthetist or a GP surgeon. It is these additional specialties that allow a wide range of medical services to be provided in rural hospitals. The reorganization of

[104] At the time of the fieldwork the waiting time for a hip replacement was over one year and often up to two years. Excessively long waiting lists for CT scans and ultrasounds were also mentioned by four physicians.

Canadian medical training in the 1990s virtually eliminated the creation of similar GP specialists in Canada. Restricted opportunities for re-entering medical training has resulted in Canadian graduates either training in a specialty immediately after they become general practitioners, or entering a practice as a GP without any additional specialties. Additionally, the refusal of some health professions to train GPs in certain diagnostic procedures (ultrasounds for example) will also prevent needed services from being available when doctors leave or retire.[105] In 1996 South Africa also made it more difficult for physicians to become GP specialists, so the pool of available specialist physicians is restricted to those South African GPs who graduated before the change.

In Westtown the recent departure of two South African GPs has resulted in a reduction of surgeries at the hospital. This has reduced the need for anaesthesia, and three GP anaesthetists may have difficulty maintaining their certification for lack of use. If the anaesthetists leave then the hospital will no longer be able to offer caesarean sections, or any surgery, unless they are able to recruit another GP anaesthetist or a specialist anaesthetist (which has been tried and is impossible because the relatively small number of surgeries performed will not support an anaesthetist in a fee-for-service payment scheme, and many of the same issues of rural life that make physician retention difficult such as isolation, lack of services, heavy on-call work, and burnout also drive

[105] Though GPs can no longer learn to perform ultrasounds (there was some contradiction as to the reason for this loss of training, either the provincial government or the College of Physicians and Surgeons bowing to pressure from radiologists, the restructuring of medical training, or the outright refusal of radiologists to train GP's who would steal their work) radiologists do travel to rural communities to perform ultrasounds in local hospitals. However, a technician has refused to travel to the hospital in Westtown to perform ultrasounds using the local machine and insists that patients travel to the nearest city (200 kilometers away) where he or she will perform them. This is a source of aggravation in Westtown as the nearing retirement of a physician will leave a (nearly new) local machine underutilized while waiting lists in the nearest city are several weeks long. This same inflexibility, combined with a lack of supervisory personnel, has prevented some IMGs from qualifying to perform procedures in Canada that they routinely practiced in South Africa. A physician explained that he or she was unable to qualify to perform certain procedures in Canada not just because "the door was closed" but because, in some cases, "the door" didn't exist.

away specialists). This would drastically reduce the availability of obstetrical services as all emergency cases would be flown or driven to a hospital over 150 kilometres away at a time when the number of deliveries in the hospital is increasing.

Despite this murky future none of the physicians in either community were actively searching for employment elsewhere. One of the IMG who left the community said that he and his wife had decided that Westtown would be their home but he was offered "the perfect job" in another community where he did not have to be on call, and his wife was also assured work. Likewise a Canadian physician said that if the staffing situation in town worsened and the workloads increased anymore than they were at present "if the perfect job came along I wouldn't turn it down" but he or she was not making an effort to find employment elsewhere. Thus, it is imperative that communities not only integrate their physicians but also do not make them feel taken for granted or misused.

Conclusion

When internationally trained doctors arrive in a community they have little incentive to stay, outside of the temporary work permit, which can only guarantee their residence in a community for one year. It is the responsibility, therefore, for townspeople to not only welcome them into the community but also continually work to involve them and their families in community life. Important factors for retention include a sense of safety, high status in the community, and a high standard of living. Conversely newcomers must also choose to participate in or give back to their communities. This bi-directional exchange seems to further strengthen feelings of connectedness and belonging

to the host community incorporation. Equally important to social incorporation are the professional demands of rural healthcare. Though the community has little say in the structure of rural medicine townspeople must not take the services of physicians for granted and accept that, like many others, a physician needs time away from work as well. A strong sense of connectedness seems to mitigate the seemingly endless demands made on rural physicians and compensates, to some degree, for the limited offerings of small towns, but may not entirely compensate for the draw of a "perfect job" somewhere else. Numerous IMGs noted that "the grass will always be greener somewhere else." Effective processes of inclusion and incorporation can significantly reduce the allure of other places and persuade newcomers that the grass is green enough right where they are.

Chapter 5-Conclusions and Recommendations

Relatively poor availability of physicians in Canada is an ongoing and growing problem. The shortage of physicians is particularly acute in rural areas that have little to offer in terms of commercial diversity and entertainment when compared to Toronto, Vancouver, or Montreal. Provincial governments and rural communities have attempted to develop incentives to attract physicians, both Canadian and international, and to retain them once they arrive. Currently, the physician turnover in rural areas remains high since many physicians (Canadian and internationally trained) are unable to cope with the demands of rural medicine, or view rural positions as temporary postings until they are able to find something better. This has fostered numerous, primarily economic, incentives to increase the retention of rural physicians.

Much has been done to make rural practices and rural life more appealing to IMGs. Incentives to promote continued rural practice include bursaries and forgivable loans, guaranteed incomes, the provincial nomination of IMGs and accelerated immigration processing, and the freedom to practice medicine in the province immediately without having to first write the Canadian medical exams. These are intended to appeal to what Tsuda (1999: 689) refers to as "opportunity migrants." Much like the affluent Hong Kong Chinese immigrants in northern California discussed by Ong (1996), South African physicians are not refugees; they are highly-skilled, upper-middle class professionals who have left their homeland to find something better than what they had (or think they will have) in their home country, in this case South Africa. Growing concern for personal safety and the safety of family members, a complete lack of job

satisfaction, and the desire to maintain a certain lifestyle and quality of life are what persuaded many South Africans to move abroad. The relative ease of licensure, the presence of fellow South African colleagues, and the promise of a good life are what brought them to rural Saskatchewan. It would be possible for these physicians to return to South Africa and find work in their desired field, though not, perhaps, to live their desired lifestyle or provide their children with the future that they believe they can have in Canada. Equally possible is the option of finding employment in another Canadian community, in another province. It is has therefore been the purpose of this project to examine the social factors involved in the settlement, embedding, and retention of South African IMGs in the larger context of these non-local forces.

From Sojourner to Settler

Though it is problematic (if not impossible) to gauge the transition from sojourner to settler (see Tsuda 1999), interviews suggested that feelings of safety, job satisfaction, and a desirable quality of life have been established, to varying degrees, by the physicians in their new communities. Some co-workers noted that South African physicians initially made comparisons between goods, prices, local attitudes, and all manner of daily occurrences to their equivalent in South Africa (e.g., "In South Africa the nurses never ask questions of the doctors"; "Back home we would never pay one dollar for a loaf of bread, that's almost seven rand"). Over time these comparisons generally decreased. Specifically, one Canadian physician observed that after one year to 18 months IMGs stopped converting prices to rands altogether, and this signified to him or her that they

had "settled into a more Canadian way of thinking." The transition from sojourner appears to begin as connections or the orientation to the homeland weakened.

Changing orientations over time was apparent from the interviews with South African doctors. When asked how their life was different in South Africa, those who had been in Canada for less than a year would make comparisons of very minute things such as the cost of house plants, bread, electronics, and specific brands of vehicles. Those that had lived in Canada for two years or more, made more general situational comparisons such as the difference between a barbecue (a "braii") in South Africa and one in Canada, and the relaxed friendliness of Canadians versus the more formal British and Afrikaner cultures. They elaborated on the differences between the Canadian and South African medical systems[106] and the First World/Third world dichotomy of life in South Africa.

Ong (1996) and Tsuda (1999) suggest that settlement and integration into a community are continuous processes, and the reasons for settling may change over time. As such, one must acknowledge that retention is not simply a warm welcome to the community that entices the physician to remain permanently. A friendly welcome may encourage newcomers to settle over the short term, but other factors, such as fulfilling employment, the integration of family, and exchanges of goods, ideas, and relationships between individual townspeople and the newcomer may promote continued settlement. These integrating influences are largely dependant on institutions outside the community's control. It is the social connections of the community that can make rural

[106] This may also be due to their longer experience in the South African medical system before coming to Canada. The two most recently arrived physicians left South Africa immediately after they completed their training. A third physician, who had lived in Canada for over five years had never practiced in South Africa either but also focused more on the differences between medical systems than the costs of household goods.

towns more desirable places to live by providing numerous linkages to the community at large.

Imagined Community

Entry into the community was done through two primary avenues: (1) through co-workers and "adopted families" and (2) through their role as a doctor. Upon their arrival South African IMGs were first welcomed by their co-workers (predominantly South African IMGs and Canadian physicians). While they continue to associate with Canadian physicians, numerous community members and other health professionals observed that they interacted predominantly with fellow South African IMGs, and a few other members of the community (usually associated with the hospital in some way and/or immigrants as well). In this core group, which was often referred to as their adopted family, they often spoke in Afrikaans,[107] organized barbecues and events at the lake, and prepared South African meals (especially curries) that they enjoyed on special occasions. A key element in this group is the commonality of experience as immigrants. In Westtown one member of the retired couple (who became adoptive parents to several South African IMGs)[108] had immigrated from Britain years before, as had a nurse. IMGs from both communities considered other immigrants ("Hindu," "Muslim," Iranian, Bangladeshi, Hungarian) to be friends as well. The presence of other immigrants encouraged the retention of IMGs, particularly if they were professionals, because they had people of equal status, of similar life experience and of a kind with whom to associate (Ortner 1997; Stoller and McConatha 2001).

[107] Noted most often by respondents in Westtown.
[108] Refer to page 77.

The process of integration into the imagined community begins when an IMG (and his or her family) is included in one of these small groups, or core group that is similar in occupation, history, economic status, and marital and family status (Stoller 2002). The personal relationship with adoptive kin members of the core group acted as a "family" in Canada and a bridge to the community at large. Adopted families provided the greatest amount of support for newcomers, and members took new IMGs "under their wing" fostering a sense of belonging for immigrants. As time passed IMGs met the friends of their core group, and met other townspeople as they became more involved in local sports, local churches,[109] and local events. In Westtown it was this adoptive family that organized the triathlon and accounted for most of the participants (as well as other friends of adopted family members and some "die-hard triathloners" from the community at large). Though the core group remained the principal base of their interactions, they made numerous secondary connections (e.g., through the church) and tertiary connections (e.g., buying groceries in a local store), all of which added to their feeling of belonging to the community.

Non-South African core members also treated South African ties as family. For example, an immigrant health professional in Canada traveled to South Africa and visited parents of IMGs. In Westtown, when the parents of South African physicians came to visit them in Canada, they were introduced to the retired couple and this same health professional who were Canadian members of their adopted family. South Africans "wanted [their] parents to meet [their] Canadian family." Networks were developed and

[109] The host communities both offered a dozen different Christian churches from a Catholic church and an Orthodox church to a charismatic Pentecostal Assembly. Physicians attended predominantly evangelical Christian and liberal Christian churches which some community members noted were closest to the Dutch Reformed Church in South Africa.

cultivated not only within the core group but also between the Canadian and South African families.

Entry into the community was also enabled by their position as a doctor. IMGs are well aware of their importance to rural towns:

> Young people are leaving rural towns...Rural Saskatchewan needs the younger generation. There were three doctors in this town and without South Africans there would be no healthcare in this community. Those doctors would have worked themselves into a heart attack without more doctors...

All members of the health community who I interviewed, and two community members at large, recognized the need for IMGs: "Without South Africans there would be no rural healthcare." This immediately provided a sense of belonging because they were filling a needed function in the community.[110]

The work environment is a two-edged sword in that, while it promoted embedding in the community, it also hindered this same process. First was a sense of frustration with the structure of the health system. Regionalization of health services had the effect, locally, of reducing the sense of community in the hospital. Health professionals felt alienated and cut off from the decision making process in their own hospital. They were given orders from the CEO of the health district and they followed those orders. Territoriality, especially of radiologists, prevented physicians (specifically in Westtown) from ensuring the continued delivery of an essential service. Second, the expectations of townspeople, such as demanding access to one's family physician 24 hours a day, aggravated numerous health workers, though it was most pronounced in younger IMGs and Canadian doctors. Health professionals of all stripes believed that "excessive" demands for care, and abuse of the local emergency room in particular, were

[110] See Abu-Laban *et al.* (1999) for more discussion of the international 'bonus' expressed by immigrants providing needed skills to their host communities.

endemic to rural towns and instrumental in driving doctors out of the community. However these aggravations did not appear great enough to drive any of the IMGs in the study out of their community except for one. The physician who did leave who participated in this study said that it was a "perfect job" in his or her preferred area of practice that drew him or her away to another province. Discussion with other physicians and health workers also revealed that this doctor was very close to another physician who also left the community during the time of the field research (though I was unable to speak to him or her). The departure of a close friend weakened ties to Westtown and the local imagined community and the appeal of a job elsewhere in his or her preferred field, without any on call duties, was incentive enough to "domino out" and begin to create ties to another community.

Several physicians who had lived in Canada for over two years also discussed how their profession distanced them from the town. Though they spoke with 30-40 different people every day in their offices these doctor-patient interactions did not lead to friendships because of that same relationship. As one physician observed:

> The problem with socializing in a small town is that when people start treating you as a friend they can't open up to you as a doctor. How would you like to have a pap smear done by your friend? Or be checked for prostate cancer by your friend?

As such, a certain degree of separation from their patients was maintained by IMGs so that they could be more effective physicians.

Though there are numerous hassles that drive doctors out of communities, and a certain degree of separation is maintained to be an effective doctor, these can be countered by social integration, or membership in the imagined community. IMGs enter the community primarily through "adoption," relationships with co-workers, and daily

interactions with other community members. Over time, their immediate "family" and surrounding imagined community grows to encompass the community at large. However if this community is eroded at the core and ties to the community are weakened, such as when a close friend moves away, the difficulties of rural medicine may become unbearable. The key to integration is a sense of belonging to the "imagined community" and as a result, if small towns want to keep their doctors, they must create an environment that encourages and facilitates entry into the imagined community to the same extent as material incentives already being provided.

Identity

Through the integration into a new imagined community most IMGs have changed their identities to include or focus on their new communities. All acknowledged that they did at times feel foreign, or at the very least different because of their accent, or if they spoke to their children in Afrikaans in the supermarket and people looked. However they were quick to note that they did not feel like outsiders or unwelcome. One, who was the most recent arrival in Canada, still spoke about the community in which he or she was practicing medicine in tentative terms: "It seems like a very nice place to live...." "The people in town here have been very friendly...." Other doctors, one of whom was Afrikaner, explained that, though they will always be South African "in our hearts" they are now members of the community in which they live: "We must put those [Afrikaner] things behind us. We're in Canada now...and we must become Canadian." These physicians plan to remain in their community at least until their young children have completed school. As such they seem to straddle the two worlds of which

they are a part. They are no longer completely (white, Afrikaner, English) South Africans, neither are they Canadians, but they are a part of their community none the less and have made a long term commitment to it. The sixth physician felt that he or she had become Canadian. There were still ties to family in South Africa, but the physician and his or her spouse felt that they had settled into rural life and were a part of their community. The general consensus was that, taking all things into account, their present home was good enough. They could go to the movies, go to restaurants, they had close friends, the community was friendly and they were involved in numerous community-based activities; they were successfully embedded and thus were happy.

Retention

Rural medicine is demanding at the best of times. Workloads are heavy, hours are long, and traditional expectations of rural physicians are in conflict with the values of new doctors. Options for entertainment and leisure associated with cosmopolitan living are limited. Easttown and Westtown have a great deal to offer given their remote setting, however this may seem inadequate in terms of appealing to largely urban physicians and IMGs. The beauty of the rural setting was noted by many participants but it was the social activities within that environment that promoted integration and settlement. It is the openness and depth of relationships that the imagined community allowed that mitigated numerous shortcomings of rural life and help internationally trained physicians feel connected and at home in these peripheral communities.

A summary of the research indicates nine key points that physicians (IMGs and to a lesser extent Canadian physicians) find important to their settlement in rural Saskatchewan:

1. Rural towns and local organizations (charities, faith communities, professional organizations) need to create/organize/support more local events (e.g., local hockey tournaments, carnivals, walks, runs, charity drives, community beautification, volunteer activities) that will build overall community cohesion and solidarity and provide points of entry for newcomers.
2. A welcome wagon geared toward physicians and health professionals that would provide a more in-depth introduction to the community and hospital/health system. This includes increased orientation to the community, the hospital, and health system.
3. A "helpful tips" guide on the immigration process and a contact person to answer any additional questions (preferably a fellow physician or IMG) as well as information on the climate, location, local attractions etc. of the community.
4. Communities can offer free passes to the local regional park, the use/free rental of a cabin at the lake, and for those with children, free passes to local family attractions such as the swimming pool, mini-golf, hockey games, a year subscription to the local newspaper, etc.
5. Rural communities are increasingly becoming retirement communities and elderly people will not retire in a community without a hospital. As such local businesses need to ensure that physicians are able to buy a car and other "big ticket" items, create bank accounts, and invest locally.
6. Organize and encourage activities that promote a feeling of community and appreciation within the hospital. These may include birthday/retirement parties for physicians and hospital staff.
7. Communities, hospitals (both the administration and health service providers), and health regions, must work out a long-term retention plan for physicians and other health professionals that addresses the process of replacement and recruiting of physicians and other health professionals.
8. Prevent professional bodies and professions from limiting access to care in rural communities through self-interest and the protection of their "territory."
9. In general, governments and other stakeholders need to focus much more on non-financial, quality of life incentives. As mentioned by several physicians, "Money is good but it can't buy back time with my children."

Based on these points, I have made four recommendations that will enhance integration and retention of physicians. In keeping with the scope of the research project these recommendations focus primarily on local initiatives within the current billing system:

1. Recruit families as much as possible. Families integrate more quickly because of increased exposure to the community and increased ties to the community. Families generally want to buy a home quickly and spouses often work locally and have increased exposure to other community members. Children attend school and/or become involved in recreational activities in the community, and parents are reluctant to interrupt their children's schooling by relocating. All of these factors promote embedding and retention.

2. Treat physicians well. Make certain that they are involved in the community, that they feel that they are a part of the community, and that they feel appreciated. Prevent abuse of health services, and emergency services in particular, and recognize that younger IMGs and Canadian physicians do not share the same values as older physicians. They want a life outside of the hospital.

3. Ensure that physicians (and other health professionals) are able to use all the skills they have. Health professionals indicated a high level of job satisfaction when they felt that they were being challenged professionally and using all of their skills and abilities. Feeling that one is part of an effective team and delivering a very high standard of medicine is imperative to morale and job satisfaction.

4. On the provincial and national scale, remove political roadblocks that hinder the delivery of healthcare in rural communities. Make the educational environment for health professionals more conducive to rural practice, address the inter-provincial discrepancies that perpetuate the inequitable distribution of health service providers, and ensure that the system is focused on providing health service workers with all the tools that they need to care for their patients.

While the nine key points do seem to encourage giving even more to physicians who are already given a lot, this is done for the simple fact that these physicians are crucial to rural healthcare in Saskatchewan (and other provinces). They are equally indispensable to the continued survival of rural communities. As the rural population ages, these communities are becoming retirement communities (as evidenced by the participants in the focus group in chapter one), and one of the most important considerations for retirees is proximity to health care. In the current state of affairs, with fragmented provincial health policies competing for scarce personnel, communities must be willing to give every effort (and incentive) to attract physicians and foster a sense of belonging and embeddedness that will retain them despite the lure of other, competing, communities. Additional research should be conducted with a much larger sample to ascertain whether the findings above are applicable to the larger community of rural physicians or a local effect in the two field communities. Further, the effectiveness of incentives to attract rural students to medical school should be assessed with an eye to improving the supply of healthcare workers in rural Saskatchewan. The effects of an increasingly female physician workforce on rural healthcare delivery and labour planning must also be assessed and addressed with relevant policy modifications.[111]

On the national scale, a comprehensive Canadian strategy must be implemented to stop the movement of physicians from rural to urban communities, from poor to rich provinces, and from "developing" to "developed" nations. Obviously this will require considerable changes on the part of governments, medical training institutions, and health care providers. While these larger issues enter and exit the public eye, small rural

[111] This research topic was suggested by a physician in Easttown.

hospitals continue struggling to maintain personnel so that they can provide adequate care to their patients.

APPENDIX A

Guide of Interview Questions

1. Questions to <u>All</u> Participants

- Could you describe your community?
- Could you describe your place/role in this community?
- Could you describe the quality of health care in your community?
- Has the quality of health care service been affected by internationally trained doctors?
- How do South African Doctors fit into this community?

1.1. Additional Questions to South African Physicians

- What was your life like in South Africa?
- What is it like to train to become a physician in South Africa? Could you compare this to training in Canada?
- Have you maintained relationships with people in South Africa? Explain.
- Why did you choose to immigrate?
- Could you describe your immigration experience?
- How have you been treated during your immigration process? Settlement in this community?
- What sort of relationships have you developed with people in this community?
- What are your futures plans?

1.2. Additional Questions to Medical Professionals

- Could you describe your role in the hospital/health care system?
- Could you describe the culture or "feel" of your work place?
- How would you characterize your contact with South African doctors? (At work, off duty)
- Are South African doctors different from Canadian doctors?

1.3 Officials

- What is your role in the hospital/health care system?
- What is the history of international recruitment in this health district?

- How do you decide who, when, and where to recruit internationally trained physicians?
- How frequently do you have contact with South African doctors?

APPENDIX B

Hospital Classification System

	Community and Northern	**District**
CORE SERVICES	• 24 hours per day/7 days per week coverage (24/7) in general medicine and emergency stabilization. • Low-complexity surgeries and low-risk obstetrical services will also be offered at designated sites.	• 24/7 coverage in general medicine and emergency stabilization. • Low-complexity surgeries and low-risk obstetrical services at all sites.
EMERGENCY	• 24/7 physician on-call. • Initial assessment and triage of all outpatients. • Stabilization and transfer to appropriate expanded emergency services. • Thrombolytic therapy.	• 24/7 physician on-call. • Initial assessment and triage of all outpatients. • Stabilization and transfer to appropriate expanded emergency services. • Thrombolytic therapy.
DIAGNOSTIC	• 24/7 basic radiography and laboratory services available. • Saskatchewan lab licensing category 4 laboratory. Category 5 laboratory at designated sites.	• 24/7 basic radiography and laboratory services available. • Category 5 laboratory.
MEDICINE	• 24/7 acute care – stable medical conditions. • 24 hour observation and assessment, convalescent care, and palliative care.	• 24/7 acute care – stable medical conditions. • 24 hour observation and assessment, convalescent care, and palliative care.
ICU/CCU	• No intensive care unit (ICU)/coronary care unit (CCU).	• Constant observation beds at designated sites.
SURGERY	• General outpatient surgeries with local anesthesia. • Surgical privileges as defined by the College of Physicians and Surgeons of Saskatchewan with consideration of clinical supports available.	• Surgical privileges as defined by the College of Physicians and Surgeons of Saskatchewan with consideration of clinical supports available.
ANESTHESIA	• Local anesthesia. • Family physicians with additional training as defined by the College of Physicians and Surgeons of Saskatchewan at designated sites that perform procedures requiring more than local anesthesia.	• Family physicians with additional training as defined by the College of Physicians and Surgeons of Saskatchewan.

OBSTETRICS	• Emergency obstetrical services. • Low-risk deliveries with appropriate back-up at designated sites.	• Emergency obstetrical services. • Low-risk deliveries with appropriate back up.
PEDIATRICS	• Observation and assessment.	• Observation and assessment. • Stable pediatric medical conditions.
PHYSICIAN STAFFING GOAL	• Minimum 1 family physician on staff linked into group practice consisting of 3 family physicians. 3 or more family physicians on staff at larger facilities.	• 5 to 7 resident family physicians plus family physicians with additional training in anesthesia and surgery.
NURSING STAFFING	• 24 hour on-site registered nursing (RN) coverage.	• RN staffing may include a mix of basic and advanced skills and training.

	Regional Subdivided into 2 Groups - Level 1, Level 2	Provincial
CORE SERVICES	• Services at District Hospitals plus core specialty services (internal medicine, general surgery, obstetrics, and gynecology).	• Services at Regional Hospitals plus subspecialty services. • Some services may be offered from 1 designated site within a city. • Highly specialized services may be offered from 1 designated site within the province, or in neighbouring provinces.
EMERGENCY	• Services at District Hospitals plus: • Range and complexity of care appropriate to diagnostic and critical care supports available.	• Services at Regional Hospitals plus: • 24/7 emergency room physician. • Full trauma services.
DIAGNOSTIC	• Services at District Hospitals plus: • Fluoroscopy • Additional diagnostic imaging capabilities at designated sites. • Category 6 laboratory.	• Services at Regional Hospitals plus: • Interventional radiology, magnetic resonance imaging (MRI), nuclear medicine, hemodynamic laboratory services.
MEDICINE	• Services at District Hospitals plus: • Internal medicine.	• These hospitals will offer the broadest range of specialist services in the province including cardiology, neurology, and nephrology among others.
ICU/CCU	• Services at District Hospitals plus: • Intensive care unit. • 24/7 physician on-call assigned to unit.	• Services at Regional Hospitals plus: • Full critical care response. • 24/7 physician on-site assigned to unit(s).
SURGERY	• General surgical procedures as determined by clinical supports available (e.g. anesthesia, pathology). • Designated sites may provide services in the following areas after core programs fully functional: orthopedics, ophthalmology, urology, and otolaryngology.	• These hospitals will offer surgical procedures of higher complexity across all disciplines. • Specialist coverage in: orthopedics, ophthalmology, urology, otolaryngology, neurosurgery, plastic, cardiac, vascular, thoracic, and oral surgery.
ANESTHESIA	• Specialist anesthetists and family physician with additional training as defined by the College of Physicians and Surgeons of Saskatchewan.	• Specialist anesthetists.

OBSTETRICS	• Obstetrical services including planned and emergency cesarean sections.	• Services at Regional Hospitals plus: • High-risk deliveries. • Neo-natal intensive care unit (NICU).
PEDIATRICS	• Services at District Hospitals plus: • More complex case management in sites with pediatricians.	• Services at Regional Hospitals plus: • Pediatric surgery. • Pediatric subspecialists. • Pediatric intensive care unit (PICU).
PHYSICIAN STAFFING GOAL	• 3 specialists (certified or family physician with additional training) in core specialty areas.	• 3 physicians in each specialty area. • 24/7 on-site or on-call coverage in select subspecialty areas.
NURSING STAFFING	• Nurses covering ICU and other specialized units must have education and qualifications appropriate to services provided at a regional facility.	• Nurses covering ICU and other specialized units must have education and qualifications appropriate to services provided at a provincial facility.

Source: Saskatchewan Government 2001: 70-71.

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