

THE STING OF NETTLES IN FOREIGN PASTURES

Impending laws strike financial fear into the guts of private local physicians, tertiary institutions crumble alarmingly and public sector salaries are woeful — but the foreign grass on the other side of the fence hides some very prickly green nettles. This emerged from a special CME probe prompted by doctors' fractured and sometimes emotive reactions to the current wave of change sweeping South Africa's health care environment.

A study of comparable foreign health care regulations and interviews with local doctors who made the leap, either to improve their financial lot or to hopefully sink roots into foreign soil, unfurled three main cautionary red flags. The first bears the heraldry of the 'golden handcuff', the second shows a temporarily empty wallet and the third sports interlocked Olympic loops of red tape. All are ignored at some peril by doctors willing to brave foreign climes in search of financial security and less stressful environments.

Dr Lynette Nel, a returnee Pretoria psychiatrist, bought herself out of a lucrative Australian contract in which she oversaw 800 colleagues, registrars, nurses and occupational therapists in the Illawara region of Sutherland, south of Sydney. As the Mental Health Manager for an area 300 km long by 100 km wide with a population of 800 000, she simply got 'tired of being told how to boil the kettle, attending one-hour lectures on hand-washing and how to use the fire extinguisher'. The region has just 80 acute mental health beds. 'They employ you to make changes, but you find yourself hamstrung by bureaucratic procedures, the unions...and everything, including your visa, is tied to your job — it's like a golden handcuff,' she warned. She said virtually every decision was made on behalf of foreign qualified doctors, down to the make and colour of their 'company' car.

Getting a doctor's job in Australia has become easier, and within 2 years you can now sit your fellowship exam and even apply for a permanent position, if appropriately qualified. Nel said her recruitment agent netted R238 500 (AU\$ 53 000), 'just to get my backside in the seat'. Yet her initial contract failed to mention that if she quit she would have to repay the authorities on a *pro rata* basis, nor that her child's annual school fees of R22 050 (AU\$ 4 900) had to be paid in advance. It also cost her R9 000 (AU\$ 2 000) to have her CV and degrees reviewed by the Royal College of Psychiatrists of Australia and New Zealand, and to take the observed short clinical examination. Foreign doctors can wait for well over a year for this as they stand in line behind local doctors.

Nel says Australian IT infrastructure is generally excellent, some hospitals have 'very fancy' equipment and doctors may dispense drugs, but the free MediCare health system for residents creates a patient entitlement mentality and a litigious climate. Australia has some of the world's highest premiums for medical protection, and physicians' estates can be sued for up to 14 years after their death.

Most doctors work sessions with government and do limited private practice. As in South Africa, foreign GPs tend to be despatched to remote areas. A private psychiatrist earns R675 (AU\$ 150) per hour.

While her contract allowed her 5 weeks' annual conference time and a R112 500 (AU\$ 25 000) allowance for travel and accommodation, the reality was that her work schedule made this impossible. 'I thought the weather, the large expat community, the slightly more expensive cost of living, plus the idyllic coastline would make it OK, but the people are really different, and the bureaucracy is too much,' she said.

Nel said the lustre of the 'golden handcuff' had proved too bright for some of her colleagues who had 'stayed too long' and could no longer afford to return home. 'I must say my working environments in Ireland and the UK were better and my colleagues who went to Canada seem much happier — if you want to be a slave for 10 years, go Down Under,' she concluded.

On the other side of the world, in Manitoba, Canada, sits Dr Anton Meyer, a former family physician from Reitz in the Free State. Meyer 'jumped the fence' to explore the Manitoban vastness 3 years ago — and stayed. Not only has he untangled Canadian red tape and forked out over R75 000 to settle and write the necessary exams, he's persuaded the federal government to grant him the first-ever private licence to deliver medical services in under-resourced rural areas.

A former JUDASA chairman and HPCSA councillor for 2 years, Meyer is an emergency medicine specialist and has set up a company flying family physicians into remote, under-served communities in Manitoba. He says only three provinces in Canada will take foreign doctors — British Columbia, Manitoba and Saskatchewan, in that (declining) order of difficulty (to get into). Alberta might look at South African qualified physicians under exceptional circumstances.

In the first two, doctors can potentially earn four times their equivalent South African salary, and in Saskatchewan about double, Meyer reckons. 'But they must be prepared to endure the difficult and sometimes unpleasant environment of isolated, under-serviced areas. For many it wouldn't be conducive to an acceptable quality of family life,' he added.

A prime mover and architect of a currently stalled scheme to set up a structured government-to-government physician service between South Africa and Canada, Meyer's business involves the 'ethical recruitment' of foreign qualified, Third World physicians. He plugs them into his 2-year Canadian government contracts to deliver rural health services. He cites the example of a married couple he recently hired, both physicians, who qualified in South Africa 3 years ago before going to work in New Zealand. 'The guy still had a R134 000 student debt and his wife a R121 000 student debt — after 4 months of arriving here from New Zealand they paid it all off, even visited Disney World, and are now set for life.'

Meyer contrasts this with the 7 years it took him to pay off his student debt through his private practice in South Africa. He says if doctors are prepared to carry the initial financial burden, write the exams and keep on learning, few would think about returning to South Africa.

However, a survey of 82 South African doctors by the Canadian Colleges of Medicine shows that after 10 years (1992 - 2002) a full 71% had left Canada. Of those surveyed, 35% were back in South Africa. Meyer claims this trend will change as South African doctors' income and capital assets are eroded by the fast changing local legislative environment.

A former Vice President of the vast Burntwood Regional Health Authority in Manitoba, Meyer remains shocked at the poor educational standards in Canada. When his daughter was promoted from grade 9 to grade 12 in just 6 months, he realised 'just how much better' South African standards were.

Foreign qualified doctors in Canada have 5 years to qualify for the licentiate of the Medical Council. Meyer did his in 3, writing the equivalent of the final-year South African exam, doing the clinical case presentation and then, in addition, retaking the speciality degree in family medicine to enter the equivalent Canadian College certification exam (CCFP).

His country-to-country physician service idea stalled when his key fellow negotiator, former South African Director General of Health, Dr Ayanda Ntsaluba, resigned. It currently languishes with former SAMA CEO and chief DOH advisor, Dr Percy Mahlati, who is powerless until Ntsaluba's successor is officially appointed.

Meyer's idea is to give preference to under-paid, suitably qualified local public health sector Medical Officers and have them deliver services in rural Canadian areas for between 6 months and 2 years. They would then work this time back with their respective South African provincial health authorities. 'They'd be paid very handsomely and could in time return to a position as senior MO, then go into rotation once again if they chose,' he added.

Meyer says the proposal is currently with the South African and Canadian consulates and he is confident that it could become a 'win-win ethical reality' within 6 months. At present he oversees the placement of about 50 foreign qualified doctors per year into Saskatchewan and Manitoba and says he is flooded with 'hundreds' of e-mails. Only half of the applicants meet the criteria, which require at least 2 months of rotation in internal medicine, pediatrics, psychiatry, surgery, and obstetrics and gynaecology. In addition applicants need to have at least 2 years of post-graduate training and then 2 years of experience (which can overlap).

He said the South African government approached Canada 4 years ago requesting it to stop actively recruiting South African health care staff, leading directly to the steep spike in transition costs. The evaluation exam alone now costs the equivalent of R5 000, and the subsequent assessment and registration a further R17 500.

On the foreign health care legislative front, CME queries show that attempts to regulate where doctors, particularly newly qualified ones, may practise were abandoned in nearly every province in Canada. However, drug dispensing by doctors there today remains confined to remote locations, and is almost exclusively the domain of pharmacists.

In New Zealand, doctors face no geographic practice restrictions once they've completed their internship year or later, but they must complete specialist or vocational post-graduate training before they can work independently. According to Fleur-Ange Lefebvre, executive director of the Federation of Medical Regulatory Authorities of Canada, South African doctors (who now comprise 10% of Canada's hospital-based physicians) would empathise with the problems faced by their counterparts in Canada's public health system, which is entirely public. Lefebvre said doctors face heavy time demands, struggle to balance their work and personal/family lives, have to deal with serious staff shortages and rely on a 'revolving door' pool of foreign physicians.

While there are limitations in resources and at times long patient waiting lists, the principle is that everyone has the same access to the same resources. Lefebvre says primary health care reform is being examined in many jurisdictions, but no 'brilliant solution' has yet been found.

The biggest HIV/AIDS issue in Canada and New Zealand is what kind of practice physicians with infectious blood-borne pathogens may or may not carry out. The chief concern in South Africa is the opposite — the risks posed to doctors by huge AIDS-related caseloads. These were some of the themes to emerge from the CME straw poll. If you thought doctors were only scrambling to get 'out' of South Africa, think again.

Shaun Allan-Smith, head of the South African health department's Foreign Workforce Management Programme, says his office now receives over 1 000 pages worth of faxed queries daily from foreign health care workers. He advised any foreigner due to sit HPCSA entrance exams to 'first e-mail, fax or DHL me their fully dated details, endorsements and letters of support, so we can determine their employability'. This would save 'much heartache' if they passed the exam but fell foul of the international 'non-poaching' agreements South Africa had with various countries.

Foreigners studying medicine at South African universities must sign agreements to return to their countries of origin upon qualifying. Anyone offering them a job in South Africa is subject to legal penalties. Since the tangle of confusing red tape between the departments of Home Affairs and Health was unravelled last year, the number of foreign doctors and dentists whose applications were approved has quadrupled (from 25 to 100 per month). This is mainly due to the long overdue alignment of the public health sector's recruitment policy with the 2002 Immigration Act — prompted in part by court actions brought by foreign qualified doctors. The DOH now has a fledgling but aggressive scarce skills recruitment strategy carried out by Allan-Smith's fully staffed Foreign Workforce Management unit set up in April last year.

Yet overall it seems discrimination remains the one nettle foreign qualified doctors the world over have to grasp if they are to benefit from foraging in 'greener' pastures.

Chris Bateman



Dr Gawie Muller enjoys a new-found job perk in Northern Manitoba.



Taking some ice with his water; Dr Hermann Visser now works in Manitoba.

SINGLE SUTURE

ONLY FREE CONDOMS WORK

Well, not quite the correct phraseology, but the message is correct. Research done in the USA by Deborah Cohen and Thomas Farley found that the difference in uptake between low-price condoms and free condoms was enormous. And this was in Louisiana, hardly somewhere you would expect large numbers of indigent people. Cohen and Farley started a programme in 1993 that now distributes some 13 million free condoms annually through about 1 900 retail outlets and publicly-funded clinics. In the first 3 years they found that this free distribution was followed by an increase in condom use from 40% to 54% in men and from 28% to 36% in women. Between 1996 and 1997, they added a small cost, \$0.25 each. Immediately, the number of condoms distributed plummeted by 98% and condom use among people with 2 or more sexual partners dropped from 77% to 64%. Their message? Social marketing of condoms is great, but we need more free condoms.

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