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On the Move: The Migration of Health Care Providers in Canada

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Abstract

A key sector to examine the mobility of highly skilled workers is within the domain of health care. The purpose of this pilot study/environmental scan was to: 1) examine the demographic and policy contexts around the migration of physicians, nurses, midwives and psychologists into and out of Canada using the provinces of Ontario, Manitoba and Quebec as referents; and 2) begin to identify the gaps that exist between the policies of various institutions and regulatory bodies to best match the supply and demand of skills and resources needed in our evolving health care system. The methodological approach employed in this study involved first examining the flow of physicians, nurses, midwives and psychologists into and out of Canada through available datasets and published documents; and second linking these flows to the policies of professional regulatory bodies and government departments (i.e., immigration, health, human resources) at the national and provincial/state level through the analysis of key policy documents and key informant interviews. Our findings highlight how the key health care migration issue before us is not so much the emigration of health care providers which was salient in the late 1990s, but the effective and efficient integration of the internationally educated into the health care system. Indeed, we have better data on the inflow of some health care providers into Canada than we do of the outflow. We also found that the ebb and flow of health care providers into and out of Canada is due in large part to policy decisions and the broader policy context of health human resources. Many of the most recent policies attempt to address the key barriers experienced by internationally educated health care providers. Some of the key partnerships that have emerged in the new programs to reduce barriers has been between the various organizations involved - both government and professional - at the national and provincial level. A key ethical debate that has emerged is whether we should be viewing immigration as a solution to our skilled worker shortages or whether we should be attempting to achieve *self-sufficiency* insofar as the number of health care providers in the country are concerned. Because of Canada's unique position of being both an importer as well as an exporter of health care providers, it is imperative upon us to use this position to become a world leader in ways in which to attend to the issues that both draw health care providers to our country and away from it.

Résumé

L'un des secteurs clés où il convient d'examiner la question de la mobilité de la main-d'œuvre hautement qualifiée est celui des soins de santé. Cette étude pilote ou analyse de l'environnement avait pour but : 1) d'examiner les contextes démographique et politique entourant la migration des médecins, des infirmières, des sages-femmes et des psychologues qui entrent au Canada ou qui en sortent en utilisant les provinces de l'Ontario, du Manitoba et du Québec comme références; 2) de commencer à cerner les écarts entre les politiques des divers établissements et organismes de réglementation de manière à mieux jumeler l'offre et la demande de main-d'œuvre spécialisée et de ressources nécessaires à notre système de soins de santé en évolution. La méthodologie utilisée consistait tout d'abord à examiner les flux de médecins, d'infirmières, de sages-femmes et de psychologues qui entrent au Canada ou qui en sortent à partir des ensembles de données existants et des documents publiés; ensuite, nous avons

lié ces flux aux politiques des ordres professionnels et des ministères (p. ex. l'immigration, la santé, les ressources humaines) à l'échelle de la nation, de la province ou de l'État grâce à l'analyse d'importants documents stratégiques et d'entrevues auprès de personnes clés. Les résultats de notre étude montrent que la question de la migration des soins de santé qui nous préoccupe ne concerne pas tant l'émigration des fournisseurs de soins de santé, qui était importante vers la fin des années 1990, mais l'intégration efficace et efficiente des personnes instruites à l'étranger dans le système de soins de santé. Or, nous disposons de meilleures données sur l'entrée de certains fournisseurs de soins de santé au Canada que sur leur sortie. Nous avons aussi constaté que le flux et le reflux des fournisseurs de soins de santé à destination et en provenance du Canada est, en grande partie, attribuable aux décisions stratégiques et au contexte global des politiques en matière de ressources humaines de la santé. Bon nombre de politiques récentes visent à lever les principaux obstacles auxquels sont confrontés les fournisseurs de soins de santé instruits à l'étranger. Dans le cadre des nouveaux programmes destinés à abolir ces obstacles, des partenariats ont été formés principalement entre les divers organismes intéressés, gouvernementaux ou professionnels, à l'échelle nationale et provinciale. Une question éthique se pose : devrait-on envisager l'immigration comme une solution à notre pénurie de main-d'œuvre spécialisée ou devrait-on essayer d'atteindre *l'autosuffisance* en ce qui a trait au nombre de fournisseurs de soins de santé au pays. Étant donné la position particulière du Canada en tant qu'importateur et exportateur de fournisseurs de soins de santé, il importe au plus haut point que nous profitions de cette position pour devenir un chef de file dans la manière d'aborder les questions qui attirent au Canada les fournisseurs de soins de santé et celles qui les en éloignent.

Table of Contents:

Executive Summary

A key sector to examine the mobility of highly skilled workers is within the domain of health care. While health-care workers have long been nationally and internationally mobile, there has been little study of the policy or institutional response to their migration patterns particularly from a comparative perspective. The purpose of this pilot study/environmental scan was to:

- examine the demographic and policy contexts around the migration of physicians, nurses, midwives and psychologists into and out of Canada using the provinces of Ontario, Manitoba and Quebec as referents; and
- begin to identify the gaps that exist between the policies of various institutions and regulatory bodies to best match the supply and demand of skills and resources needed in our evolving health care system.

The methodological approach employed in this study involved:

- examining the flow of physicians, nurses, midwives and psychologists into and out of Canada through available datasets and published documents; and
- linking these flows to the policies of professional regulatory bodies and government departments (i.e., immigration, health, human resources) at the national and provincial/state level through the analysis of key policy documents and key informant interviews.

The Demographic & Policy Context of Health Labour *Immigration* to Canada

Internationally educated physicians, nurses, midwives and psychologists are a crucial component of health human resources in Canada. For example, immigrant doctors account for roughly one quarter of all physicians practicing in Canada and similarly, six percent of all nurses have been trained in other jurisdictions. The source countries for internationally educated physicians, nurses, midwives and psychologists differ across these cases and have also shifted over time. For example, whereas physicians used to come from the U.K., the more likely source has recently been South Africa. Internationally educated nurses largely come from the Phillipines but also from the U.K. The demographic data available on midwives and psychologists is more variable making sound comparisons with these groups difficult.

The ebb and flow of health care providers into and out of Canada is due in large part to policy decisions and the broader policy context of health human resources. Many of the most recent policies attempt to address the key barriers experienced by internationally educated health care providers. Several barriers to internationally trained health care provider integration have been noted in the literature, including:

- Poor information available to prospective immigrants overseas;
- Difficulty in having educational credentials recognized;
- Navigating through the policies, practices and procedures for registration; and
- The time and costs associated with being assessed.

An overarching criticism has been the many layers of organizations involved in the integration process and the lack of communication across these stakeholders. In response to these concerns, one of the key partnerships that has emerged in the new programs to reduce barriers has been between

these various organizations - both government and professional bodies both at the national and provincial level. For example, the integration processes for medicine, nursing and midwifery have with federal funds all moved towards a national based system of information and coordination.

The Demographic & Policy Context of Health Labour *Emigration* from Canada

Canada is both an importer as well as an exporter of health labour. Just as we have found fluctuations in the volume and demographics of health care providers who migrate to Canada, we find similar fluctuations in the number of providers leaving the country. We do, however, have better data on the inflow of health care providers into Canada than we do of the outflow. Generally speaking, across all professions the primary destination for those who leave is the United States - largely for better pay and working conditions.

Similar to the case for immigration, what is also clear from these demographic trends is that various health care and health human resource policy have an important influence. For example, many have linked anger over health care cuts to the emigration of physicians and nurses in the mid 1990s. Indeed, we know that the reasons cited by health care émigrés from Canada were primarily job-related, including job availability and satisfaction, and the amount of resources devoted to the health care system. Trade agreements may help ease the flow but generally have not had as great an impact as some would have thought. Very little is know about the factors affecting return migration of health care providers who leave Canada though there are a few dedicated provincial 'repatriation' programs.

To summarize, the key health care migration issue before us is not so much the emigration of health care providers which was salient in the late 1990s, but the effective and efficient integration of the internationally educated into the health care system - that is a 'brain waste' rather than a 'brain drain' issue. A related ethical issue of increasing international significance is whether we should be viewing immigration as a solution to our skilled worker shortages or whether we should be attempting to achieve *self-sufficiency* insofar as the number of health care providers in the country are concerned. Moreover, if we direct our attention and our policies towards international migration - as it seems to be we are determined to do - a related concern is regarding whether we should actively recruit internationally trained health care providers (as has been the case) or simply focus on better integrating those providers who are already here. This latter group is "a source of untapped skilled workers and if not integrated into the Canadian labour force, represents a loss of human capital" both to Canada and the country from which the provider came. Because of Canada's unique position of being both an importer as well as an exporter of health care providers, it is imperative upon us to use this position to become a world leader in ways in which to attend to the issues that both draw health care providers to our country and away from it. In both cases, a strong argument can be made for better recruitment and retention strategies within Canada to stem the tide of those leaving the health professions - not just for other countries, but altogether - and reducing the necessity for us to go outside our borders to recruit.

Abbreviations

ACHDHR	Advisory Committee on Health Delivery and Human Resources
AIPSO	Association of International Physicians & Surgeons of Ontario
APT	Access to Professions and Trades *(Ontario)*
CAM	Canadian Association of Midwives
CaRMS	Canadian Resident Matching Service
CAPE	Clinicians Assessment and Professional Enhancement *(Manitoba)*
CARE	Creating Access to Regulated Employment *(Nurses, Ontario)*
CFNU	Canadian Federation of Nurses Unions
CFPC	College of Family Physicians of Canada
CIC	Citizenship and Immigration Canada
CICIMG	Canadian Information Centre for International Medical Graduates
CMA	Canadian Medical Association
CMM	College of Midwives of Manitoba
CMO	College of Midwives of Ontario
CMQ	Collège des médecins du Québec
CMRC	Canadian Midwifery Regulator's Consortium
CNA	Canadian Nurses Association
CNO	College of Nurses of Ontario
COFM	Council of Ontario Faculties of Medicine
CPA	Canadian Psychology Association
CPO	College of Psychologists of Ontario
CRNE	Canadian Registered Nurse Examination
CRNM	College of Registered Nurses of Manitoba
CPSM	College of Physicians and Surgeons of Manitoba
CPSO	College of Physicians and Surgeons of Ontario
DLI	Department of Labour and Immigration *(Manitoba)*
EPPP	Examination for Professional Practice in Psychology
FCR	Foreign Credential Recognition program *(HRSDC)*
FMRAC	Federation of Medical Regulatory Authorities of Canada
FTNs	Foreign Trained Nurses
GoFMS	Graduates of Foreign Medical Schools
HRSDC	Human Resources and Skills Development Canada
IENs	International Educated Nurses
IEN-DP	Diagnostic Project for International Educated Nurses
IMGs	International Medical Graduates
IMPP	International Midwifery Pre-registration Program *(Ontario)*
ITWI	Internationally Trained Workers Initiative *(HRSDC)*
LMCC	Licentiate of the Medical Council of Canada
LPN	Licensed Practical Nurse
MAFTD	Manitoba Association of Foreign Trained Doctors
MCC	Medical Council of Canada

MCCEE	Medical Council of Canada Evaluating Exam
MCCQEI	Medical Council of Canada Qualifying Exam I
MCCQEII	Medical Council of Canada Qualifying Exam II
MICC	Ministère de l'Immigration et des Communautés Culturelles *(Quebec)*
MLI	Manitoba Labour and Immigration
MLPIMG	Medical Licensure Program for International Medical Graduates *(Manitoba)*
MMH	Manitoba Ministry of Health
MRCI	Ministère des Relations avec les citoyens et de l'Immigration *(Québec)*
MSSS	Ministère de la Santé et des Services Sociaux *(Québec)*
NAS	National Assessment Strategy *(Midwifery)*
OACCPP	Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists
OIIQ	Ordre des infirmieres et infirmiers du Québec
OIMGP	Ontario International Medical Graduate Program
OMCI	Ontario Ministry of Citzenship and Immigration
OMHLTC	Ontario Ministry of Health and Long Term Care
OPAS	Office for Partnerships for Advanced Skills *(Ontario)*
OPQ	Ordre des psychologues du Québec
ORA	Ontario Regulators for Access
OSCE	Objective Structured Clinical Exam
OSFQ	Ordre des sages femmes du Québec
PAM	Psychological Association of Manitoba
PLA	Prior Learning Assessment
PLAR	Prior Learning Assessment and Recognition program *(HRSDC)*
PLEA	Prior Learning and Experience Assessment
RCPSC	Royal College of Physicians and Surgeons of Canada
RM	Registered Midwife
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
RSQ	Recrutement Santé Québec
SAEE	Self Assessment Evaluating Examination *(MCC)*

1. Introduction

A key sector to examine the mobility of highly skilled workers is within the domain of health care. While health-care workers have long been nationally and internationally mobile, there has been little study of the policy or institutional response to their migration patterns particularly from a comparative perspective. An examination of the process and impact of current health care migration trends is of critical importance because labour markets are becoming international in scope and labour mobility under international trade agreements is often a requirement.[1] This has increased both the size and velocity of migration internationally. Moreover, concerns about the international migration of health care providers have become a more prominent and controversial feature of health sector analysis in recent years in light of severe staff and skill shortages in health systems of many countries.[2]

While some have lamented about Canada's health care "brain drain" [3] [4] it is important to note that we are not just an exporter of health labour, but a significant importer as well. For example, immigrant doctors account for roughly one quarter of all physicians practicing in Canada and similarly, six percent of all nurses have been trained in other jurisdictions.[5] [6] But although many internationally educated health care providers get in, many do not. Some have claimed that this is because immigration and professional regulatory policies have become more complex and with greater disconnect between these institutions leaving a gap in matching available skills to requirements. As one health care commentator has pointed out, there are "[c]omplex and interdependent actors in multiple jurisdictions with unaligned accountabilities. Governments do one thing, educational institutions do another, and regulatory authorities do a third."[7] This lack of coordinated policy for health labour immigration (until most recently) has become much more salient in the political landscape across Canada.

Further, although there is a growing literature devoted to the migration of nurses and physicians [8] [9] [10] [11] [12] [13] very little compares the situation of these two professional groups. Doing so would better enable analysts to tease apart the influences of various institutional forces – such as hospital employment versus private practice – as well as gender influences on migration. Bringing into focus the migration of other health care provider groups, such as midwives and psychologists,[14] [15] rarely addressed in policy or in the literature could help expand the lens of comparison along gender and institutional lines while at the same time addressing issues related to the prevailing human resource crises in maternity and mental health care.[16] Comparative research of this nature would also allow us to contrast the process and outcomes of the various models created across professions to deal with the issue of migration.

1.1 Research Objectives

The goals of this study was to:

- examine the demographic and policy contexts around the migration of physicians, nurses, midwives and psychologists into and out of Canada using the provinces of Ontario, Manitoba and Quebec as referents; and
- identify the gaps that exist between the endeavours of various institutions and regulatory bodies to best match the supply and demand of skills and resources needed in our evolving health care system.

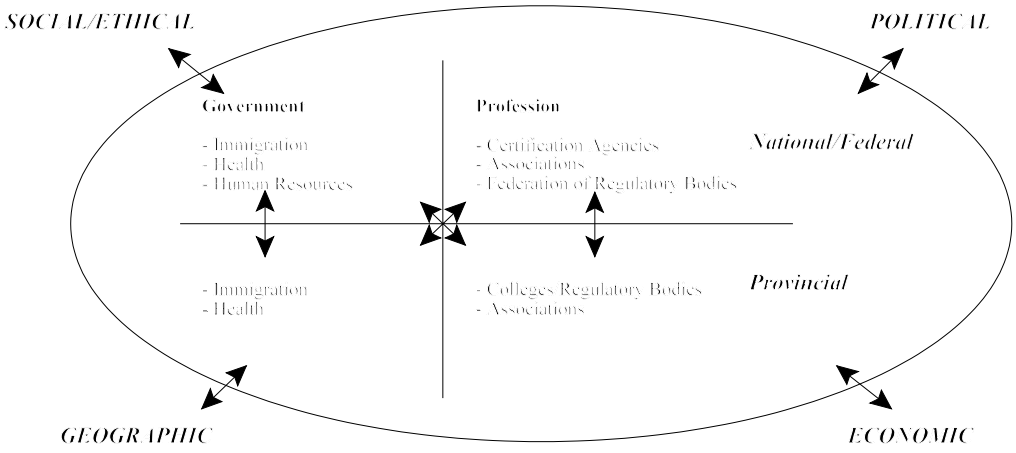
1.2 Conceptual Framework

The analysis of the relationship between state policies and professional regulation of health care immigration and emigration brings together two key levels of analysis – the *meso* (institutional) and the *macro* (contextual):

- We began our analysis at the *MESO LEVEL*, examining the strategies and policies of professional associations and colleges, government departments (i.e., immigration, health, human resources), professional regulatory bodies and recruitment agencies at the national and provincial/state level through a combination of document analysis and key informant interviews;
- We then link this level of analysis to the *MACRO LEVEL,* examining the impact on health labour migration of national and multinational trade agreements, immigration policy and the health and social service needs in Canada. This was accomplished through a subsequent search and analysis of contextual documents and interviews with relevant key informants to help better situate the policies in the three provinces in a political, social, economic and geographic context.

Both of these levels of analysis informed the other to ensure the most accurate understanding of the interconnectedness of policies and the broader contexts under question. A visual depiction of this conceptual framework of the policy influences on the migration of health care providers is provided in Figure 1.1 (below).

Figure 1.1 Conceptual Framework of the Policy Influences on the Migration of Health Care Providers



2. Methods

An exploratory, largely qualitative approach was employed in this environmental scan involving the collection of documents and conduct of interviews with key informants influential in the policy and regulatory decision-making process around the migration of health care providers into and out of Canada.

2.1 Selection of Provincial Cases

Given that professional regulation in Canada is a provincial jurisdiction, it is important to have more than one province from which to gather data with some variability in migration policy, practices and experiences. The provinces of Ontario, Quebec and Manitoba were chosen as the provincial referents for the comparative analysis in Canada because they represent variability as well as comparability. There is variability in the policies around the integration of internationally educated health care providers, variability with respect to immigration context, and comparability in terms of all provinces having regulation for all four provider groups.

For each of the three provinces, data were collected through: 1) the acquisition of key policy documents, position statements and commentaries from the various provider/stakeholder groups (e.g., professional associations and colleges, government departments (i.e.., immigration), regulatory bodies and recruitment agencies); and 2) interviews conducted with 31 key informants involved in the health care migration policy decision-making community. Many of the documents and several of the interviews focused on the national level and the relationship between the national and provincial jurisdictions.

2.2 Documentary Data Collection

The data collection process began first with the collection of background documents and material publicly available on various stakeholder websites (see Table 2.1 for target institutions and organizations and Appendix 1 for list of relevant websites searched). These include publicly available reports, proceedings from committee and task force meeting, memos and correspondence between various stakeholder groups involved in the migration of health care providers. Information garnered from the documents and websites helped to sketch out the context and dynamics within Canada and within each province which were further fleshed out in the interview process. The documents and website materials were also a critical source of information for the identification of the most important key informants to be interviewed.

2.3 Interviews with Key Informants

Interviews were conducted with representatives from the various stakeholder groups in each of the three provinces and federal/national key informants (see Table 2.1). Two additional interviews were conducted with the director of a midwifery bridging program in Ontario and a representative of the Association of International Physicians and Surgeons of Ontario. In selecting informants, care was taken to ensure that a variety of perspectives are represented in the interview as well as the documentary data. Interviews lasted on average 30 to 45 minutes and were with one exception tape-recorded for subsequent transcription.

Table 2.1 Key Stakeholder Groups Identified for Documentary Data & Contacted for Interviews

Level	Organization/Agency
Federal Government Agencies	• Citizenship and Immigration Canada *(unable to set up interview)* • Human Resources and Skills Development Canada *(n=2)* • Health Canada *(n=2)*
Provincial Government Agencies	Ontario • Ontario Ministry of Citzenship and Immigration *(unable to set up interview)* • Ontario Ministry of Health and Long Term Care *(unable to set up interview)*
	Quebec • Ministère de l'Immigration et des Communautés Culturelles *(n= 3)* • Ministère de la Santé et des Services Sociaux *(n= 1)*
	Manitoba • Manitoba Labour and Immigration *(Referred to Ministry of Health)* • Manitoba Ministry of Health *(n= 4)*
National Professional Organizations	• Medical Council of Canada *(n= 1)* • Royal College of Physicians and Surgeons of Canada *(n= 1)* • Canadian Nurses Association *(n= 1)* • Canadian Midwifery Regulators Consortium *(n= 1)* • Canadian Psychological Association *(n=1)*
Provincial Professional Organizations	Ontario • College of Physicians and Surgeons of Ontario *(n= 2)* • College of Nurses of Ontario *(n= 1)* • College of Midwives of Ontario *(n= 1)* • College of Psychologists of Ontario *(n= 1)*
	Quebec • Collège des médecins du Québec *(n= 1)* • Ordre des infirmieres et infirmiers du Quebec *(n= 1)* • Ordre des sages femmes du Quebec *(n= 1)* • Ordre des psychologues du Québec *(n= 1)*
	Manitoba • College of Physicians and Surgeons of Manitoba *(n= 1)* • College of Registered Nurses of Manitoba *(n= 1)* • College of Midwives of Manitoba *(n= 1)* • The Psychological Association of Manitoba *(declined)*

The content of the interviews differed for each participant so that we could tap into their specific area of knowledge and expertise and help fill the gaps left by the documentary analysis. Therefore, the interview guides were more fully developed throughout the research and interview process but a draft received full ethics approval with the McMaster Research Ethics Board (see Appendix 2 and 3 for Letter of Information and Consent forms). The interviews followed a loosely structured guide to ensure that key issues were addressed but at the same time included several open-ended questions that allowed for unanticipated information of critical importance to the research questions at hand (see Appendix 4).[I]

[I] The Letter of Information, Consent Form and the Semi-Structured Interview Guide were all translated into French for the Quebec interviews.

Structured questions addressed the following key issues:

- *a description of the role of the key informant's agency, institution or organization in this process;*
- *a description of the present state of affairs in terms of the migration of physicians, nurses, midwives and psychologists* (depending on the informant's background)*;*
- *a description of the various policies or other contextual influences;*
- *the identification and description of the position of various stakeholder groups; and*
- *identification of critical debates and disjunctures of policy.*

These structured questions were modified depending on the feedback of participants throughout the interviewing process. Unstructured questions (i.e., probes) were used to help obtain further depth and completeness to participants' responses and to help identify relationships between responses.

2.4 Data Analysis

Data collected through the documents and the key informant interviews were analyzed simultaneously via systematic, documented procedures of thematic and constant comparative analysis. This involves a constant iterative process of going back and forth between documents and interviews in producing a multifaceted description of the demographic and policy contexts in each of the three cases. It began with the analysis of the documentary data collected to help frame the context and to begin to identify the views of key stakeholders. Key segments from the documents were excerpted and organized according to common themes that began to emerge from the data – e.g., relationship between federal immigration policy and provincial health professional regulatory policy, ethical issues arising from health care migration, etc. A preliminary coding scheme was developed and subsequently applied to the remaining data gathered - interviews and subsequent documents. Running lists of what is known and not known from the documentary analysis were developed for each province and federally which informed the selection of key informants and the questions they were asked. These draft descriptions of key policies, processes and perspectives were then fleshed out with the key informant interview data.

Each taped interview with the exception of one was transcribed verbatim and prepared for analysis using QSR-NUD*IST, a software program that assists in the management of the analysis of qualitative data. Using this software program, codes from the preliminary scheme were applied to segments of the interviews and analysed across the cases to assess the range of responses that exist on particular issues. Some of the key themes that have emerged from the documentary analysis and the interviews that we will be exploring further include the following:

- regarding immigration to Canada
    - *the issue of competency and equivalency with Canadian standards;*
    - *barriers to the process of gaining entry*
        - *discrepancies between policies at the national and provincial levels and between government and professional bodies*
        - *programs to help streamline this process;*
    - *the relationship between immigration and the crisis of underserved areas*
    - *the ethical issues involved in the migration of health care providers to Canada.*

- regarding emigration away from Canada
  - *the impact of local remuneration and working conditions;*
  - *trade agreements (e.g., NAFTA)*
  - *factors affecting return migration.*

Relationships between themes and between the responses of different participants were then identified. Key segments of the interviews were excerpted and merged into the draft documentary analysis to both address existing gaps in what is known or to provide more clarification on existing themes.

We begin our presentation of our preliminary findings first with a description of the demographic context of health care provider immigration to Canada focusing on physicians, nurses, midwives and psychologists followed by the policy context that exists federally and within each of our provincial case studies. Our findings on the issue of health care providers emigration from Canada and that policy context follows.

3. Key Findings

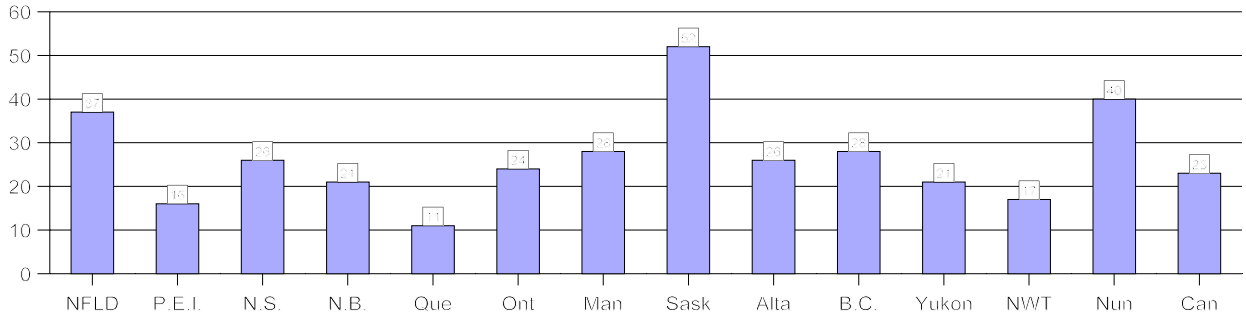
3.1 The Demographic Context of Health Labour Immigration in Canada

Canadian provinces have to a varying degree relied historically on foreign health labour to help solve shortages in underserviced areas and in particular specialties.[17] [18] [19] This has been true for medical and nursing labour and to a lesser extent for the need for midwives (due largely to our unique historical exclusion of midwifery from our formal health care division of labour). Little is known of the historical impact of the immigration of clinical psychologists in helping to meet the mental health care needs of Canadians. Similar to the case of midwives, this may be due to the lack of direct funding for psychologists (i.e., in private practice) and thus their defacto exclusion from the public health care division of labour (unless located in hospitals).

Internationally Trained Physicians in the Canadian Health Care System

Foreign *medical* labour is often referred to in the policy literature as international medical graduates (IMGs). Though often considered a homogeneous group, IMGs are a varied group which include: 1) Canadians who pursue training elsewhere; 2) visa physicians who are recruited into Canada to meet particular needs; 3) graduates who enter Canada as refugees or who otherwise meet immigration requirements; and 4) visa trainees who enter Canada through postgraduate training positions.[20] The probability of achieving full registration status with a provincial licensing authority varies dramatically across these categories and across provinces and territories (see Figure 3.1). For example, the province of Quebec has the lowest percentage of IMGs whereas Saskatchewan has the highest.[21] Manitoba, for example, as well as Saskatchewan and Newfoundland have recruited extensively in South Africa to meet the needs of their rural communities (Grant 2004).

Figure 3.1 IMGs as a Percentage of Active Canadian Physicians by Province/Territory, 2002



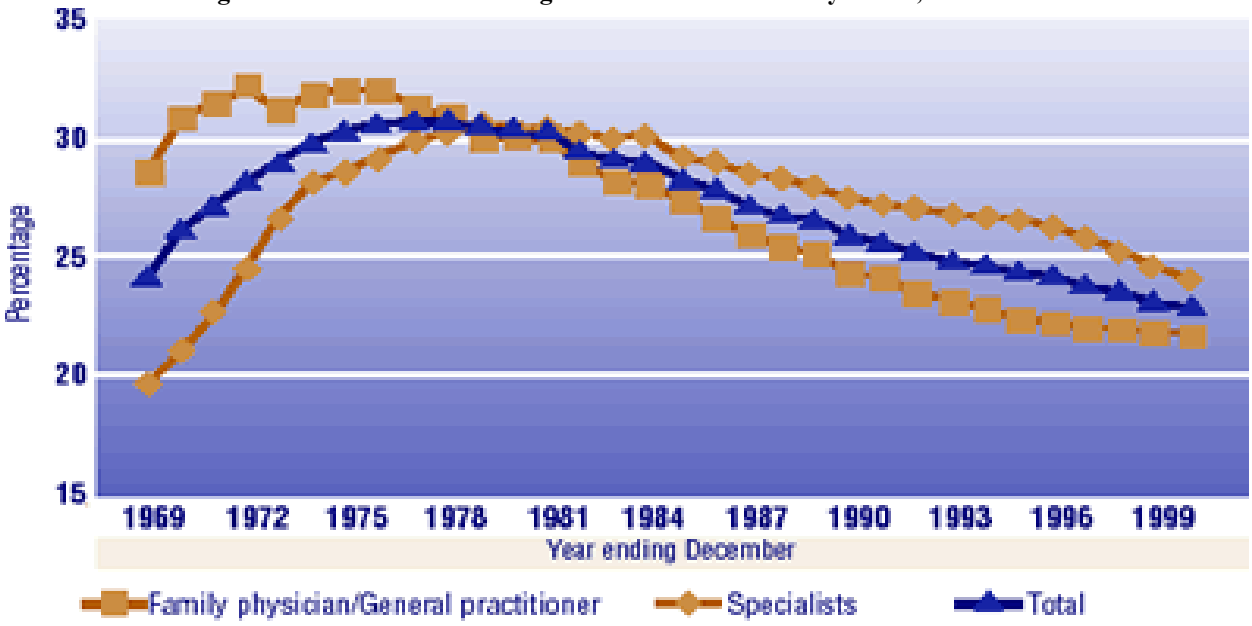
Source: Derived from the CIHI (2002) *Supply, Distribution and Migration of Canadian Physicians, 2002*.

Throughout most of the 1970s, roughly one third of our physicians were IMGs but this has most recently dropped to 23%.[22] (see Figure 3.2). This downward trend reflect limits on the number of post-graduate training spaces available as well as a number of other factors.[23] For example, whereas prior to 1975 physicians were granted the maximum 15 points for occupational demand, in 1975 incoming physicians were assigned no points virtually disqualifying an applicant who could not produce evidence of a concrete job offer (Roos et al 1976). Indeed, as Grant (2004) states,

> "Since 1975, Canadian immigration policy has been generally hostile to an inflow of physicians, largely because additional physicians were seen as the major cause of the rapid increase in the cost of maintaining Canada's publicly funded health care system. Their admission, therefore, has been highly selective and largely restricted to the graduates of medical schools in former Commonwealth countries where academic standards are compatible with those in Canada. " (p. 2)[24]

As a result, the number of immigrants claiming medicine as their intended occupation fell dramatically subsequent to these decisions in 1975. These trends were consistent with the recommendations of the National Committee on Physician Manpower who wanted to focus on the goal of *self-reliance* for future physician needs.[25]

Figure 3.2 IMGs as a Percentage of Active Canadian Physicians, 1969 to 1999



Source: Dr. Mamoru Watanabe, Canadian Physician Workforce: The Role of IMGs, International Medical Graduates National Symposium Proceedings, 2002. Data from Southam Medical Database, Canadian Institute for Health Information.

More recently, according to the CMA (2001), the number of IMGs recruited has increased quite dramatically in recent years from 388 in 1993 to 790 in 1997.[26] As Grant (2004) states,

> "Part of the explanation for the recent increase in migration also rests with changes in Canada's supply of physician services. After years of seeking to curtail the number of physicians, and foreign-trained physicians in particular, practising in the country, there is growing support for the view of an impending shortage. Despite a relatively high and stable physician/population ratio ... , with an aging population increasing the demand for medical services, and demographic changes in the physician workforce (both in terms of aging and gender) resulting in a decline in the average hours worked by physicians, talk of a "crisis" in Canada's health care system is more frequent. " (p. 7)[27]

The proliferation of temporary medical licenses to IMGs is just one indication, as argued by CMA representatives, of the physician shortage in both family medicine and in particular specialties.[28]

Where are they coming from?

In terms of the source of immigrant physicians who end up working within the health care system, they used to be mainly graduates of medical schools in the U.K. or Ireland. Specifically, in 1985 they were 35% of those who entered but this has fallen to just over 5% in 2000. Now the primary source of IMGs who are working within the health care system are from South Africa and India, with India being a notable source of specialists, and South Africa, of general/family practitioners (many of whom are recruited into rural/remote areas) though this differs across provinces.[29] For example, South African physicians account for 24% of those who entered in 2000, up from under 9% in 1985.[30] Interestingly, in 1998 only 3.3% of Canadian IMG physicians in active practice had been trained in the United States, of which one-quarter had been trained in California or New York. The relative importance of Eastern Europe as a source of IMGs has declined over this period, as Western European countries have become a more significant source.[31] Demographically, IMGs tend to be older than Canadian-educated physicians (47 percent are age 55 or older, compared with 29 percent of all physicians) and a smaller proportion are female (22 percent versus 30 percent).[32]

Figure 3.3a Distribution of Active Civilian IMG Physicians by Place of Graduation and Type, 1980

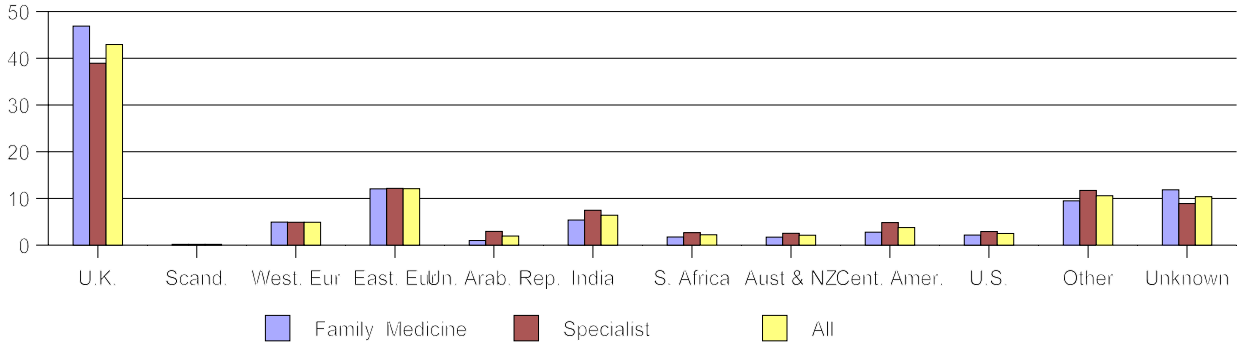


Figure 3.3b Distribution of Active Civilian IMG Physicians by Place of Graduation and Type, 1998

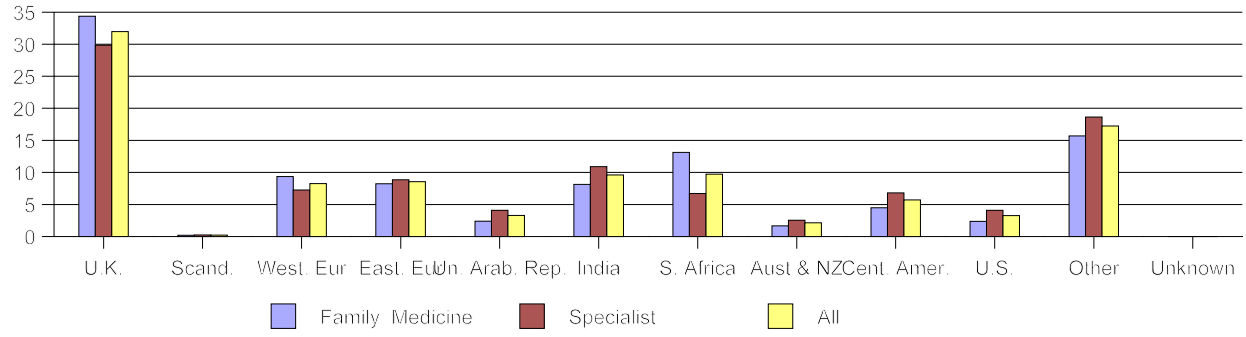


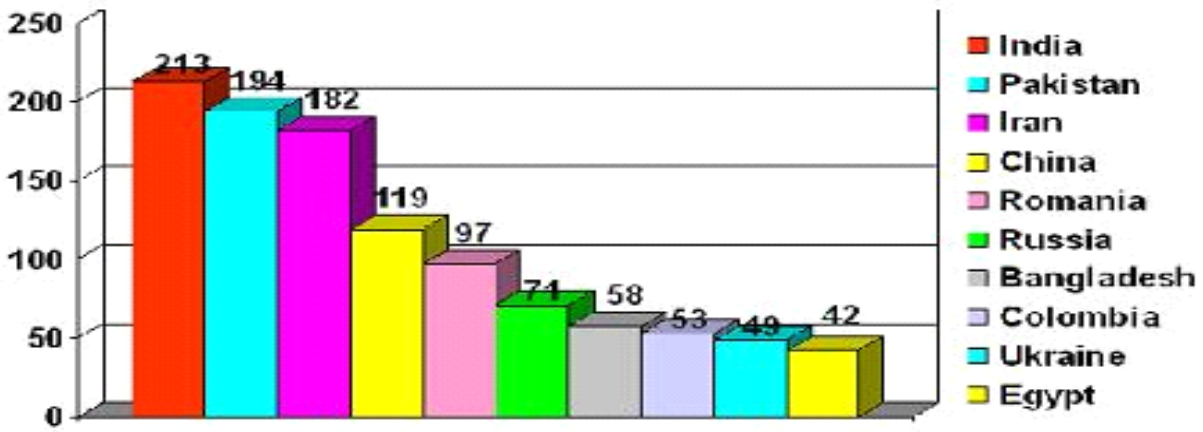
Table 3.1 Immigrant Physicians to Canada & Destined for the Labour Force by Year of Arrival, 1986 to 2000

	All Immigrant Physicians			Destined for the Labour Force		
Year of Arrival	From all countries	From S. Africa	% from S. Africa	From all countries	From S. Africa	% from S. Africa
1986	419	31	7.4	119	8	6.7
1990	450	38	8.4	163	28	17.2
1994	361	71	19.7	185	66	35.7
1998	306	39	12.7	186	38	20.4
2000	348	66	19.0	196	61	31.1
1986–2000	5781	817	14.1	2917	711	24.4

Source: Grant, H. From the Transvaal to the Prairies: the migration of South African physicians to Canada - Data Derived from Citizenship and Immigration Canada (2001)

It is important to make some distinctions in the statistics presented here. First, there is a difference between the proportion of IMGs *in* the country (depicted in Figures 3.3a & b) and those *entering* the country (partially depicted in Table 3.1). Thus even the number of physicians emigrating to Canada from the U.K. is in decline, they nevertheless still represent a sizeable proportion of IMGs in the country. Moreover, it is important to emphasize that it is not necessarily the case that those entering the *country* enter the *health care system*. Indeed, this difference is what has been highlighted by many as one of the key policy problems in this sectors (see detailed discussion below). In terms of the availability of demographic data, the latter number is tracked by CIHI therefore easier to find, whereas the former is much more difficult to ascertain. The Association of International Physicians and Surgeons of Ontario (AIPSO), for example, present the following statistics (see Figure 3.4) based on their membership. These differs substantially from the data presented in Figure 3.3a & b above.

Figure 3.4 Top Ten Countries of Origin of IMGs Wishing to Practice in Canada



To sum up thus far, there are clearly some dramatic changes occurring to the number and source of IMGs immigrating to Canada. These fluctuations are due in large part to the changing policy context, discussed more fully below, and the fluctuations in the supply and demand on physician human resources in general (including our domestic training capacity). Similarly, changes have occurred to the migration of nurses and midwives to Canada to which we now turn.

Internationally Trained Nurses & Midwives in the Canadian Health Care System

Many nurses from Britain, particularly those with advanced training in midwifery, were recruited by Health Canada in the 1950s and 1960s to serve in northern outposts.[33] Both tighter immigration policies and a change in Health and Welfare Canada policy in the late 1960s and early 1970s requiring all pregnant women residing in isolated and underpopulated northern areas of Canada travel to urban hospitals located in the south to deliver their babies, led to an overall reduction in the number of immigrant nurse-midwives practicing in rural and remote areas of Canada.[34] Unfortunately, unlike the case for medicine, we do not have readily available demographic data to describe these trends.

More recently, the overall percentage of internationally educated nurses (IENs) has remained relatively steady over the last five to ten years (see Table 3.2). Specifically, in 2003, 7.3% of all nurses working in Canada were internationally trained up from 6.8% in 1999.[35] There has, however, been a slight increase in the recruitment of foreign trained nurses in some provinces and territories—notably British Columbia (15.0%), Ontario (11.4%), Saskatchewan and the Northwest Territories — in the face of impending shortages (see Table 3.3).

Table 3.2 Number and Percentage of IENs in Canada, 1990 to 2003

Year	# of IENs in Canada	% of RN population
1990	19,144	8.6%
1999	15,564	6.8%
2000	14,177	6.1%
2001	15,659	6.8%
2002	15,847	6.9%
2003	17,633	7.3%

(Sources: Little, 2005[36] and CIHI, 2000)

Where are they coming from?

Nurses from the Philippines have been one of the primary sources of immigrant nursing labour in Canada (up to 26% of all IENs in 2003 from 23.5% in 1999) as it is elsewhere,[37] but nurses from the U.K. represent an equal proportion (albeit down to 26% in 2003 from 30.5% in 1999), with nurses from the U.S. (7% in 2003 down from 9.4% in 1999), Hong Kong (6% in both 2003 and 1999) and India (4.7% in 2003 and 4.3% in 1999) representing smaller groups (see Figure 3.5). In 2003, nurses from the Phillipines, the U.K., and the U.S. represented 2.1%, 1.7%, and 0.5% of all RNs employed in nursing in Canada.[38]

Table 3.3 RN Workforce by Location of Graduation and Province/Territory of Registration, Canada, 2003

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
						(percentage distribution)								
Canadian-trained	**97,8**	**97,9**	**97,7**	**98,8**	**97,5**	**88,5**	**94,1**	**95,5**	**88,9**	**84,5**	**93,1**	**89,1**	**85,7**	**91,8**
Retained Graduates	93,0	69,0	77,6	85,9	95,7	80,8	83,8	81,4	61,6	55,6	0,0	11,1	0	80
Interprovincial Graduates	4,9	28,9	20,1	12,9	1,9	7,7	10,4	14,1	27,3	28,9	93,1	78,0	85,7	11,9
Canadian-trained (location unknown)	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0	0
Foreign-trained	**1,7**	**1,8**	**2,3**	**1,2**	**2,5**	**11,4**	**5,9**	**3,1**	**3,9**	**15,0**	**6,9**	**10,4**	**13,6**	**7,3**
Philippines	0,3	0,0	0,2	*	0,6	2,9	2,6	0,6	1,9	4,7	*	2,2	*	2,0
United Kingdom	1,0	**	0,9	**	0,3	2,8	1,1	0,7	0,3	4,1	2,1	5,8	5,4	1,7
United States	0,2	1,0	0,6	0,5	0,1	0,9	0,7	0,5	0,0	0,7	*	*	*	0,5
India	*	0,0	*	0,0	<0.1	0,7	0,1	**	0,4	0,4	0,0	0,0	0	0,3
Hong Kong	0,0	0,0	*	0,0	<0.1	0,6	**	*	<0.1	1,5	0,0	0,0	0	0,4
Poland	0,0	0,0	0,0	0,0	<0.1	0,5	**	0,0	0,1	0,2	*	0,0	0	0,2
Australia	*	0,0	0,1	*	<0.1	0,1	0,1	0,2	0,3	0,6	1,7	*	3,1	0,2
Other Foreign	0,2	*	0,5	0,2	1,4	2,9	0,9	1,1	0,8	2,8	*	*	3,5	1,9
Not Stated	**0,5**	**0,3**	**0,0**	**<0.1**	**<0.1**	**0,1**	**0,0**	**1,3**	**7,2**	**0,5**	**0,0**	**0,5**	**0,8**	**0,9**
Total RN Workforce	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100, 0**	**100,0**	**100**	**100,0**

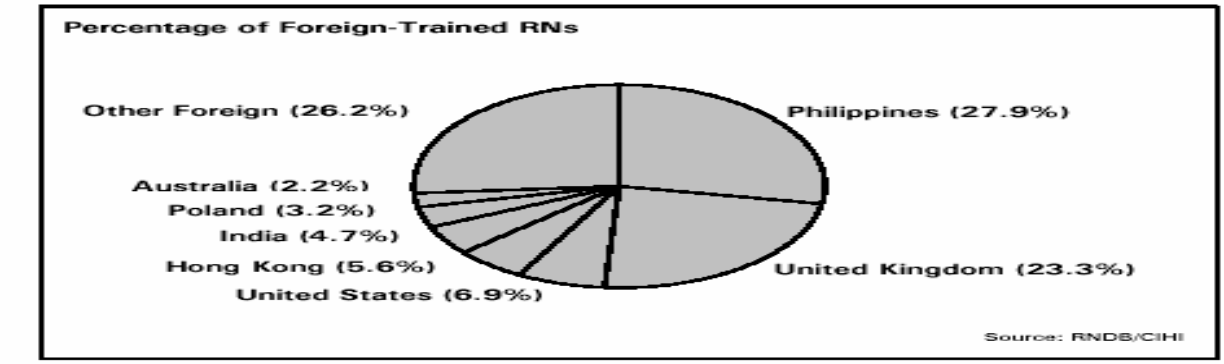
Notes * Value suppressed in accordance with CIHI privacy policy; cell value is from 1 to 4
** Value suppressed to ensure confidentiality; cell value is 5 or greater
<0.1 Value is less than 0.05%; value is replaced to prevent displaying cells of 0.0 that are not true zero values

In addition to being disproportionately distributed across provinces, IENs from particular jurisdictions also tend to "cluster" in one province or region of the country. This is likely to also be the case for physicians. For example, as it was stated in the CIHI (2004) report,

> "virtually all graduates from France that are now in Canada are located in Quebec, while Hong Kong graduates locate primarily in Ontario or British Columbia, and virtually all graduates from Jamaica are located in Ontario." (p. 31)

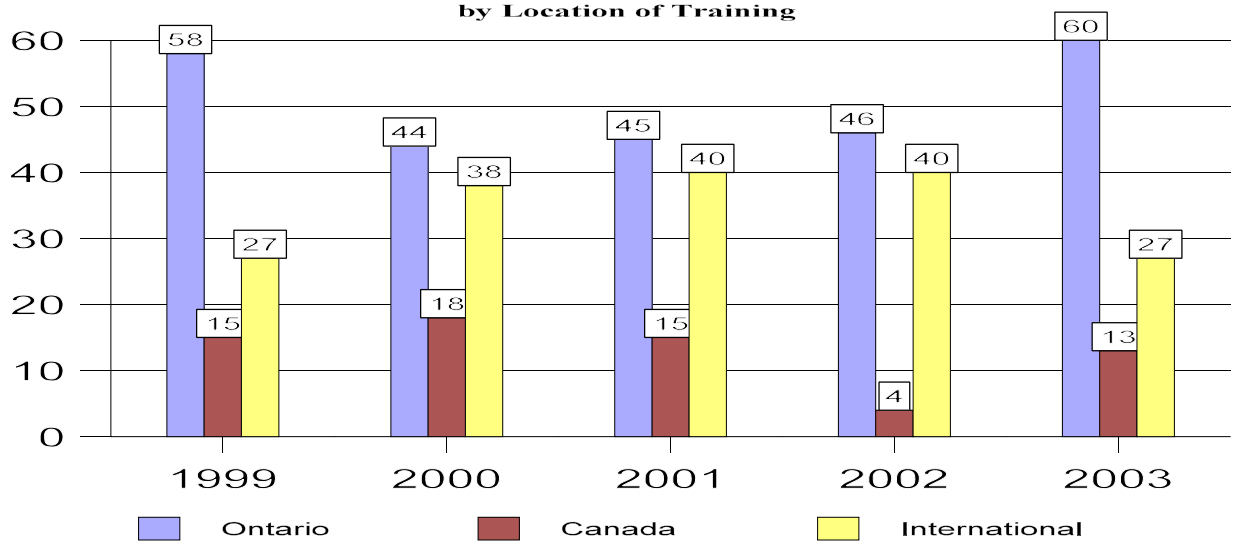
In the case of Québec, for example, immigration had a barrier in place to prevent the entrance of nurses until 2000 when this was lifted. Now, the provincial government agency, Recrutement Santé Québec (RSQ - see discussion below) specifically goes to Switzerland, France and Belgium to entice Québec nurses to return home.[39]

Figure 3.5 Percentage of IENs by Country of Graduation, Canada, 2003



Further, similar to what we found in the case of physicians, the percentage of IENs as per the population of active nurses may mask some of the recent changes that are best captured by statistics on new entrants. For example, in Ontario, we find that from 1999 to 2003, the number of IENs have been on average 34% of the new registrants (see Figure 3.6). How long these new foreign trained applicants stay in the country is difficult to track. Indeed, many key informants noted how Canada may act as a sort of 'weigh-station' with the ultimate destination being the U.S. This has also been noted to be the case for physicians, but again this is a trend that is difficult to track statistically.

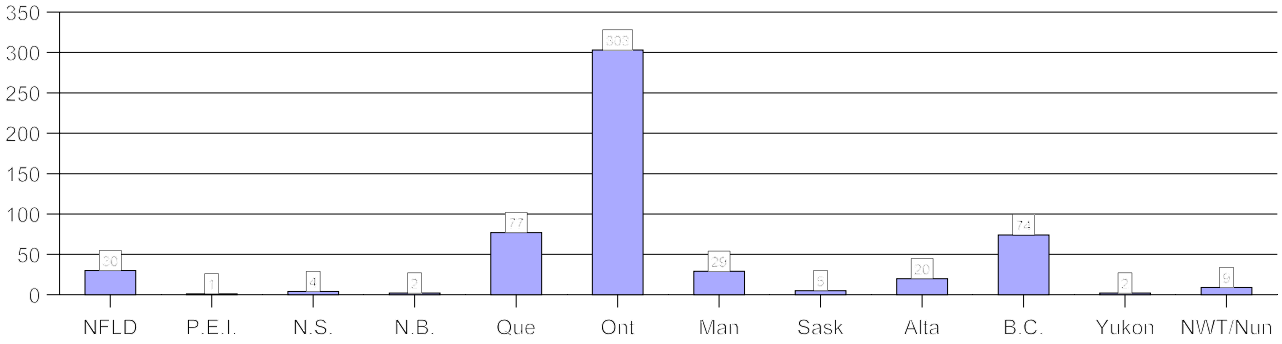
Figure 3.6 Percentage of New Registrants to the College of Nurses of Ontario by Location of Training



Demographically, it has been found that IENs in the current workforce are, on average, more than five years older than Canadian-trained nurses (49.4 years to 44.1 years in 2003).[40] We also know that immigrant nurses, particularly those of colour, occupy the lowest echelons of the profession if they do manage to make it in.[41] Indeed, it is common to find deskilling occurring simultaneously with immigration and this trend is not unique to Canada (see more detailed discussion below).[42]

Although initially the migration of midwives was bound up with the migration of nurses - because prior to the 1980s midwives were considered by many to be a specialty of nursing- their recent integration into some provincial health care systems has taken a direct-entry approach. That is, midwives need not have prior training in nursing in order to practice in Canada. Further, the relatively recent integration of midwifery has also meant that there are only three small university-based schools for midwives (one in Ontario established in 1993 which graduates 30 to 40 midwives per year, one in Quebec established in 1999 which graduated its first class of 12 in 2003, and one in B.C. established in 2001 which had its first graduating class of 10 in 2005[43]). The newness of these programs has dictated that almost all of the midwives practising in Canada prior to legislation have been trained outside of the country. Others were trained informally which adds another layer of complexity to the assessment of equivalency. This situation has also meant that there are few practitioners from which statistics can be gathered and reported in a confidential fashion (There are approximately 550 midwives across Canada (see Figure 3.7) but an estimated 50 to 60 are not in active practice). Therefore, good demographic data of the nature available for medicine and nurses

Figure 3.7 Number of Midwives by Province both Canadian and Foreign Trained, 2005



As a case study, however, midwifery is important to examine in large part because of its newness, its strong linkages to foreign training, its internationally unique baccalaureate entry to practice requirement (in most countries, midwives are trained in vocational institutions or at the equivalent of community college level), and its recent HRSDC-funded study to streamline the integration process for foreign-trained midwives across the provinces where it is presently regulated (see discussion below).

Internationally Trained Clinical Psychologists in the Canadian Health Care System

As noted at the outset, less is known about the immigration of other health care providers and this is particularly the case for the clinical psychology profession. For example, data regarding foreign versus Canadian training are not readily available through the CIHI databases. We do have data on the number of psychologists by province (see Tables 3.4) and by population. We do not, however, know is how many of these are practising clinical psychologists in the health care field.

Upon special request, the College of Psychologists of Ontario (CPO) prepared the following table outlining the statistics of their members by the location of their graduate training (see Table 3.5).

Table 3.4 Number of Active Registered Psychologists by Province/Territory, 1993-2002

Source: CIHI (2004) *Health Personnel Trends, 1993-2002.* (p. 186)

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
N.L.	27 [3]	28 [3]	29 [3]	30 [3]	31 [3]	185	186	195	210	221
P.E.I.	13	14	14	15	15	19	22	21	22 [11]	28 [11]
N.S.[7]	210	287	290	297	310	331	350	369	383	414
N.B.	195 [3]	202 [3]	209 [3]	215 [3]	219 [3]	241	186	256	213	265 [12]
Que.	5,112	5,320	5,486	5,602	5,671	5,728	5,898	6,076	6,271	6,455
Ont.[9]	2,023	2,092	2,176	2,190	2,281	2,369	2,501	2,575	2,665	2,740
Man.	136 [3]	141 [3]	146 [3]	150 [3]	153 [3]	140	149	156	156	160
Sask.[4]	75 [3]	77 [3]	71 [3]	76 [3]	70 [3]	70	73 [3]	74	73 [3]	387 [8]
Alta.[6]	1,224 [7]	1,619	1,647	1,642	1,671	1,712	1,768	1,833	1,930	1,892
B.C.	871	886	937	977	1,010	1,043	1,035	1,068	934	939
Y.T.[8]	7 [3]	8 [3]	8 [3]	8 [3]	8 [3]	8 [3]	8 [3]	8 [3]	8 [3]	8 [3]
N.W.T.[10]	24	25	30	34	37	38	45	53	71	74
Canada	9,917	10,699	11,043	11,236	11,476	11,884	12,221	12,684	12,936	13,583

Source: HRDB/CIHI

From these data we can see that internationally educated psychologists (i.e., doctoral level) (18%) and psychological associates (Master's level) (14%) make up a sizeable proportion of the College register of which U.S. training predominated (particularly for psychologists). These data, however, do not indicate how many of these psychologists are Canadian or foreign-born. It is very likely that students will seek training in the U.S. where there are a greater number of clinical psychology programs.

Table 3.5 Statistics of Members of the College of Psychologists of Ontario by Graduate Training Institution Location as of: October 12, 2005

	Ontario	Other Canadian	USA	Other	Total
C.Psych. AP*	1623	275	336	72	2306
C.Psych. (Sup)†	95	16	25	7	143
C.Psych. (Cand)‡	14	8	10	5	37
Total Psychologist	**1732**	**299**	**371**	**84**	**2486**
C.Psych. Assoc. AP	352	39	28	25	444
C.Psych. Assoc. (Sup)	21	5	3	7	36
C.Psych. Assoc. (Cand)	25	4	5	4	38
Total Psychological Associate	**398**	**48**	**36**	**36**	**518**

* Autonomous practice means registered for independent practice.

† Supervised practice means members who have an acceptable degree in psychology, have been issued a certificate of registration authorizing supervised practice and are completing the supervision and other requirements for registration for autonomous practice.

‡ Candidate means that the person has submitted an application but has not yet progressed any further in the registration process.

Summary

In sum, what is clear in undertaking this comparative analysis of the demographic context of the migration of internationally educated physicians, nurses, midwives and psychologists into Canada is:

- Internationally educated health care providers are a crucial component of these health human resources. IMGs account for roughly one quarter of all physicians practicing in Canada and similarly, six percent of all nurses have been trained in other jurisdictions.
- The source countries for internationally educated physicians, nurses, midwives and psychologists differ across cases and have also shifted over time. For example, the U.S. is a prime source of internationally educated psychologists (as least as far as Ontario is concerned) and is likely also the main source for Canadian midwives (though this is anecdotal data at best) but not so for internationally educated nurses and physicians. Moreover, whereas physicians used to come from the U.K., the more likely source has recently been South Africa. IENs largely come from the Phillipines but also from the U.K.
- There are clear differences in the availability of data on internationally educated physicians, nurses, midwives and psychologists making sound comparisons difficult.
- These demographic trends are influenced by various immigration and health human resource policy. Less is known, however about how these trends and the policy influences compare across professions. Recent policy changes remain to be fully examined in the case of midwives and psychologists and greater attention to the collection of basic demographic data.

3.2 The Policy Context of Health Labour Immigration in Canada

The ebb and flow of health care providers into and - as we shall see - out of Canada is due in large part to policy decisions and the broader policy context of health human resources. In this section we begin to map out the policy context in Canada regarding the following key immigration issues:

- *the process of gaining entry and the barriers to experienced by internationally educated health care providers*
- *the programs developed to reduce unnecessary barriers and to help streamline the integration process;*
- *the relationship between immigration and the crisis of underserved areas*
- *the ethical issues involved in the migration of health care providers to Canada.*

The Process of Getting In

The first step for most providers is the national system of immigration though for some this is the next step following recruitment. Citizenship and Immigration Canada (CIC) officials assess applicants using a point system. These points are awarded according to a social capital model that includes the applicant's age, language ability, whether prospective immigrants have arranged employment in Canada, the type of work they intend to do here and their skills, qualifications and experience in that area, and whether their occupation is in demand in the Canadian labour market.[44] As noted above, physicians used to be penalized in the 'points system' but as of 2002 this situation has changed.[45] Presently, all four health care providers we studied are on the list of sought after skilled professionals. This is, however, but one step in the integration process and one which often sends mixed messages to applicants. For example, as Brouwer (1999) states,

> Unless informed otherwise by a visa officer, many immigrants who are accepted as skilled workers understandably mistake the federal government's granting of 'points' for their occupation, education and training as recognition and approval of their qualifications. These immigrants assume that they then will be able to practise their profession or trade in Canada. In fact, however, the number of points granted by a visa officer and the Department of Citizenship and Immigration has no bearing on an individual's ability to practise an occupation in Canada.[46]

Some of our key informants mentioned cases of health care providers 'just showing up at the door' of a provincial regulatory body without preparatory knowledge of the system of integration but these cases are the exception. In the case of Quebec, Immigration Québec insists that immigrants who work in regulated professions sign a document (two in the case of physicians) prior to immigrating to Québec. This amounts to informed consent as they outline the meaning of a regulated profession, the steps (briefly) to be able to work in the field, and that being admitted into Québec does not mean that they will necessarily find employment nor be registered in their profession. This is done so that newcomers are clear on the fact that access to the regulated professions is difficult requiring considerable effort. Doctors must sign a second document that lists some of the steps required to practice the profession in Québec.

Each of the professions we investigated in each of the provinces has unique features through which internationally trained providers must navigate.

<u>Getting into Medicine</u>

There are six key steps to gain licensure to practice as a physician in Canada. The first step is proof of completing an undergraduate medical degree (M.D.) program in an approved university listed in

either the International Medical Education Directory or the World Health Organization World Directory of Medical Schools. Prior to 1993, there were two categories of IMGs, depending on where they went to medical school. *Category I* IMGs had studied in the United States, Great Britain, Ireland, Australia, New Zealand or South Africa. IMGs from any other country were *category II* and thus had to take additional training.[47] Milne (2003) details how,

> In a pivotal legal case, called Bitonti, physicians from Italy, Romania, the Philippines and Russia who had been unable to secure employment as physicians in BC, argued they were discriminated against be the College of Physicians and Surgeons of British Columbia. Category I and II distinctions were abandoned in 1993 and now all applicants for full registration must complete two years of postgraduate training in Canada.

Next, IMGs must pass the Medical Council of Canada Evaluating Exam (MCCEE) in order to demonstrate equivalent general medical knowledge and demonstrate English/French language/communications proficiency. The third step often requires taking two to six more years of postgraduate medical training (2 for Family Medicine and 4-6 for certain Specialties), of which the number of places in such assessment/postgraduate training programs are limited, particularly for IMGs. For example, according to the Canadian Resident Matching Service (CaRMS), approximately 10% match to a program in part because with the exception of Quebec, IMGs are only eligible to do so on the second round (IMGs are not eligible at all in the Ontario portion of CaRMS; there is a separate program for IMGs in Ontario discussed below) (see Table 3.6).[48]

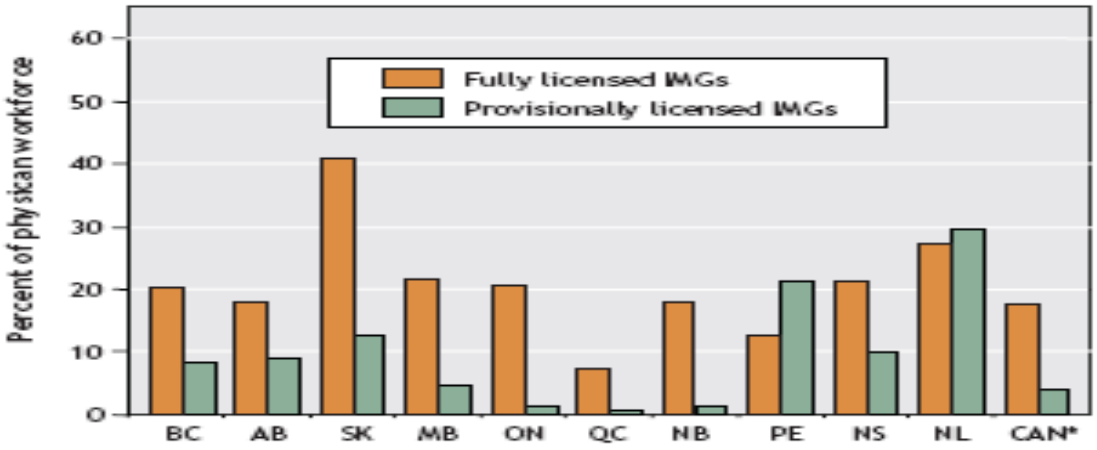
Table 3.6 Percentage Match Result for IMGs in CaRMS, 1995 to 2005 [49]

Year	International Medical Graduate Participation[1]	Match Results	Percentage
2005	629	80	12.7
2004	657	87	13.2
2003	625	67	10.7
2002	496	83	16.7
2001	387	60	15.5
2000	294	39	13.3
1999	231	35	15.2
1998	205	19	9.3
1997	208	16	8.0
1996	236	11	4.6
1995	240	23	9.6

Following this step, IMGs must pass a certification exam in either Family Medicine (through the College of Family Physicians of Canada (CFPC)) or a Specialty (through the Royal College of Physicians and Surgeons of Canada (RCPSC)) in order to be fully licensed.[50]

Exceptions have been made to these rules, however, such as in the case of hiring needed specialists from abroad for urban hospital placements and fast-tracking the licensure of foreign medical graduates to meet the needs of underserved areas (often through temporary VISAs and work permits - see Figure 3.8). In some cases, specialists are permitted to take the certification exams without additional postgraduate training through special assessments of equivalency of training by the RCPSC.[51]

Figure 3.8 Percentage of IMGs Practicing with Provisional and Full Licences by Province
(source: Audas et al., 2005, CMAJ, p. 1315)



The fifth step involves passing the two part Medical Council of Canada (MCC) qualifying exam in order to obtain an independent license to practice medicine in Canada (known as the Licentiate of the Medical Council of Canada (LMCC), which is recognized by the 12 medical licensing authorities in Canada). Together these exams cost over $3000 to take not to mention the costs of residency training which is largely unpaid .[52] The final step is registration with a provincial regulatory body (such as the College of Physicians and Surgeons of Ontario (CPSO)).[53]

It has been found that on an individual basis many IMGs do as well as Canadian graduates on qualifying examinations but as a group they do not. For example, of a group of 100 hypothetical IMGs challenging the examinations for the first time, approximately 21% will have passed the three levels whereas the success rate for Canadian medical graduates is approximately 95%. According to the CMA,

> This may be due to several factors, including the age (time from medical school until they challenge the exam), language and cultural issues, and differences in the quality of the medical school training. ... Canada and the United States have a joint demanding accreditation process for their medical schools. Few other countries have such a demanding and uniformly high standard of accreditation. Many medical schools listed in the World Health Organization list of medical schools do not have a review of programs or any form of vigorous accreditation.[54]

Some provinces, such as Ontario, offer recently immigrated IMGs who have become legal permanent residents of the province a special training program in preparation for working as a medical resident - The International Medical Graduate Ontario (IMGO) program (*see discussion below*).[55] The content and length of these programs vary from province to province.

Getting into Nursing

The process of getting into nursing as a IEN involves fewer steps than it does in medicine, but as we shall see, these steps can put up equally effective barriers to integration. We focus here specifically on obtaining the designation of Registered Nurse (RN) though some IENs will attempt

to gain entry and experience first through Licensed Practical Nurse (LPN) status. First, candidates must apply for registration with their provincial/territorial regulatory bodies (and the application process differs across provinces see Table 3.7[II]), have their credentials assessed (and some contact an credential evaluation service for advice), and then they must pass the Canadian Registered Nurse Examination (CRNE) or for Québec, l'examen professionnel de l'Ordre des infirmières et infirmiers du Québec.[56] This examination must be written in Canada or Quebec respectively. Many nurses make applications to more than one province making accurate statistics of the total number of IEN applicants in Canada difficult to assess (see Figure 3.9). Across all provinces, however, there have been in some cases rather dramatic increases in the number of applications. In Quebec, for example, whereas the OIIQ screened 105 application in 1998, the number in 2003 was 348.[57]

Table 3.7 Documentation Required for IEN Applicaitons by Province, 2004

	CAF	Lng	Ver 1	Ver 2	Mar	Tra	Pas	Dip	NPC	Emp 1	Emp 2	Ver 3	Cri 1	Cha	Cri 2
BC	x	x	x	x	x	x	x	x	x	x	x	x	-	x	x
AB	x	x	x	x	x	x	x	-	-	-	x	-	-	-	-
SK	x	x	x	x	x	x	x	x	x	x	-	-	-	-	-
MB	x	x	x	x	-	x	x	-	x	-	x	x	x	-	-
ON	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
QC	x	x	x	x	x	-	x	x	x	x	x	-	x	x	x
NB	x	x	x	x	x	x	x	x	x	x	x	x	-	x	-
NS	x	x	x	x	x	x	x	x	x	-	x	-	-	-	-
PEI	x	x	x	x	x	x	x	-	-	-	x	-	-	-	-
NL	x	x	x	x	x	x	-	-	x	x	-	x	-	x	x

Source: IEN-DP, Registrar Survey, 2004.

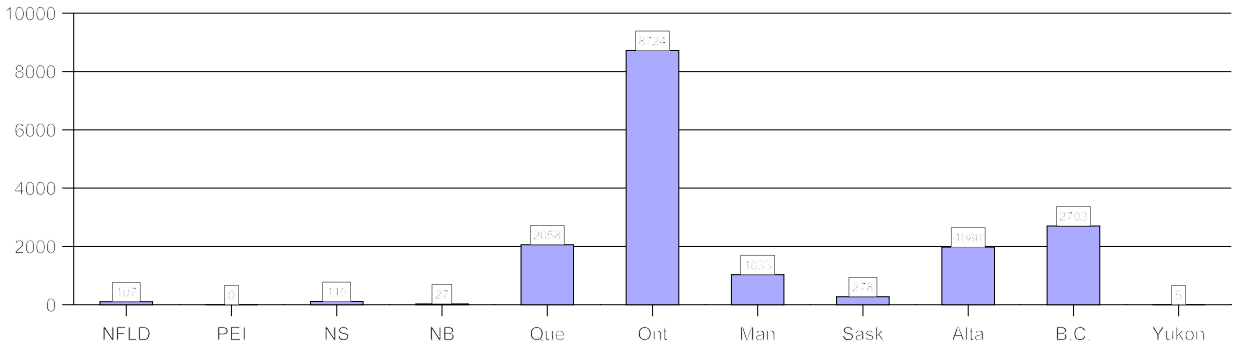
Note: (x) indicates document is required; (-) indicates document is not required.

CAF – Completed Application Forms
Lng – Proof of Language Proficiency
Ver 1 – Verification of Original Registration in Home Country
Ver 2 – Verification of Current Registration
Mar – Marriage/Birth Certificates
Tra – Course Transcripts
Pas – Passport, Photo ID
Dip – Diplomas, Certificates from Programs of Study
NPC – Nursing program confirmation
Emp 1 – Employment references/ Regulatory bodies request
Emp 2 – Employment references/Applicant request
Ver 3 – Verification of all Registrations
Cri 1 – Criminal Record Check
Cha – Character Reference
Cri 2 – Criminal Record Review

Beyond the basic RN, applicants can seek certification in 14 nursing specialties through the CNA and specialist nursing associations.[58] Similar to provisionally licensed IMGs, an IEN may also come to Canada to work under a temporary work visa for a period of one year while making applications for permanent residency and registration in some provinces with the support of an employer.[59] This is made particularly easy if the country of the IENs' education is governed under an international trade agreement with Canada (such as NAFTA).

II For example, as of January 1, 2005 all newly registered nurses in Ontario must have completed a four-year university degree which will greatly impact upon IENs who have a diploma instead of a degree.

Figure 3.9 Total Number of IEN Applicants by Province, 1999-2003



Getting into Midwifery

Midwives educated in other jurisdictions who wish to become registered in those provinces where midwifery is regulated - Ontario, Quebec, B.C., Manitoba, Alberta and soon in the NWT - are required to undergo an assessment of their previous education and experience to determine the equivalence of their credentials for practice. This was initiated in Ontario, the first province to regulate midwifery. The CMRC summarized the Prior Learning and Experience Assessment (PLEA) process there as follows:

> [The] PLEA included portfolio assessment, written exams, and a series of OSCEs [Objectively Structured Clinical Examinations]. All successful candidates had to have a period of supervised practice under the supervision of an experienced midwife. This period of supervision allowed for additional assessment of competencies and provided support for addressing competency-gaps identified in a candidate's portfolio or examinations. In 1997-98, the second cycle of the program, the in-depth portfolio assessment was dropped, mainly due to the time intensive nature of the assessment. ... After the 2001 PLEA cycle, the College decided to stop offering this particular process [and] ... chose instead to pursue public funding that became available for a bridging program that could address the obvious need for upgrading and education that had been identified in the earlier cycles of the CMO's PLEA. (p. 14-15)

Similiar PLEA processes have occurred in Québec between 1992 and 2002 and in Manitoba beginning in 2003. Thus, each of the provinces that regulate midwifery run a semi-regular assessment process that involves written exams, OSCEs and portfolios to a certain extent. It is only in Ontario, however, that an educational upgrade component has been added (*see description of International Midwifery Preregistration Program (IMPP) below*).

Getting into Clinical Psychology

Unlike for physicians, nurses and midwives, there is wide variation in the registration requirements for clinical psychologists across Canada increasing the complexity of entry for those who are trained outside of Canada and the U.S. (See Table 3.8).

Table 3.8 Requirements for Registration as a Psychologist by Province, 2002

	Academic Entry Requirements	Supervised Experience	Examinations
BC	*Doc. (Indep.) *Masters (P.Assoc. Indep.)	*Doc. (1 year pre-doc.) *Masters (1 year post-masters internship and 3 years supervised practice)	*EPPP 70% *Written jurisprudence
Alberta	Masters (Indep.)	1 year (1600 hrs.) post- Masters	*EPPP 70% *Oral
Saskatchewan	Masters (Indep.)	1 year (1600 hrs.) post- Masters	*EPPP 70% *Oral
Yukon	No legislation governing practice of psychology		
Manitoba	*Doc. (Indep.) *Masters (P Assoc. Supervised)	*Doc. (1 pre- and 1 post- year) *Masters (2 years post)	*EPPP Doc. 70% Masters 65% *Oral (both)
Ontario	*Doc (Indep.) *Masters (P.Assoc. Indep.)	*Doc. (1 pre- and 1 post- year) *Masters (4years post plus 1 year on supervision register)	*EPPP 70% *Oral jurisprudence
Quebec	Masters (Indep.)	none	*no EPPP *no oral *Ethics
Newfoundland	Masters (Indep.) (until 2001)	*Doc. (1 pre- and 1 post-year) *Masters (2 years post)	*EPPP (pass score not set), *no oral
NWT	Masters Degree in Psychology from a Canadian University	1 year (1600 hours) while on an Intern's Registry. Previous supervised experience from another jurisdiction may be considered.	An exam "MAY" be required
Nova Scotia	Masters(Indep.)	*Doc. (1 pre- and 1 post- year) *Masters (6 years post)	*EPPP 70% *Oral
PEI	*Doc.(Indep.) *Masters(indep. in inst/agency only)	*Doc. (1 pre and 1 post year) *Masters (2 years post)	*EPPP scaled score of 500 *Oral
New Brunswick	Masters(Indep.)	*Doc. (1 pre and 1 post year) *Masters (4years post)	*EPPP 65% *Oral

Source: CPA website: http://www.cpa.ca/licensing.html#For%20assessments%20of%20foreign%20degrees

With respect to the three provinces under investigation here, both Ontario and Manitoba make a distinction between doctorally and master's trained psychologists, whereas Quebec does not (although according to our key informants, it is in the process of altering this level of qualification).[60] Both of these provinces also require the writing of the Examination for Professional Practice in Psychology (EPPP) and an oral exam. The current fee for the EPPP in Manitoba is $US 375.00 and $CDN 300.00 for the oral exam. Manitoba does not, however, have a regulatory body separate from its association (the Psychological Assn. of Manitoba (PAM)) as does Ontario (the College of Psychologists of Ontario (CPO)) and Québec (Ordre des psychologues du Québec (OPQ)). Each of these and the other provinces/territories has, however, signed a Mutual Recognition Agreement[61] effective July 1, 2003 which "evaluate[s] applicants seeking entry to the profession on the core competencies as identified and agreed upon by the Parties, and establish the

equivalence of means to assess the competencies" (p.5). Consistent with the MRA, each province must inform the other provinces of any changes it plans to make to its requirements for registration.[III]

Similar to the case for physicians, clinical psychologists are automatically eligible for registration if they have a graduate degree from a program recognized by the Canadian Psychology Association (CPA), the American Psychology Association (APA), or in the case of Ontario, a program of study that is listed in Doctoral Psychology Programs Meeting Designation Criteria (ASPPB/National Register), will satisfy this requirement. International candidates with a degree(s) from an institution outside Canada or the United States are encouraged to arrange to have it evaluated to determine if it is comparable in level to a degree from a Canadian university through the Comparative Education Service (CES) of the University of Toronto. The CPO further asserts that,

> "A degree that is not accepted by the College as a doctoral degree from a program of study with content that is primarily psychological in nature cannot be augmented by the candidate, after having obtained the degree, into the equivalent of a degree acceptable to the College. Therefore, in order to become eligible for registration as a psychologist, as applicant must complete another doctoral degree that is primarily psychological in nature as required in the Guidelines published by the College."[62]

The issue of doctoral or master's training is contentious, however, and those provinces that requires doctoral level training to be designated as a independently practising psychologist (and to use the protected title *psychologist)*, such as Ontario, Manitoba, British Columbia and to a lesser extent P.E.I., have created some difficulty for master's trained psychologists from other provinces and other countries. In Ontario, the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP) has advocated for ...

> "use of the world-wide standard for psychological training -- graduate training at a masters level or equivalent. We reject the current Ontario practice of denying full recognition in title and practice to psychologists whose academic training does not include a Ph.D. "[63]

It is not known to what extent this has created barriers for entry to practice for foreign-trained applicants and if so, for which groups in particular. We do, however, know that there are time limits for applications. In the case of Manitoba, for example,

> Candidates are expected to complete the required period of post-degree supervision and the EPPP examination within two years of receiving their doctoral degree (for psychologist candidates) or within four years of receiving their master's degree (for psychological associate candidates). [64]

III

The CPO and the PAM are also members of the ASPPB (Association of State and Provincial Psychology Boards) Agreement of Reciprocity. U.S. members include Iowa, Kentucky, Maine, Missouri, Nevada, Oklahoma, and Texas.

Barriers to the Entry of Internationally Trained Health Care Providers

Several barriers to internationally trained health care provider integration have been noted in the literature dating back in some cases 15 years. Some of the key barriers highlighted by the Canadian Midwifery Regulators Consortium (CMRC)[65] from their review of several reports[66] include the following:

- Poor information available to prospective immigrants overseas, especially with regards to what they must do in order to legally practice their profession in Canada.
- Difficulty in having educational credentials recognized due to, for example, difficulties in getting official transcripts sent by institutions outside of Canada.
- Difficulty in having professional experience gained outside of Canada recognized.
- Absence of sufficient upgrading/bridging programs to assist newcomers to fill gaps in knowledge or experience vis á vis professional expectations in Canada.
- Need for improved orientation to Canadian workplace culture.
- Lack of occupation-specific language training, especially at high levels.
- Absence of or difficulty in accessing appeal processes.
- Direct and indirect costs of assessment processes can be prohibitive. (p. 10-11)

Specific barriers experienced by IMGs noted in several of the documents we reviewed include that:

> While some lack the required preparation, knowledge and skill, others have been unable to confirm or demonstrate their skill levels due to tight workforce policies, limited access to assessment and/or training opportunities and lack of support to understand the licensure requirements in Canada. (*Report of the Canadian Task Force on Licensure of International Medical Graduates*, 2004, p. 1)

One of the key barriers is the above noted limitation in the number of residency training positions.[67] [68] [69] This is a direct result of policy decisions to curb what was at that time considered to be a physician surplus:

> During the 1980s and early 1990s, studies predicting an oversupply of physicians resulted in policy development designed to limit the supply of physicians. In Ontario, the first direct response to these reports was the recommendation of the Joint Working Group on Graduates of Foreign Medical Schools in 1986 to limit access for international physicians. The outcome was the implementation of a restricted program for the integration of international physicians.[70] (p. 1)

Ultimately the limits on residency positions lie with the provincial governments and many informants echoed the following sentiments:

> Because all physicians or virtually all doctors are paid for in one way or another either by Ministries of Health or regions and because all training posts are controlled by Ministries of the provinces ... [so] post graduate training is not open. It's closed and it's controlled by the ministries as another way to deal with resource planning. *Medical Informant 1*

Even prior to the bottleneck the limited residency positions create, the Association of International Physicians & Surgeons of Ontario (AIPSO) (2000) highlighted several barriers - in terms of time and money - that the various exams IMGs must take prior to gaining licensure in Canada. First, it expressed the view that taking the MCCEE is both redundant with the MCCQE1, it is also much more expensive and should be eliminated and IMGs allowed to take the QE1 directly. The MCC, however, argues strongly that the two exams test two very different forms of knowledge. Similar

to the methods employed by midwives and clinical psychologists, the AIPSO also feel that the assessment of IMGs should be more oriented to a competency based system:

> The emphasis should not be on the route taken to acquire a particular set of skills, but rather an evaluation of those skills. There is a need for regulatory and licensing bodies to remain open to new and innovative methods of comparing courses and training within a comparable and equitable scale. The examination and training requirements which Canadian medical graduates must undergo need not necessarily be the same for international medical graduates because the latter have already gone through these processes in other jurisdictions. Rather, their competencies should be assessed, and if there are areas identified that require further training, bridging programmes to meet those needs can be undertaken. All international physicians and surgeons should not be required to begin their integration into the health care system at the same point as new Canadian graduates. Developing methods that are comparable to the peer assessments and quality assurance programs of licensed physicians in Ontario is a more equitable and economical approach.[71] (p. 5)

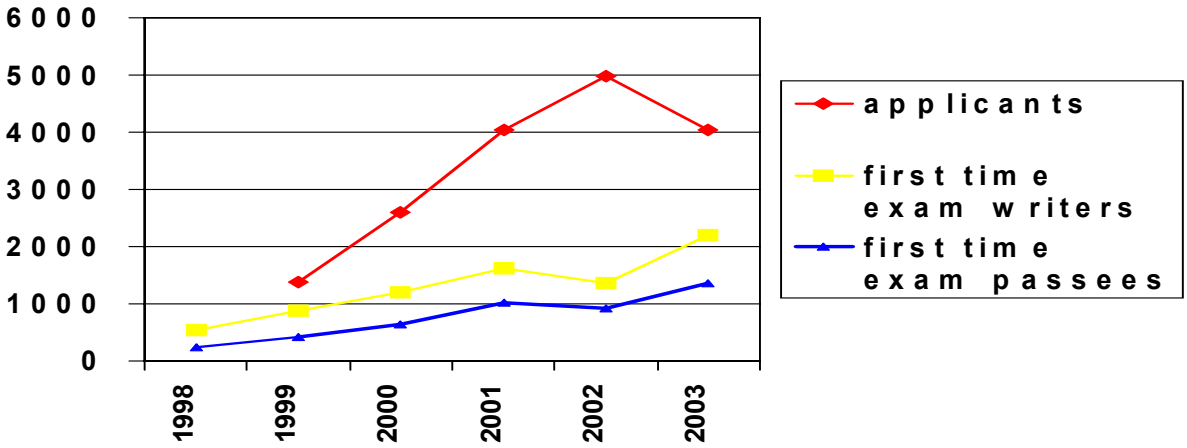
Such an approach would be based on the premise that IMGs have practical experience and the objective should be to establish equivalence to Canadian standards. AIPSO also recommended that in line with this that the residency and pre-residency programs should be replaced with a professional orientation and clinical evaluation process. This is similar to what exists with the IMPP for midwifery in Ontario discussed below.

With respect to IENs, they have a higher failure rate on their licensing exams (see Figure 3.10) again similar to what was found for physicians. In Ontario, for example, the failure rate was found to be 66 percent. What was particularly frustrating with this statistic is that some argue perhaps as high as 70 percent of those applicants are excellent candidates with good formal education and experience.[72] Estimates of the costs of integration for IENs are in the range of almost $4000 when the assessment process (~$220), English tests (~$320 – $500), licensure exams (~$440), criminal records check (~$25), refresher books (~$2500), and their annual licensing fee (~$200) are included.[73]

In the recently released report, *Navigating To Become A Nurse In Canada* (2005), the barriers to integration of IENs were summarized as follows:

> The first barrier confronting the immigrating IEN is locating the required information from government departments and regulatory bodies. The system is fragmented and there appears to be a lack of communication among and between the various players. Some of these problems have been described in other studies of internationally educated professionals (Canadian Council of Professional Engineers, 2003). There needs to be a concerted effort by all governments to improve communication and coordinate departments.
>
> The next challenge for IENs is navigating through the policies, practices and procedures for licensure/registration. Canada has 25 regulatory bodies for some 300,000 nurses. While each of these bodies has a similar general approach to assessment, there are some discrepancies and their assessment may differ. The assessment process can be protracted and take months, even years, to complete. ... Moreover, IENs may apply to more than one jurisdiction and/or to more than one nursing regulatory body, resulting in duplication of effort. ... The approach to the integration of IENs into the workforce is haphazard and problematic. Some provinces offer specific bridging programs for IENs but they are not all similar in content, length or cost and only some incorporate language and communication training.

Figure 3.10 RN IEN Applicants vs. First Time Writers & Passees
(Source: Little, 2005)



Moreover, as noted by Lisa Little, Chair of the Steering Committee of the IEN-DP,

> There is widespread recognition that correcting the problems confronting IENs will require the co-operation of governments at all levels, regulatory bodies, unions, employers, government and community agencies and that addressing these particular issues must be part of an overall strategy.

It was anticipated that due to the unique entry to practice requirements for Canadian midwives - a baccalaureate degree - that this may increase the burden on internationally trained midwives who are not university-trained.[74] But because the various PLEA processes that provincial midwifery regulators have established are based on core competencies rather than credentials, this is avoided to a certain extent. Specific barriers identified in a recently conducted review of entrance to the midwifery profession in Canada undertaken through the Canadian Midwifery Regulator's Consortium (CMRC) National Assessment Strategy (NAS)include:

- Incorrect information being provided to foreign-educated midwives prior to their arrival in Canada (e.g. via government websites or uninformed contacts in Canada)
- Insufficient resources to offer midwifery-specific language tests in every jurisdiction. ...
- Insufficient English and French language programs relevant in both content and level for midwifery candidates.
- Insufficient programs or mentoring to assist candidates in understanding the practice of midwifery in Canada ...
- Insufficient preparatory support for candidates in the assessment process ...
- Lack of adequate bridging programs which candidates may be referred to once gaps in competencies or education are identified in assessments.
- Insufficient clinical refresher programs to refer candidates to when it is clear that they require more current experience.
- Insufficient intercultural/diversity training (and insufficient diversity) of staff, assessors, examiners, evaluators, and supervisors which can lead to misunderstanding and frustrations of all involved. ...

Many of the above issues may not be particularly unique to midwifery but the following are:

- Small numbers of midwives available to be assessors, evaluators, examiners, supervisors, and preceptors to be able to sustain assessment and bridging programs.
- Lack of human and financial resources to maintain and revise examination materials as often as this should be carried out.
- Lack of human and financial resources and lack of an adequate number of midwifery applicants for registration to be able to offer assessment processes more often and in a more streamlined fashion (a common complaint is the length of time an assessment takes).
- Expense of offering assessment must be largely passed onto candidates since midwifery colleges are small with correspondingly small budgets and no way to offer assessment without fees. ...
- Lack of funded midwifery in Alberta and the fact that funding for midwifery positions in Manitoba, Ontario and Québec may not meet the needs of a potential applicant (or may not even be available), as well as limited funding to support supervision and the integration of new foreign-educated midwives in British Columbia. ...
- Difficulty in obtaining sufficient information about midwifery in other parts of the world to effectively evaluate an applicant's qualifications and experience. (p. 17-18)

One of the key barriers, however, seems to be the primary care model of practice where midwives are not supervised but rather are the most responsible provider. This is quite unlike the systems of midwifery care in many countries so is an issue with which some internationally trained midwives must come to terms:

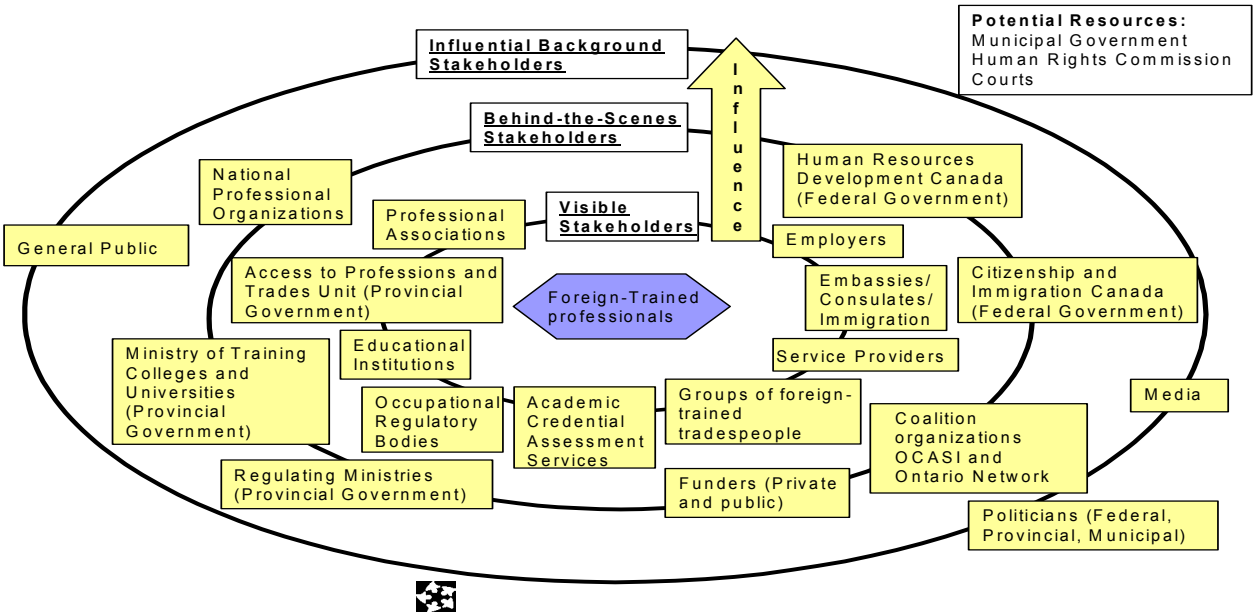
> In the rest of the world most midwifery systems do not have midwives providing primary care. And that is the biggest challenge we've been able to hone in on ... the biggest need to assist foreign trained midwives ... it's a paradigm shift, it's, I mean the way you think is going to be different when you're a primary care giver. *Midwifery Informant 1*

We know little about the barriers in the case of clinical psychology, but according to our informants these seem to be more salient between provinces than with other jurisdictions:

> It's an issue actually more within Canada than from outside of Canada ... In the U.S. I think just about all the States with the exception of one or two, you have to have a doctorate to become licensed as a psychologist. In Canada there's quite a bit of variability between province to province to territory about whether you need a doctoral or Masters degree. So ... ironically if you're just migrating from the States for example, and you have a doctorate the likelihood of you getting registered is probably somewhat easier than it is from within Canada if you practice in a Masters level jurisdiction. However, that's what the mutual recognition agreement was intended to resolve, was to allow for mobility within the country *Psychology Informant 2*

To sum up thus far, the process of being integrated into the Canadian health care system if you are trained internationally as a physician, a nurse, a midwife or a psychologist is clearly complex and costly. First, with respect to its complexity, a useful visual depiction is that proposed by The Centre for Research and Education in Human Services (see Figure 3.11). This 'Web of Stakeholders' situates the internationally trained professional at the centre of a web of visible and less visible stakeholders.

Figure 3.11 Web of Stakeholders involved in the Recognition of Internationally Trained Professionals in Ontario
(© 2000 Centre for Research and Education in Human Services)



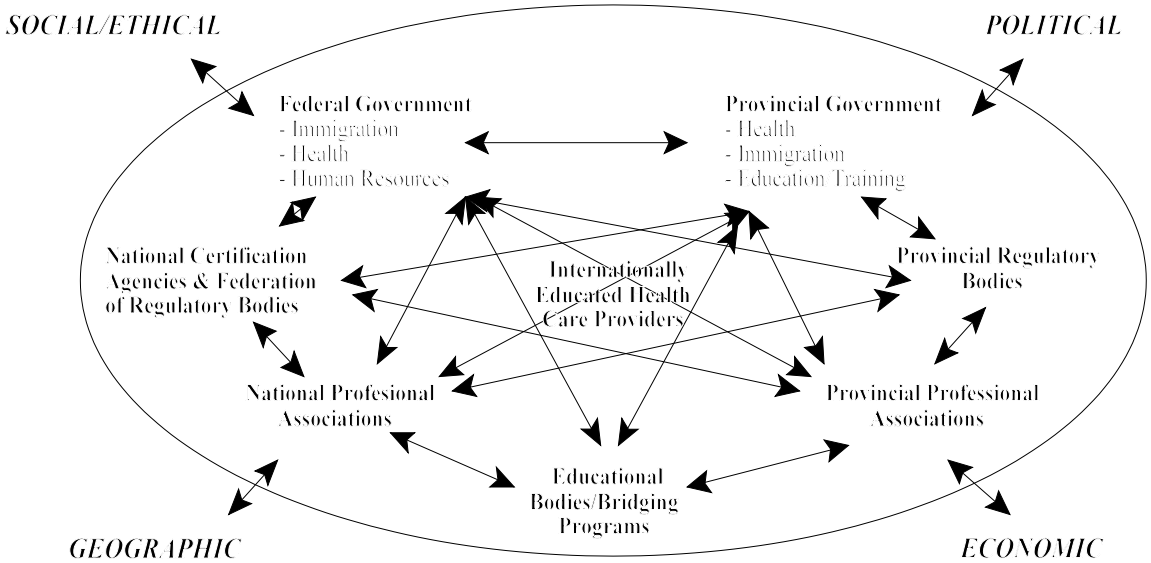
What is lacking from this web, however, is an acknowledgement of the relative power and autonomy of organizations and structured interests, their interrelations and the broader federal/provincial relations through which internationally educated health professions must navigate in Canada. A revised web which expands upon our initial conceptual framework that better captures some of the key (though not all) broader political and economic context factors including the relations between various professional organizations and government agencies which are critical to examine in the case of the integration of health professionals trained is depicted in Figure 3.12 below.

The barriers to timely and effective integration of internationally educated health care providers in Canada is also costly to all involved - candidates, regulatory agencies and the society at large. As Brouwer (1999) has argued:

> According to a Price Waterhouse report commissioned by the Ontario government, failing to recognize foreign academic credentials alone (not to mention foreign work experience) results in losses to the Ontario economy due to:
> - increased costs to the welfare system and social services
> - losses to employers who are unable to find employees with the skills and abilities they desperately require
> - costs associated with unnecessary retraining for foreign-trained individuals
> - the loss of potential revenue from foreign trained individuals who are unable to work and contribute to the tax base and other parts of the economy [1998;iii].[75]

It is not surprising, therefore, that several programs have recently been employed to attend to these difficulties.

Figure 3.12 Revised Web of Federal and Provincial Government and Structured Interests involved in the Recognition of Internationally Trained Health Care Providers



Programs to Reduce Barriers to Integration of Internationally Trained Health Care Providers

One of the key criticisms preventing efficient integration of internationally trained health care providers has been the many layers of organizations involved in the integration process and how there can sometimes be little communication across these key stakeholders.[76] Unintentional barriers are also a result of regulatory bodies' lack of adequate financial and human resources to develop and maintain equitable and time sensitive assessment processes.[77] In response to these concerns, one of the key partnerships that has emerged in the new programs to reduce barriers has been between government and professional bodies both at the national (i.e., through Health Canada and HRSDC in particular) and the provincial level. This has resulted in a flurry of committees, task forces and pilot projects set up in the past few years.

<u>Government-Profession Partnerships at the National Level</u>

Advisory Committee on Health Delivery and Human Resources

The Advisory Committee on Health Delivery and Human Resources (ACHDHR) is federal/provincial/territorial committee reporting to the Conference of Deputy Ministers of Health (CDM). One of the initiatives undertaken by the ADHDHR with respect to the integration of internationally educated health providers was to identify foreign credential recognition as a priority and as an initial step, it established a task force in June of 2002 to address the integration of IMGs into the Canadian health care system. This followed upon the heels of a National Symposium on IMGs held in Calgary in April of 2002 which included representation from governments and key

stakeholders in the medical community (see Table 3.9 for timeline). The goals of the IMG Task Force was to:

> ...develop strategies to aid in the integration of qualified internationally trained physicians to the Canadian physician workforce. The Task Force was asked to submit recommendations to the Advisory Committee by September 2003 with a goal of reporting the recommendations to the Conference of Deputy Ministers of Health in December 2003. (p. 6)

Table 3.9 Timeline of Recent Policy, Programs and Inquiries into the Issue of IMGs in Canada

April	2002	National Symposium on IMGs held in Calgary
June	2002	The Task Force on Licensure of International Medical Graduates was established with the mandate to aid in the integration of qualified internationally trained physicians into the Canadian physician workforce.
September	2003	The Task Force presented six recommendations to achieve this goal to the Advisory Committee on Health Delivery and Human Resources.
October	2003	Transition Committee Developed Implementation Plan
December	2003	Task Force Recommendations approved by the Conference of Deputy Ministers
February	2004	Final Report of the Task Force
Summer 2004	International Medical Graduate Implementation Steering Committee established	
March	2005	$75 million in funding over six years to address the recognition of internationally trained health care providers announced in Federal Budget to Health Canada

The key recommendations of the Task Force include:

1. Increase the capacity to assess and prepare IMGs for licensure.
2. Work toward standardization of licensure requirements.
3. Expand or develop supports/programs to assist IMGs with the licensure process and requirements in Canada.
4. Develop orientation programs to support faculty and physicians working with IMGs.
5. Develop capacity to track and recruit IMGs.
6. Develop a national research agenda, including evaluation of the IMG strategy. It would include the evaluation of the IMG licensure recommendations and the impact of the strategy on physician supply.

(*Report of the Canadian Task Force on Licensure of International Medical Graduates*, 2004, p. 1-2)

Most of these are in the process of being addressed largely through the recently announced funds to Health Canada. Moreover, the ACHDHR viewed the work of the Task Force as a "successful template" that could be used to address the integration of other internationally trained health care providers:

> The ACHDHR is considering the establishment of a task force to examine other health professionals who have current or projected shortages, access to practice challenges, and are identified as priority by the provinces and territories.
> (http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/recru/internat-graduates-diplomes_e.html)

For example, more recently the ACHDHR held an inaugural Taskforce meeting on the recognition of IENs in February 2004. Similar to the case in medicine, this was in response to an environmental scan of current practices and policies with respect to IENs undertaken by the Canadian Nurses Association with funds from HRSDC (see below). Shortly thereafter, the ACHDHR asked in September 2004 that HRSDC bring together the key health professions who were identified as being in short supply in many provinces and territories to begin the process of examining the issues pertaining to the integration and recognition of internationally educated providers.

Foreign Credential Recognition Program

The Foreign Credential Recognition (FCR) program was established in 2003 within the HRSDC Ministry as one of the key components of the governments broader Internationally Trained Workers Initiative (ITWI). Its mandate is to provide:

> ... an integrated, comprehensive strategy in which over 14 federal departments work together to address the barriers to working in Canada that internationally trained workers face. http://www.hrsdc.gc.ca/en/cs/comm/hrsd/news/2005/050425bb.shtml

And the barriers they intend to address are not individual but systemic:

> The goal is to try to achieve systemic change in terms our how we assess and recognize the credentials and competencies that internationally educated folks bring with them when they come. And we're looking really to achieve systemic change on a pan-Canadian or a national basis so that we have processes and systems in Canada that function with a degree of consistency from coast to coast. *Government Informant 1*

In 2003 and 2004, the federal government provided a total of $68 million over six years to implement the FCR program and fund the key activities aimed at improving FCR in Canada. Some of the health care provider initiatives funded are listed below.

Further, the 2005 budget earmarked $75 million (through Health Canada in follow up to the Health Accord the previous fall) to be spent over the next five years to accelerate and expand the assessment and integration of internationally trained health professionals. So far these groups include Pharmacy, Physiotherapy, Occupational Therapy, Medical Laboratory Technology and Medical Radiation Technology (in addition to Medicine and Nursing) which they believe should receive priority actions. Midwives are in the process of finding a way to get on this list. A sizeable proportion of these funds are to be distributed to the provinces for initiatives that are presently being negotiated.

In concert with these efforts of the ACHDHR and the FCR, there were a series of programs and projects announced in 2004 and 2005 by federal government agencies including HRSDC, CIC and Health Canada to address IMGs, IENs and to a lesser extent internationally trained midwives. The issue of the effective integration of internationally educated clinical psychologists has received little attention to date.

Medicine

In March 2004, HRSDC announced funds in the order of $341,050 for the Medical Council of Canada (MCC - which contributed matching funds) for the Self-Assessment Tool project. The goal

of this project was to "create a self-assessment examination and associated delivery system to be made available to foreign-trained medical graduates wishing to come to Canada to train or practice in the field of medicine." This is further elaborated on the MCC website[78]:

> The Self Assessment Evaluating Examination (SAEE) is a multiple-choice question practice examination and is intended for graduates of international medical schools wishing to test their level of preparedness for the Medical Council of Canada's Evaluating Examination (MCCEE.)
>
> The (SAEE) does not cover all of the material that is covered in the (MCCEE) and therefore **is not meant to take the place of the MCCEE**. It is provided solely as a sample of the type and style of multiple-choice questions that may be found in the (MCCEE) and is intended to be a study aid to help participants prepare themselves for the (MCCEE).

Through the MCC website, IMGs can register for the SAEE online with the following provisions:

> **People who take the (SAEE) will be allowed four hours across a seven day period to complete the examination.** For results to be of the most use, however, it is suggested that the examination be completed within 2½ hours. Upon completion, feedback will be e-mailed to participants consisting of the number of questions answered correctly and a comparison to other (MCCEE) participants.

The issue of effective integration of IMGs has remained high on the policy agenda with an announcement by Health Canada and CIC a little over one year later of a $75-million plan implemented across 5 years to integrate "up to 1000 physicians, 800 nurses and 500 other health care professionals who want to practise in Canada."[79] IMGs into the Canadian workforce. As it was announced in the *Canadian Medical Association Journal,*

> A National Credential Verification Agency, run by the Medical Council of Canada, would create both a one-stop process to assess credentials and a national registry of graduates. Another $1.3 million would help convert the council's evaluation exam [MCCEE] into electronic form to make it more accessible. The Association of Faculties of Medicine of Canada would also receive $830 000 to create a database to track all such graduates. Health Minister Ujjal Dosanjh also unveiled a Web site (www.IMG-Canada.ca) to help immigrants prepare for medical licensing before they come to Canada.[80]

This website is presently hosted by the AIPSO. As for the database, one of the key reasons behind it, as explained by Dale Dauphinee of the MCC and co-chair of the IMG Task Force, is that it is not known how many uncredentialed IMGs live in Canada:

> The estimates is that it's probably hundreds, not thousands and thousands, but we don't actually have an accurate estimate," he said. "That's one of the reasons why some of the things we're suggesting are so important, is to be able to identify who they are.[81]

The implementation of many elements of this announcement would be through the provinces, given that they are the ones that handle the regulatory process. As Health Minister Ujjal Dosanjh said,

> The provinces and territories will determine the number of training positions based on their needs. They will get money based on the number of people they integrate into the workforce from amongst the medical professions.[82]

Nursing

In March, 2004 HRSDC (and specifically its FCR Program) also announced funds in the order of $545,145 for the Diagnostic for the National Assessment of International Nurse Applicants project

by the Canadian Nurses Association (CNA). This diagnostic project (IEN-DP) was aimed at "identifying and assessing the current practices and policies with respect to the licensing of international applicants for each of the three regulated nursing groups [Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses(LPNs)] and providing draft recommendations for further action." This was seen as a critical first step in the process of understanding where systemic changes needed to be made to better integrate IENs into the Canadian health care system:

> In order to have a really good understanding of what needs to be done you really need to understand what the situation is in advance. In the case of the physicians they did that on their own without any funding from anybody. So they already had their diagnostic in place. ... nurses didn't have as complete a picture of what the labour market is in Canada for nursing particularly as it relates to internationally educated nurses, as is necessary in order to have a good understanding of where are the challenges, what are some of the barriers that need to be removed, and then how to go about doing that. *Government Informant 1*

The report of this project, *Navigating to Become a Nurse in Canada* was released May 12, 2005 which according to its press release, "paints a disquieting picture of the experience internationally educated nurses (IENs) face in integrating into the Canadian health system. The report shows that language and culture remain two of the largest issues for IENs and makes several recommendations that will make the process more efficient, coordinated and responsive to today's realities." Some of the key recommendations included in the IEN-DP report are:

- The establishment of a national assessment service to create an evidence-based standardized approach to the assessment of IENs ...
- The establishment of nationally standardized and flexible bridging programs to ensure IENs have the competencies required to meet Canadian nursing standards. ...
- The development of strategies to address the financial challenges incurred by IENs who enroll in bridging programs.
- The development of a central source of information such as a Web site specific to IENs to access complete, clear and easily understood information related to immigration and nursing licensure/registration.

Midwifery

In 2003, HRSDC (through it Prior Learning and Assessment and Recognition (PLAR) program) provided over $300,000 over three years to fund the National Midwifery Assessment Strategy (NAS) project through the Canadian Midwifery Regulator's Consortium (CMRC - who also provided support in-kind). As described in its *Research Plan*, the Consortium is

> "the umbrella group of regulatory organizations in the five provinces where midwifery is currently regulated: Québec (L'Ordre des sages-femmes du Québec), Ontario (College of Midwives of Ontario), Manitoba (College of Midwives of Manitoba), Alberta (Midwifery Health Disciplines Committee, AB Health and Wellness) and British Columbia (College of Midwives of British Columbia). The College of Midwives of British Columbia is coordinating the project with the assistance and support of a Steering Committee comprised of provincial representatives." (*precis,* p. 5)

The overall goal of the project is to "determine an efficient, effective, and fair pan-Canadian strategy for assessing internationally-educated midwives (IEMs) who wish to register to practice in a Canadian province or territory." Its specific aims are to:

> • increase access by internationally educated midwives to the profession;
> • build on the high degree of similarity in professional requirements and standards across the country to create an efficacious inter-jurisdictional process;
> • honour the unique aspects of midwifery in each province and territory; and
> • support each regulator in carrying out its legislated responsibility to protect the public. (*Report on Focus Group with Midwifery Supervisors,* July 2005, p. 3)

The project involves three phases, the first of which was undertaken from April 1, 2004 – March 31, 2005, withe the following key objectives:

- Determining what assessment processes are being used by Canadian midwifery regulators;
- Researching the midwifery competencies for safe practice in the five regulated provinces and considering the possibilities for creating a national competency document;
- Researching and analyzing promising assessment models, approaches and tools;
- Determining the constraints and issues that must be considered in developing a national assessment strategy.(*precis,* p.1)

Thus far the CMRC has:

- approved a document entitled, *Competencies for Canadian Midwives*
- approved the development of a pan-Canadian website for internationally educated applicants
- approved the development of pan-Canadian expertise and a credential evaluation database
- approved the recommendation that certain policies, procedures, forms, and criteria related to the "portfolio assessment" process (application process), be analysed for the purpose of creating standardization wherever possible (*precis,* p.1)

<u>Government-Professional Partnerships at the Provincial Level</u>

In addition to partnerships between relevant government agencies and national consortia of provincial regulators), specific provinces have also undertaken similar partnerships of their own. Given the demographic situation presented in the first section that highlights the overwhelming burden of the integration of internationally trained health care providers in Ontario, it is not surprising, therefore, that many of the provincially-based programs are found in that province. We briefly describe some of those recently announced or implemented programs there followed by programs in Manitoba and Quebec.

Ontario - General

Ontario has introduced several programs both specific to health care and about the integration of internationally trained professions in general. Many of these emanate from the review it undertook in the late 1980s on access to the professions and trades culminating in *ACCESS!* - the report of the Task Force on Access to Professions and Trades in Ontario (1990). Following on the recommendations of this report, an Access to Professions and Trades (APT) unit was established in 1995 initially within the Ministry of Training, Colleges and Universities but it has moved this past summer (2005) to the Ministry of Citizenship and Immigration. Its mandate is to "Promote fair and merit-based registration and employment practices for foreign-trained professionals and trades people to enhance their social and economic contribution to the province".[83]

The APT unit operates similarly to the federal FCR program providing funds to projects that further its mandate (a few profession specific examples are described below):

> The Access to Professions and Trades Initiative is based on the understanding that systemic solutions are required to address the systemic barriers facing the internationally trained.

They target funds specifically to the following barriers: assessment of academic credentials and skills; licensure and certification testing; language testing and training; supplementary education and training; and the review and appeal of licensure and certification decisions. With assistance from the APT unit a consortium of professional regulators in the province (including the CNO and the CPSO), called Ontario Regulators for Access (ORA) has also been established to "help Ontario regulatory bodies improve access by international candidates to self-regulated professions in Ontario while maintaining standards for public safety."[84] It serves as a "catalyst for regulators to work collaboratively on practical, proactive approaches and to benefit from each other's experiences. ORA also helps to foster collaborative partnerships with regulators and other players such as educators, community groups, employers, and governments."

More recently in January 2005, the Office for Partnerships for Advanced Skills (OPAS) received funding from the provincial government to lead a project addressing the barriers facing foreign-trained professionals who require university upgrading:[85]

> Initially OPAS will work with an advisory committee of representatives from Ryerson University, University of Toronto, University of Windsor and York University. Together, they will research and identify barriers, and then develop a call for proposal submissions by universities to address these barriers. It is expected that this will lead to new practices that will more effectively integrate foreign-trained professionals into the Ontario university system. The project will be ongoing until March 2007. (p.3)

This may have prove to have wide reaching implications for internationally trained health care providers.

Ontario - Medicine

In 2004/05 The Ministry of Health and Long Term Care launched a new program to integrate IMGs in Ontario called IMG Ontario (IMGO):

> The IMGO integrates Ontario's current IMG programs while creating many new opportunities for qualified IMGs to become licensed in Ontario. The system is administered through the Council of Ontario Faculties of Medicine (COFM) and is a co-operative endeavour of COFM, the College of Physicians and Surgeons of Ontario (CPSO) and the Ministry of Health and Long Term Care (MOHLTC).[86]

The specific ways in which IMGO intends to streamline the assessment process for IMGs by offering: 1) "an integrated, co-ordinated system for information, support, assessment, and training" meaning that "IMG physicians now only need to apply to one office to access all of Ontario's IMG opportunities, thereby reducing duplication of the application process to various programs;" and 2) the opportunity for "IMG physicians who do not need full postgraduate training are able to access advanced-level training positions, bringing them to practice in the shortest time possible." It provides approximately $26 million to expand the number of training and assessment positions from 65 to over 200 annually.[87] As stated on the IMGO website,

> By providing this significant financial support, the MOHLTC wants to ensure that a large percentage of these IMGs are fully utilised in our healthcare system, especially in underserviced communities where they are most needed.[88]

Included in this new package are also five-year Return-of-Service (ROS) agreements to help ensure that IMG participants fill the need for physicians in communities considered underserviced by MOHLTC (*see further discussion below*). As the website states,

> Provided the 5-year ROS agreement is successfully completed with an underserviced community, the investment paid for by the Government of Ontario is considered recovered.[89]

Ontario - Nursing

Provincial government funds addressing the issue of IENs has primarily gone into bridging programs. In Ontario, this is specifically called, the Creating Access to Regulated Employment (CARE) for Nurses bridge training program which was first announced by the Ontario government in May 2001 as a partnership between the Ministry of Training, Colleges and Universities, St. Michael's Hospital, Yee Hong Centre for Geriatric Care, Woodgreen Community Centre and Kababayan Community Centre, with support from the Ontario College of Nurses and the Ontario Ministry of Health and Long Term Care, Nursing Secretariat. Its results are expected to be as follows:[90]

- approximately 400 participants will have gone through the project.
- provision of a sustainable program to approximately 200 participants annually
- creation of prior learning assessment tools/processes leading to course exemptions or advanced standing
- new and adapted curriculum options to address gaps in skills and education
- new and adapted processes, and curriculum and tools to address the 2005 baccalaureate requirement for nurses and ensure program remains relevant
- how-to process guide – a tested educational model and materials that are sufficiently flexible to be adapted to other health care professions
- contribution to the field of best practice approaches through dissemination of program and approach to other stakeholders
- contribution to the reduction in health human resource shortages, thus enhancing access to and quality of patient care in Ontario

In April 2003, an additional investment of $475,000 the CARE program was announced to help more than 100 IENs practise in Ontario.[91] One of the related objectives of this new announcement was "to prepare internationally trained nurses to meet the requirements for the new nursing baccalaureate degree, which will be required in 2005 for everyone who wants to practise as a nurse in Ontario." At that point, the CARE program "has more than doubled the success rate for internationally trained nurses writing the examination for registration to over 70 per cent from 33 per cent."[92][IV]

Ontario - Midwifery

The International Midwifery Pre-registration Program (IMPP) was established in 2002 through financial support from the Access to Professions and Trades initiatives of the Ministry of Training, Colleges and Universities. It is similar to the CARE program for nurses in that it is a bridging program.

[IV] See also http://www.care4nurses.org/

> The IMPP can be characterized as an "enhanced PLEA" process, allowing international midwives to have their skills assessed within a program that can include upgrading, with no supervision being necessary upon graduation. It still involves written and objective structured clinical exams, and candidates create portfolios which are used to identify weak areas. It also includes educational courses and a clinical clerkship. It is offered at arm's length from the regulatory college by Ryerson University Continuing Education. 2004/05 will be the third cycle of IMPP.[93]

In 9 months, it specifically provides experiences internationally educated midwives, fluent in English, who have practised midwifery within the past five years with an assessment of their skills, information about midwifery practice in Ontario, clinical placements, mentoring and a final pre-registration exam.[94] The admission process to the program is described as very competitive and the costs for participants in the 2005–2006 program is approximately $4,900.00, plus textbooks and clinical equipment (approximately $500.00), plus possible relocation costs for the three- to four-month clinical clerkship program.

The results expected from this project include:[95]

- a comprehensive process and sustainable program that will provide internationally trained health-care professionals with the skills, knowledge and Canadian work experience necessary to reach midwifery licensing standards in Ontario
- the addition of approximately 25 qualified midwives annually to help address future provincial health care needs
- how-to process guide - a tested model and materials that are sufficiently flexible for adaptation by other organizations and occupations
- new or adapted curriculum: occupation-specific language supports, technical skills, workplace/sector orientation

Interestingly enough, some of the initiatives undertaken by the IMPP may also be employed in the assessment and bridging of IMGs. Because IMGs are a larger group than IEMs, this will not only help to make such initiatives more financially viable for Ryerson's continuing education department, they will also increase their impact to other internationally trained health care providers.

Ontario - Psychology

As far as the documentary and key informant interview data suggests, there are no specific government-profession partnership program for internationally trained psychologists in the province of Ontario other than the initiatives undertaking by the overarching Access to Professions and Trades Unit.

Manitoba - General

The provincial Department of Labour and Immigration (DLI) through its Settlement and Labour Market Services Branch formulates policy and supports activities that facilitate immigrants' access to the labour market. To date it has established partnerships with post-secondary institutions, professional licensing bodies and others to "establish ways of recognizing the knowledge and capabilities of highly skilled immigrants."[96] It has also established and funded a Prior Learning Assessment (PLA) centre which is to ...

> work with regulatory bodies to change the methods used to assess and accredit foreign-trained professionals. The aim is to support the licensing bodies to ensure their assessments are comprehensive, flexible and diagnostic. This may include credentials review, transfer of credit, challenge/confirmatory examinations, demonstrations of skills/knowledge, portfolios and others.[97]

The DLI has also established a Credentials Recognition Program which "provides financial and career counselling supports to assist immigrants with professional and/or technical backgrounds in gaining recognition for education and work experience obtained outside of Canada." (p. 2); an Academic Credentials Assessment Service; employment services for immigrants; and manages the Province's PLAR strategy which involves three cornerstone activity areas:

> increasing capacity in post-secondary institutions; expanding PLAR advisory services into the communities ... ; and increasing PLAR activities in industry, including business, labour, regulatory bodies, sector councils, other business organizations and Apprenticeship.[98]

Manitoba - Medical

From 1999 to 2001, the Settlement Branch of the DLI has provided funds to the Association of Foreign Medical Graduates to:

> ... provide orientation/counselling to IMGs on licensure process; organise and co-ordinate enhanced study sessions for exam preparation; co-ordinate the development and delivery of a series of lectures on exam relevant topics by local practising physicians; provide opportunity for IMGs to attend Continuing Medical Education lecture series offered by the Faculty of Medicine, [University of Manitoba]; enhance their collection of study materials; and identify potential alternate careers for IMGs for further research and program development.[99]

In 2001, Manitoba launched the first permanent program in Canada to assist in the integration of IMGs called the Medical Licensure Program for International Medical Graduates (MLPIMG), a partnership between Manitoba Health, the College of Physicians and Surgeons of Manitoba (CPSM) and the University of Manitoba Faculty of Medicine. Its main intent is to increase the number of primary care practitioners in rural areas in part requiring the IMG to gain sponsorship with a rural regional health authority. Other qualifications for this program include that the:

> ... physicians must be Canadian citizens, have been living in Manitoba for at least one year, have passed the MCCQEI, have a postgraduate position, and have completed a CAPE (Clinicians Assessment and Professional Enhancement) assessment. The assessment takes three days. There is no application fee but the assessment fee is $3500. The four components are multiple choice questions, structured oral interview, therapeutics assessment, and clinical and communication skills evaluation.[100]

If the IMG passes the CAPE assessment satisfactorily, he or she may apply for conditional registration with the CPSM. Further,

> They will have up to 5 years to complete the Medical Council of Canada Qualifying Examinations and seven years to obtain the Certificate of the College of Family Physicians of Canada (CCFP). During that period the International Medical Graduate will practise in an underserviced area of the province (as declared by the Minister of Health for the Province of Manitoba) with a medical practice advisor who will provide support and guidance to the individual.[101]

If, however, the IMG does not pass the CAPE assessment, he or she, may be eligible for a training program offered through the University of Manitoba Faculty of Medicine:

> This individualized program is designed to enhance the physician's previous training and address the specific learning needs as identified in the assessment process. The enhanced training must be completed within one year.[102]

It is intended that up to 12 IMGs will undergo the CAPE assessment per year and that ten training upgrade positions will be made available through the University of Manitoba.[103]

The province also funds the delivery of *Canadian Communications for Physicians Trained Abroad* - a 300-hour communication program for Physicians trained overseas wishing to re-enter their profession in Manitoba. This is provided at no cost to participants but enrolment is limited to 18. Priority is given to those candidates who have gone through the CAPE process. First offered in 2001-02, the programs have been offered numerous times with an average of 17 participants completing each course.

Shortly following this initiative, the CPSM began in early 2003 to open "conditional registration to IMGs from any country and standardizing the required qualifications."[104] As a result,

> All IMGs will be eligible for conditional registration if they have either two years of post-graduate medical education or one year of post-graduate education with three years of practise experience within the past five years. This move aims to address human rights concerns and recognizes the learning value of practise experience. This change will also create opportunities in Manitoba for IMGs across Canada who until now did not qualify for conditional registration. These licensure changes aim to address human rights concerns by opening conditional registration to foreign trained doctors from any country and standardizing the required qualification.[105]

Most recently, the provincial government has established a physician resource coordination office which will not only address immigration and recruitment but also retention issues.

Manitoba - Nursing

Although the Province of Manitoba has established a Nursing Recruitment and Retention Fund (NRRF), the programs that it entails do not specifically target IENs. (*see description below in emigration policy section*). The DLI is also exploring since 2004 a PLAR, bridging program and a *Language Support for Internationally Trained Nurses*, but this is primarily for the College of Licensed Practical Nurses of Manitoba.

Manitoba - Midwifery

As mentioned above, Manitoba has established a bridging and upgrading program for internationally trained midwives with funding from the Settlement and Labour Market Services Branch of the DLI:

> The project was developed after the Colleges refresher programs identified gaps in the training and experience of foreign-trained midwives.[106]

At the time (2001) there were no other programs in place to help internationally trained midwives gain the skills they need to gain recognition in the province. As noted above the CMM is fully involved with the CMRC NAS process. A new school of midwifery, initially open only to Aboriginal students, is also set to be established soon.

Manitoba - Psychology

As far as the documentary evidence suggests, there is no government-profession partnership program for internationally trained psychologists in the province of Manitoba. Indeed, our informants told us that "because it's a private practice issue ... our provincial government's ability to track and monitor what they're doing in private practice around recruitment and retention is much more limited." *Government Informant 1*

Quebec - General

Similar to the APT unit in Ontario, the Ministère de l'Immigration et des Communautés Culturelles (MICC) established the Groupe de travail sur l'accès aux professions et métiers réglementés (Task Force on Access to Regulated Trades and Professions) with the mandate to "outline the difficulties involved in recognizing competencies and training, and to propose solutions to eliminate some of these problems." Consultations were initiated in September 2004 as described below:

> To initiate discussion, a consultation document [Les personnes immigrantes formées à l'étranger et l'accès aux professions et métiers réglementés] was prepared by the *Groupe de travail* and distributed in September 2004 to nearly 1,500 affected organizations: regulatory bodies, teaching institutions, immigrant's aid organizations, professional associations, and representatives of employers and unions. These stakeholders were asked to submit reports to the *Groupe de travail* . Forty-seven briefs were duly submitted to the *Groupe de travail* . These ... reports outlined the issues and constraints involved in prior learning assessment and recognition, as well as tools or projects developed to remove certain obstacles and explore various solutions. The people of Québec were also invited to send the *Groupe de travail* their personal experiences, comments, or suggestions, and some fifty individuals responded. ... The *Groupe de travail* also met with some thirty concerned organizations. ... The Groupe de travail also consulted with an eight-person committee of professionals of immigrant origin who have been through the process of assessment and recognition of prior learning and are now involved in organizations operating within their cultural communities or individuals working within organizations familiar with immigrant professionals. [107](p.4)

It released its final report in February 2005 with several recommendations including improving information on accessing regulated professions and trades; improving the PLAR process; providing more opportunities for bridge training (including professional immersion and mentoring); and offering financial assistance to immigrants groing through the PLAR process. Overseeing these recommendations the *Groupe de travail* also recommended the establishment of:

> ... a permanent interdepartmental coordination committee bringing together deputy ministers concerned by the question of access to regulated trades and professions, and headed by the MICC. This committee's mandate would be to ensure coherence and continuity of government action on access to regulated trades and professions and follow up on the Groupe de travail recommendations chosen for implementation.(p. 6)

Overall, the *Groupe* concluded that:

> ...the time to act is now. Immigration is vital to Québec's future growth, but Québec will face ever-increasing competition in attracting qualified immigrants. If obstacles to the recognition of experience and training are not overcome, it will be harder for Québec to attract qualified workers. The prior learning assessment and recognition process, while respecting the principle of the protection of the public, must be as fair, transparent, and expeditious as possible, and these principles of fairness, transparency, and celerity must apply to all regulated trades and professions. (p. 16)

In addition to the recommendations of the *Groupe* , the MICC has a strategic plan to accelerate the social and employment integration of immigrants and members of visible minorities. It is specifically pursuing: the acceleration and personalization of the integration process; the facilitation of the recognition of skills acquired abroad through exchanges with professional orders and educational institutions in order to find concrete solutions to the problem of recognition of credentials; and the encouragement of businesses and public organizations to welcome and retain a diverse labour force.[108]

Quebec - Medicine
In 2003, the Collège des médecins du Québec participated in a working group constituted by the MRCI to find ways in which to better prepare IMGs (outside Canada and United States - *diplômés hors du Canada et des États-Unis DHCEU*) for their OSCEs (*l'examen clinique objectif structuré (ECOS)*). Several key solutions emerged from this working group including preparatory workshops and improved access to the libraries of the faculties of medicine faculties. The success rate for these examinations have increased from 27% in 2002 to more than 50% in 2004 for the candidates who have participated in the workshops.

In 2002, the Collège also collaborated with the MRCI to set up an information service on the regulated professions (*le Service d'information sur les professions réglementées - SIPR*). The SIPR currently offers IMGs all pertinent information concerning the steps to take to secure a restrictive permit to practice medicine in Quebec. The Collège ensures that the information is up-to-date. Since its development, the SIPR has helped close to 450 IMGs progress through the regulatory system in Quebec.

The Collège also collaborates with the Ministry of Health and Social Services (MSSS) through its *Recrutement Santé Québec* (RSQ), to recruit physicians outside of professorial positions and assist them in preparing a dossier to present to the Collège with the objective of obtaining a restrictive permit to practise. Again, the Collège ensures that the RSQ has pertinent and up-to-date information about the requirements for an application for a restrictive permit.

Quebec - Nursing
Similar to Manitoba, there is not much in the way of sponsored partnerships between Quebec government agencies and the nursing profession with respect to IENs that we could find. We do know that a background in nursing science either at the university or post-secondary level is considered to be 'favoured training' by the MICC in Quebec, and RSQ actively recruits nurses from other francophone countries (see above) but strangely enough nurses are not on the list of "occupations in demand'. Further in the OIIQ's submission to the *Groupe de travail*, they called

for just such a partnership with the Ministère des Relations avec les citoyens et de l'Immigration (MRCI) with the intention of developing a targeted recruitment strategy and a coordinated effort amongst stakeholders.

Quebec - Midwifery & Psychology
Partnerships between government agencies and professional orders in Quebec in the case of midwifery and clinical psychology were not apparent in the documentary and website data or in the key informant interviews we undertook. The argument seems to be that these two professions are not in high demand in the province.

Summary
In sum, there have been numerous task forces, working groups and joint government-profession committees that have been established to examine the barriers to the integration of internationally educated health care providers and an almost equal number of programs established to address these barriers. Generally speaking, we know a great deal about the barriers experienced by physicians and nurses, and are starting to learn what these are for midwives. Less is known about the barriers for clinical psychologists, but it likely they are not all that different from other health care providers. Perhaps related to this, funding for projects and programs have also tended to address the issues raised by the medical, nursing and midwifery professions (albeit the latter to a lesser extent).

One of the key recommendations across all professions is the importance of a single portal of information made available to internationally trained health care providers wishing to immigrate to Canada:

> So there's that aspect of it the people just sort of arriving. And that's why there was a lot of emphasis put on a portal for information and trying to think of accreditation or integration processes and trying to get as much of this done off shore before they come. And then that needs to involve the provincial Ministries cause they're then the ones that know what they need. And if they need more training, the provincial Ministries have to pay for it. *Medical Informant 1*

Similarly, the IEN report highlighted the importance of a "central source of information ... or centralized body to engage in the screening of all IEN applicants." The focus groups conducted for the CMRC National Assessment Strategy also suggested:

> A recommendation proposed and linked to the national approach was to establish a central list of international educational institutions that are recognized or accredited by the midwifery regulatory organizations. This would reduce the amount of time and resources each provincial regulatory organization would require to investigate the educational institution. (*Report on Focus Group of Internationally Educated Midwives*, March 2005, p. 16)

To date, some action has been taken towards this kind of centralization thus easing the integration process with the help of a great deal of public funds.

A couple of key issues, however, are either lingering beneath the surface - such as whether integrating internationally trained health care providers will ease the burden of underserviced areas - or is increasing in salience - such as the ethical considerations involved in the recruitment and integration of internationally trained health care providers on the countries from which they came.

Does Migration Help Solve the Problem of Underserved Areas?

One of the questions that arises from the policies directed towards the integration of internationally trained health care providers is whether they indeed help to solve the problem of underserved areas. With respect to physicians, the use of IMGs as a long-term policy solution to the shortages of physicians in particular areas is considered by many to be questionable. Indeed, there is evidence to show that IMGs are no more likely to practice in rural or remote regions of Canada than Canadian graduates.[109] For example, Barer and Webber (1999) argue that,

> "While it is commonly assumed that a large proportion of physicians practicing in non-urban areas of the country are IMGs, in fact in 1998 only about 26% of those practicing outside census metropolitan areas were IMGs. This was not appreciably different than the overall ratio of IMGs to all practicing physicians in Canada." [personal communication, Lynda Buske, Canadian Medical Association, April 1999].

Those that do immigrant health care providers usually only remain in rural areas under some form of coercive intervention, after which they often 'leak' into the overall geographically unrestricted Canadian physician supply.[110] As Grant (2004) states,

> "The difficulty arises from the tendency of many immigrant physicians, originally recruited by one province to address a shortage of physician services in remote and rural communities, to relocate to larger urban centres in another province. For some Canadian provinces, struggling to keep the burgeoning cost of their public health system in check, more physicians, from South Africa or elsewhere, in already over served areas is an unwelcome prospect. " (p. 2)[111]

Evidence also shows that the likelihood of IMGs emigrating to the US is comparable to Canadian graduates.[112] It will be interesting to see if the Return-of-Service agreements that are part of IMGO and the MLPIMG will yield similar results.

The proportion of IENs in rural areas has also been found to be relatively low:

> Only 5.6% of the foreign-trained RNs in Canada work in rural and small town areas of the country compared with 18.7% of Canadian-trained RNs; only 1.9% of rural RNs in Canada are international nursing graduates. These numbers likely reflect overall immigrant settlement patterns or trends for Canada as a whole. If so, recruitment of foreign-trained nurses would probably have little impact on the numbers of RNs in rural Canada.[113]

It is not readily apparent from the review of documents regarding the integration of IENs whether the issue of rural, underserved areas is salient. This absence is also apparent in the midwifery and clinical psychology documents. Conversely, some have argued that nursing shortages are also acute in major urban centres, such as in the case of Montreal, which is where many internationally trained nurses are recruited to work.

Ethical Issues: International Migration or Self-Sufficiency?

> The contributions of IMGs to healthcare in Canada have been great. Canada remains an appealing, safe place in which to live and work. Canada will continue to be attractive for healthcare professionals trained overseas. While focused recruitment from abroad will continue, such recruitment is not without important ethical constraints as there is a worldwide shortage of heathcare professionals, including physicians. It is wrong for Canada to actively recruit, or "poach" physicians from developing nations. Any active solicitation of physicians from countries that have a great need for physicians is troubling. Improving Canada's lot, at the expense of healthcare delivery in countries who are less fortunate is not a Canadian healthcare policy goal. (Final Report of Task Force on IMGs, 2004, p. 4)

One of the key ethical questions that arises from this issue - and one that has become increasingly salient to all stakeholders involved - is whether we should be viewing immigration as a solution to our skilled worker shortages or whether we should be attempting to achieve *self-sufficiency* insofar as the number of health care providers in the country are concerned.

International migration is commonly viewed as exacerbating shortages in source countries, particularly in African countries where the WHO has stated that the "shortage and migration of nurses and midwives continues to threaten the performance of health systems."[114] Indeed, international recruitment began to generate increasing controversy in 2001, when South African Ambassador André Jaquet asked Canada's health ministers to stop the "targeted recruiting . . . that leaves us even less able to grapple with the serious HIV/AIDS pandemic."[115] [V] Just one example noted in the literature details how when two South African anaesthetists were recruited by a Canadian institution to open a new Spinal Injuries Unit, the same day the Centre for Spinal Injuries in Boxburg, near Johannesburg, South Africa - the referral centre for the whole region - was closed and has not been open since.[116]

This has not gone unnoticed by the CMA. Its current president, Albert Schumacher, stated before a House of Commons committee in March 2005: "To continue to rely on and recruit IMGs in this way is both unsustainable and unethical, and we must overcome our reliance on them, particularly the active poaching from countries that can least afford it."[117] Schumacher argued instead for a "made-in-Canada solution" by being self-sufficient in meeting its need for physicians. Echoing these sentiments, CMA past president Peter Barrett stated at the most recent CMA annual meeting in Edmonton (2005),

> In the face of a global shortage of health care workers, he asked, can a country in which 24% of practising doctors were educated outside its own borders continue to rely on physicians from countries that can least afford to lose them?[118]

As aptly summarized in the Final Report of the Task Force on IMGs:

> To date, there has been no national consensus on the merits or meaning of physician self-sufficiency for Canada. This lack of consensus has contributed to a national physician workforce planning process that remains challenged to comprehensively address the health professional needs of the Canadian public. (p. 3)

The self-sufficiency issue has also been raised in the case of nursing. For example, in a recent presentation for an international conference on the global migration of nurses, IEN-DP Chair, Lisa

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[V] Approximately 2,000 graduates of its medical schools practise here.

Little argued that we need more domestic production of nurses; better retention strategies to improve the quality of work life for nurses, such as increasing their autonomy and decision-making powers, reducing violence expresses towards nurses, and employing appropriate workloads.[119]

The key informants we interviews in Québec all stressed that they are trying to meet their healthcare labour needs self-sufficiently through such initiatives as increasing places in colleges/universities, opening up more residency spaces, etc. At the same time, they were clear that they would need to continue to rely on immigration as well due to retirement forecasts, aging of the population, and low birthrates. RSQ, however, has not resorted to recruiting from countries with significant need of healthcare workers, such as Sub-Saharan Africa.

In the case of midwifery, self-sufficiency may not be a particularly viable option in large part due to its small size of the profession, the existence of few education programs and its labour intensive educational model. As one of our informants noted:

> In terms of growing the profession that's a huge one for everybody because we really want more students and we want more internationally educated and we really don't have the capacity to expand very quickly until we have more supervisors and preceptors. That's a big challenge. The other one is just that we are really small. So in terms of things like a bridging program, that's pretty much impossible to have in-person bridging programs anywhere other than Ontario because they don't have the numbers. *Midwifery Informant 3*

Moreover, it is generally regarded that in the face of the small school sizes there will continue to be a reliance on registering foreign-educated workers in order to meet the rising demand for midwifery services.[120] Nevertheless, midwives are also keenly aware of the ethical concerns.

But this is not simply an issue on the Canadian radar. The World Medical Association's *Statement on Ethical Guidelines for the International Recruitment of Physicians* recommends that: "Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians." [121] Moreover, because of the ethical dilemmas of recruiting nurses from poorer nations, Commonwealth countries signed a Code of Practice agreeing not to recruit health care providers from developing countries known to be experiencing shortages.[122] Canada, along with Australia and the U.K. (two other top destination countries), failed, however, to endorse the phrase demanding some form of compensation for source countries (something for which the African member nations were lobbying strongly).

Moreover, if we direct our attention and our policies towards international migration - as it seems to be we are determined to do - a related concern is regarding whether we should actively recruit internationally trained health care providers (as has been the case[123]) or simply focus on better integrating those providers who are already here. This latter group is "a source of untapped skilled workers and if not integrated into the Canadian labour force, represents a loss of human capital"[124] both to Canada and the country from which the provider came. As Linda Silas, President of the Canadian Federation of Nurses Unions (CFNU)

> There are foreign-trained nurses in Canada who with help (some of it very minimal) could be successfully integrated into our health care system. While CFNU believes that it is immoral to cherry pick nurses and other health care professionals from the needy citizens of less developed nations, we

> believe that we have a practical and moral obligation to provide help to those who are in Canada now. (p. 7)[125]

Similarly, Dale Dauphinee, Executive Director of the MCC highlighted in a recent article the following key lessons:

- Raiding the physician resources of developing countries by developed countries is unacceptable.
- It is unacceptable to promote the human capital model but fail to provide the flexibility of educational and training opportunities for international medical graduates (IMGs) to learn needed skills and to become acculturated.
- The ethics of physician recruitment extend beyond the policy failures that lead to raiding to include issues of resource management within each recruiting country.
- Physician migration to and from Canada is influenced by variables such as loss of physicians to the United States, physician practice preferences with Canada, and the application of workforce policies and health plan administrative practices within Canada.
- Planners need to consider more carefully both sides of issues: the intended results but also the unintended consequences of such plans and policies. [126](p. 22)

It is for these reasons that the programs detailed within this report and elsewhere are so important.

3.3 The Demographic Context of Health Labour Emigration in Canada

Canada is generally regarded as both an importer as well as an exporter of health labour. Just as we have found fluctuations in the volume and demographics of health care providers who migrate to Canada, we find similar fluctuations in the number of providers leaving the country. Across all professions, the primary destination is to the United States for a variety of reasons delved into more deeply in our policy section below. Here we present data that are available on the outflow of Canadian physicians, nurses, midwives and clinical psychologists.

The Medical Brain Drain

> It takes 15 years to produce a neurosurgeon, but it takes only a few days to leave the country.
> Lysiane Gagnon. The siren call of US riches. *The Globe and Mail*. April 17, 1999.

Most of the ink spilled on the health care brain drain has been regarding the outmigration of physicians from Canada and this was particularly heightened in the mid 1990s for reasons which will become clear. An article in the Vancouver Sun expounded,

> Doctors are leaving Canada in near-record numbers and there are fears of a national shortage if the hemorrhage continues. ... The numbers are even larger if they include medical students who left immediately after getting their degrees but before being licensed to practise.[127]

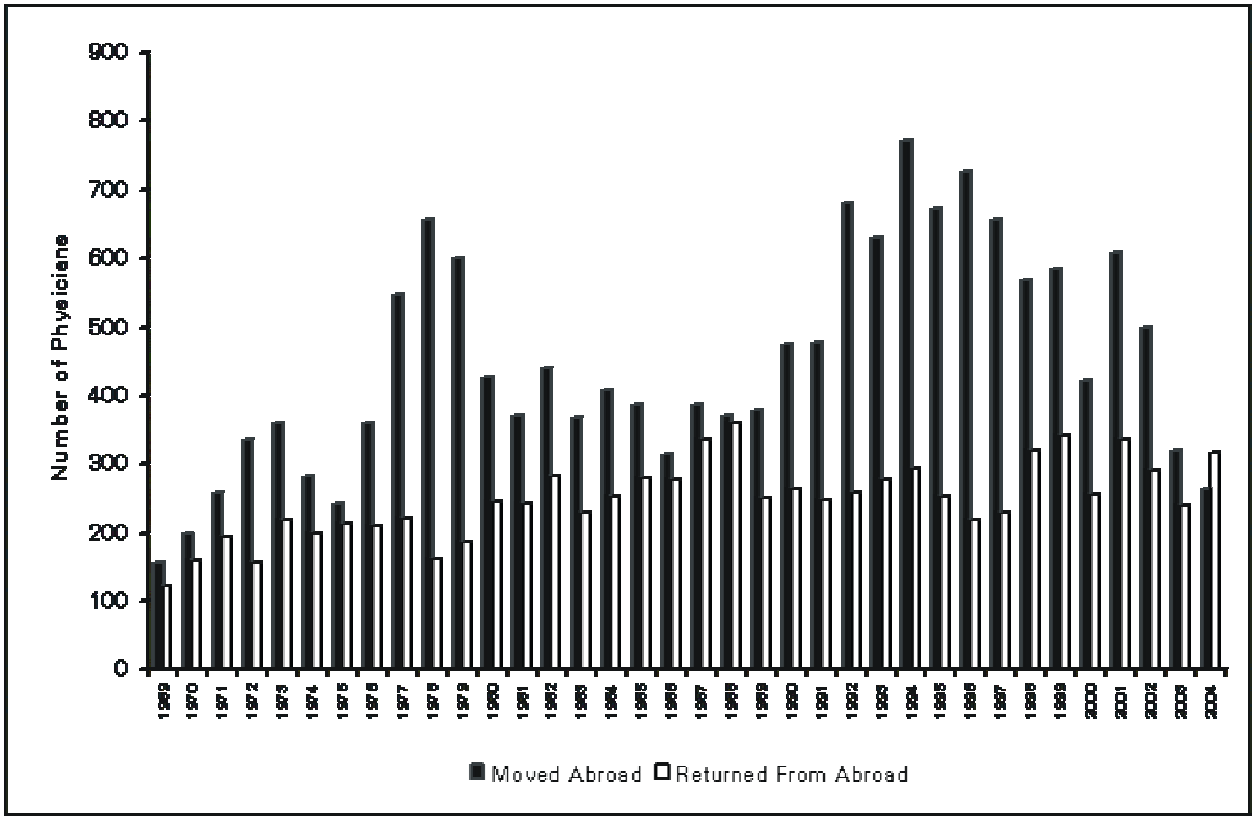
As described by Bruno l'Heureux, then president of the Canadian Medical Association, in this article,

> For 1994 the total approaches 800. ... If you take into consideration the students who left immediately on receipt of their MD, the number (of departures) is just under 1000. ... This…constitutes a loss of $750 million per year in tax-financed human capital, primarily to the United States

A few years later, a study of University of Toronto medical students reported in the September issue of the Canadian Family Physician found 48 per cent of residents intended to relocate to the US. This was attributed by chair of the department of family and community medicine, Dr. Walter Rosser, to a lack of respect.[128]

A study of physicians conducted by Ryten, Thurber and Buske in 1998 also found that the 1989 graduation cohort was diminished by 16% the majority of which was migration to other countries.[129] The trend continued with a peak in 1995 with 85% of health grads moving to the United States. This peak is widely attributed to the outflow of family physician grads when Ontario introduced geographic billing restriction legislation.[130] Physicians left Canada at a rate about 10 times higher than all other Canadian emigrant workers but this nevertheless represented less than 1% of physicians in Canada per year. These researchers concluded that "the yield of the Class of 1989 for Canada's physician workforce is insufficient to meet annual physician inflows from Canadian sources to serve population growth and to replace retiring or emigrating physicians."[131] This was, however, at the peak of the migration of physicians away from Canada (see Figure 3.13 below).

Figure 3.13 Physicians Who Moved Abroad & Returned to Canada, 1969 to 2004
(source CIHI, 2005)



In 2000, CIHI data show that 420 physicians moved abroad, down about 28% from 1999.[132] Most were male, specialist physicians who had received their MD education within the previous 10 years. Postgraduate training in the U.S. was associated with subsequent emigration.[133] In the same year, 256 physicians returned from abroad, similarly down about 25% from the year before. The characteristics of returning physicians were very similar to those that moved abroad.[134] Earlier, McKendry et al. (1996) found that 22% of Canadian physicians said they were likely to move to the U.S. whereas only 4% of the U.S. based respondents indicated a willingness to move back to Canada.[135]

In 2004, however, a dramatic shift was noted in that for the first time since 1969 (the period for which data are available) more physicians returned to Canada than moved abroad. Specifically, CIHI reported that in 2004, 317 physicians returned to Canada, and 262 moved abroad. In the period between 2000 and 2004, the number of physicians who left Canada declined by 38%. In 2004, 262 physicians left Canada down from 420 physicians who left in 2000. It was also found that roughly 25% of the physicians who moved abroad in 2004 were IMGs, and 44% received their degree within the last 10 years. Of the physicians who left Canada, the majority were male (69%). Also, more male doctors returned from abroad (74%) than female.[136]

Some of the noted limitations of these data are that it includes many physicians who leave Canada but still keep their medical licenses north of the border,[VI] and also that it does not include the Canadian medical school graduates who start their careers outside Canada.[137]

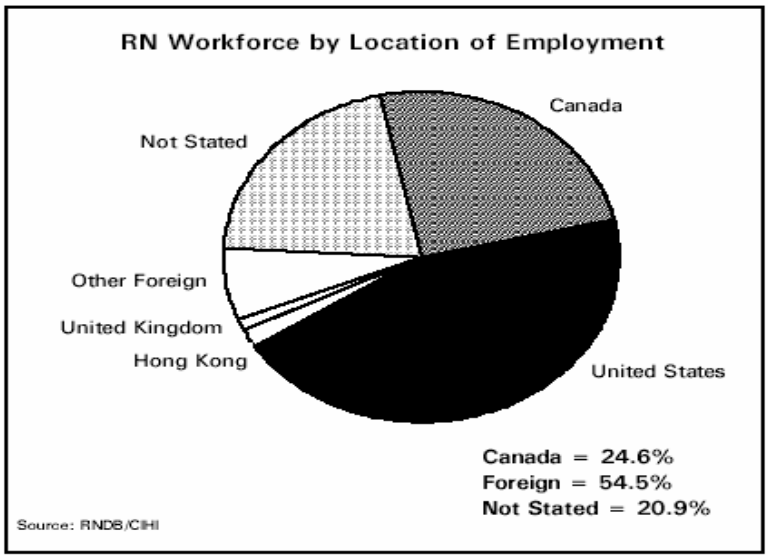
The Nursing Brain Drain

With respect to nurses, a recent CIHI report noted that over 5000 nurses maintained their Canadian licence while working outside of Canada in 2003.[138] Over 80% were employed in the United States so much so that Canadian nurses are one of the main sources of IENs in the U.S. (22% versus 32.6% for the Philliphines)[139]. As stated by Aiken et al. (2004):

> Canada has long been a source of nurses for the United States, especially in border states, where Canadian nurses' credentials are generally accepted by endorsement because of the comparability in educational and licensure requirements. (p. 72 –73)

Other countries that attract Canadian nurses are Saudi Arabia, the United Kingdom and Hong Kong. (see Figure 3.14) These totals, however, only include nurses maintaining their Canadian license while working abroad thus these data incomplete at best.[140] To date, no study has investigated whether RNs that maintain their registration in Canada while abroad are more likely to return to Canada than those ceasing registration. Moreover, this snapshot in time also masks the trends over time that indicates a net loss in the 1990s of 5,000 to 16,000 RNs.[141]

Figure 3.14 Percentage of RNs with Secondary Registrations by Location of Employment, Canada, 2003



VI According to the Canadian Medical Forum Task Force on Physician Supply (1999). Physician Workforce *CMAJ*, Nov. 22, 1999. http://www.cma.ca/index.cfm/ci_id/19522/la_id/1.htm, there are approx. 8000 Canadian medical graduates practicing in the U.S. of which 2440 maintain active licenses in Canada.

The Midwifery and Clinical Pyschology Brain Drain

Very little is known of the extent of midwives and clinical psychologists leaving Canada. In the case of midwives, because there are so few spots in the education program, aspiring midwives are often faced with the decision to leave Canada for training in the hopes that they can become integrated when they return. To date, this has not been a trend that is being tracked in any systematic way. Moreover, it is a problematic assumption to make because unlike medicine and psychology there are few U.S. based programs that are acknowledge by provincial midwifery regulators as being equivalent to Canadian standards.

In the case of clinical psychologists, a survey conducted by the CPA found that:

> the data that we collect every year from accredited programs tells us that an average proportion of about 10% of students of the Canadian programs upon graduation go to the U.S....but what we don't know is are those American students returning home or are those Canadians going to work in the U.S. *Psychology Informant 2*

One of the key factors leading to emigration may be the lack of public funding for their services:

> in the U.S. what the insurance companies do is they pay the license provider to provide the needed service. So if someone needs psychotherapy and you're a licensed psychologist or a licensed psychiatrist or a licensed social worker... then your services will be remunerated. In Canada, the public health insurance programs do not pay for the needed service. They pay specific providers. So psychologists are the single, largest, specialized, regulated provider of mental health services in this country. ... you know, six to 10 years in graduate school with this specialized skill set to assess and treat, and diagnose, by legislation certainly in Ontario, right? It's one of the License Acts that psychologists have and our services are not remunerated. *Psychology Informant 2*

This is clearly an issue of concern for the profession but it is not clear if and how it affects outmigration from Canada.

Summary

In sum, although we have better data on the inflow of health care providers into Canada than we do of the outflow. Similar to the case for immigration, what is also clear from these demographic trends is that various health care and health human resource policy have an important influence and indeed the issues of immigration and emigration are linked (as we will discuss more fully below).

3.4 The Policy Context of Health Labour Emigration in Canada

Some attention has been devoted to the problem of the emigration of nurses and of physicians but again; we find little coordinated policies evident. For example, we know that the reasons cited by health care émigrés from Canada were primarily job-related, including job availability and satisfaction, and the amount of resources devoted to the health care system.[142] [143] [144] [145] [146] [147] In this section we begin to map out the policy context regarding the following key emigration issues:

- *the impact of local remuneration and working conditions;*
- *trade agreements*
- *factors affecting return migration.*

Remuneration & Working Conditions

Many have linked anger over health care cuts to the emigration of physicians and nurses in the mid 1990s.[148] [149] For example, Dr. Lorne Tyrrell, dean of medicine and dentistry at the University of Alberta, said "This came home to me the other day when I spoke to a young ENT surgeon who is moving to North Dakota. When I asked him why he would leave Canada when we have such an acute need for specialists like him, he told me that opportunities to do surgery here were too restricted. His waiting room is always full here, but he only has access to an operating room in his Edmonton hospital for 2 hours every 2 weeks. In North Dakota, he gets 2 afternoons a week in the OR."[150] Over time, these cuts took their toll as Grant and Oertel (1997)[151] describe:

> With the widespread preoccupation of provincial governments with deficit reduction, and with the general failure of user-fees and other demand-side initiatives, the number and earnings of physicians became the target of various "cost containment" measures. Provincial initiatives sought to address the fees, incomes, and number/location of physicians:
>
> - Fee schedules. Negotiations between the province's government and its medical association over fee-for-service payments became more "one-sided" with some governments choosing a "take it or leave it approach" or unilaterally imposing fee schedules (Deber et al 1994).
> - Utilization rates. Several provinces (New Brunswick, Newfoundland, Quebec) placed absolute "caps" on their overall health care budgets or total payments to physicians. Others (Ontario, British Columbia) limited individual physician incomes and/or the rate of increase in aggregate physicians billings....
>
> The impact of these initiatives on the income of physicians became apparent by 1993. ...After suffering a substantial erosion in real earnings during the 1970s, Canadian physicians enjoyed a steady improvement in average income from $109,471 in 1981 to $126,322 in 1992. But in the subsequent three years, real earnings fell substantially such that by 1995 most of the gains physicians had made during the 1980s were dissipated.

Another reason for the outflow to the U.S. was directly related to the reduction in residency positions a trend which not only affected IMGs, it left little options for graduates by to find residencies elsewhere.[152] The departure of Canadian physicians to the United States was also facilitated by the rapid expansion of Health Management Organizations (HMOs) there which found Canadian trained family physicians ideal gatekeepers. Some of the key reasons our informants mentioned for emigrating from Canada included better remuneration, more operating time and better equipment. Together these influences help to explain the peak in physician outflow that is displayed in Figure 3.13 above.

For nurses, the southward 'brain drain' was particularly dramatic in the mid-1990s, when country-wide cuts in the hospital sector put many nurses out of work, to the delight of eager US recruiters

who lured Canadian nurses with signing bonuses of up to US$30 000.[153] [154]A Registered Nurses Association of Ontario study of Ontario RNs who left Canada between 1991 and 2000 found that most (69.5%) said that job opportunities were the main reason they left Canada (specifically, the lack of full-time employment). Family or personal reasons were cited next (25.5%), followed by pay and benefits (12.9%) and travel/weather 5.5%).[155] A report by the CNA states that

> nurses here want full-time employment, appropriate workloads, involvement in decision-making and educational opportunities. During the cutbacks of the 1990s, many nurses were forced into part-time or casual jobs, and by the late 1990s 48% of nursing positions provided only part-time work. Desperate for stable employment, up to 15% of new Canadian graduates now move directly to the US; the CNA, which represents 115 000 nurses, wants to reduce this to 5%.[156]

These reasons are not dissimilar from those found for nurses internationally (see Table 3.10).[157]

Table 3.10 Push and Pull Factors Influencing International Migration of Health Care Providers

Push factors	Pull factors
Low pay (absolute and/or relative)	Higher pay (and opportunities for remittances)
Poor working conditions	Better working conditions
Lack of resources to work effectively	Better resourced health systems
Limited career opportunities	Career opportunities
Limited educational opportunities	Provision of post-basic education
Impact of HIV/AIDS	Political stability
Unstable/dangerous work environment	Travel opportunities
Economic instability	Aid work

Trade Agreements

Some analysts we came across in the literature stress the importance of looking beyond the particular policy contexts of nation state to understand the broader impact of trade agreements, such as the North American Free Trade Agreement (NAFTA), the World Trade Organization (WTO),and the GATS on the flow of health labour. [158] [159] These trade agreements urge national governments to reduce or eliminate requirements and regulatory devices that impede or block the movement of goods and services. NAFTA, for example, allows for the following:

> Nurses who are citizens of Canada and Mexico may work in the U.S. under the NAFTA ("TN") status. Canadian nurses must demonstrate the following:
> 1. They have a written offer of employment from a U.S. employer for a period of not exceeding one year;
> 2. They are licensed in Canada and in the state of intended employment. Eighteen U.S. states endorse Canadian licenses without the exam.
> 3. They have proof of Canadian citizenship; and
> 4. They pay a US $56.00 fee to enter the United States (payable at the U.S. border).[160]

Although it has been found that as a consequence of NAFTA there has not been a massive migration of nurses from Mexico to the U.S.,[161] it has made it easier for Canadian nurses to find work in the U.S. This difference is due in large part to the equivalency of education and training.[162] The overarching GATS also facilitates increased labour migration because of its efforts towards aligning the competency and recognition requirements for health care providers between countries. So

historically where national boundaries separated licensing, regulatory and credentialing systems, the facilitation of enhanced international trade in services may weaken the autonomy and authority of nationally-based professional regulatory systems. [163] Taken together, these trade agreements represent new challenges in understanding the migration of health care providers that remain to be fully explored.

Return Migration

Very little is know about the factors affecting return migration of health care providers who leave Canada and often economic overshadow personal factors in such decisions. In the case of physicians, Webb (1997) argues that "[m]any Canadian doctors have emigrated [to the US] only to return within a year or two, frustrated with a market-driven health care system and a much more eclectic and individualistic society."[164] Anecdotal evidence suggests that HMOs in the States are difficult to deal with, family is missed and very interestingly, some doctors have said that they find it very difficult working in an environment where healthcare costs are not paid by the state. Another salient factor noted by more than one of our key informants may be that global unrest is a catalyst for the return of physicians to Canada. In the post 9-11, Iraq war era, it could well be that Canada is considered safer than Europe and certainly the US. This may be true across professions. Further, in the case of nurses, because the job market for nurses has opened up again, particularly in Ontario, the tide appears to have reversed.[165]

Our documentary and website search also uncovered two examples of 'repatriation' programs. One is offered by the CPSO as part of its IMGO package:

> The Repatriation Program offers funded training positions to physicians who have completed postgraduate training outside of Canada and require up to two years additional training to meet the certification requirements of the Royal College of Physicians and Surgeons of Canada. Upon graduation, successful candidates practise in an under serviced area for a duration equal to the length of Ontario training received. Physicians must be Canadian Citizens or Landed Immigrants. The Ontario Ministry of Health and Long-Term Care administers this program. [166]

The other is offered for nurses by the Manitoba Ministry of Health which focuses primarily on 'relocation assistance':[167]

> The 'Come Home to Manitoba' campaign continues to provide relocation assistance of up to $5,000 to nurses coming to Manitoba. Since the fund was established, almost 500 nurses have applied and been paid relocation assistance. In the past year, 178 nurses moved to Manitoba to work. Applications continue to be received from nurses requesting assistance with their move.

Between April 2001 and March 2002, this campaign received 475 applications. Although many applications were from other provinces (see Table 3.11), a sizeable were from nurses practising outside of Canada. Similar capped relocation expenses of $15,000 is also available to regions for the recruitment of specialists and midwives to a lesser extent.

Table 3.11 Relocation of Applicants to 'Come Home to Manitoba' Program, 2001-2002

Within Canada	Number of Applicants
Nunavut	2
NWT	3
Yukon	3
British Columbia	66
Alberta	39
Saskatchewan	21
Ontario	89
Quebec	11
New Brunswick	16
PEI	2
Nova Scotia	21
Newfoundland	12
Labrador	2
Outside of Canada	**Number**
USA	75
Philippines	79
British West Indies	1
Saudi Arabia	5
England	5
Australia	4
Monaco	1
Bahamas	1
New Zealand	1
Korea	5
Other	11
TOTAL:	475

In sum, a variety of human resource policy influences can impact upon the emigration of Canadian health care providers just as it can influence the immigration of internationally trained providers. The imperative, therefore, is to be able to use these policy levers in a direction of retaining as many of the Canadian trained providers as we can with the aforementioned goal of self-sufficiency.

4. Concluding Comments

There are a great deal of convergences in the ways in which policies and programs have been proposed and implemented to deal with these issues in medicine, nursing, midwifery and to a lesser extent psychology despite dramatic differences in the size of these professions and their relationship vis-a-vis public funding. An interesting issue that arises from this comparative analysis is between the cases of medicine and midwifery on one hand and nursing and psychology on the other. Specifically, the latter two professions have two different levels of regulatory status (in most provinces) being RNs and LPNs and psychologists and psychological associates respectively. What this enables is a possible two step process for integration for internationally trained health care providers. This is not presently possible in medicine and midwifery other than through the temporary licenses and conditional registration programs. Having a "lower" initial entry point - or perhaps stated more positively as a two-step process - would enable internationally trained health care providers to gain important Canadian experience while at the same time honing their skills and being gainfully employed. This is one potential policy solution that could be explored further through physician assistants (which exist in the U.S.) and maternity care assistants (which exist in the Netherlands and in the U.K.)

We also have to be clear on the implications of some of the demographic data. For example, given that we have found that internationally educated health care providers tend to be older, they may not be the most effective solution to the human resource crisis we face. In light of such data, the report *Navigating to Become a Nurse in Canada* states,

> Given that one of the root causes of the shortage of nurses in Canada is an aging workforce, a large proportion of these IENs reflect the same age profile. They will not be in a position to fill the gap when thousands of Canadian nurses retire. On the other hand, a large number of these IENs have several years of experience, which is a great asset to Canadian employers. (p. 21)

That is, better integration of internationally educated health care providers should be undertaken not so much as a solution to shortages but as an equity issue in its own right. A multi-pronged approach must be taken of which more efficient integration of internationally providers is a part but must also include attention to factors affecting recruitment and retention. This is why it was important to examine both the flows into and out of Canada and the policy and contextual factors influences these flows.

As has been hinted throughout this report, the issues of immigration to and emigration from Canada are intricately linked despite the fact that the more salient issue at this time is around immigration and integration in particular - that is a 'brain waste' rather than a 'brain drain' issue. A related ethical issue of increasing international significance is whether we should be viewing immigration as a solution to our skilled worker shortages or whether we should be attempting to achieve *self-sufficiency* insofar as the number of health care providers in the country are concerned. Moreover, if we direct our attention and our policies towards international migration - as it seems to be we are determined to do - a related concern is regarding whether we should actively recruit internationally trained health care providers (as has been the case) or simply focus on better integrating those providers who are already here. This latter group is "a source of untapped skilled workers and if not

integrated into the Canadian labour force, represents a loss of human capital" both to Canada and the country from which the provider came.

Because of Canada's unique position of being both an importer as well as an exporter of health care providers, it is imperative upon us to use this position to become a world leader in ways in which to attend to the issues that both draw health care providers to our country and away from it. In both cases, a strong argument can be made for better recruitment and retention strategies within Canada to stem the tide of those leaving the health professions - not just for other countries, but altogether - and reducing the necessity for us to go outside our borders to recruit. As Buchan and Sochalski (2004) have so eloquently summarized in the case of nurses[168]:

> These accelerated levels of nurse migration may be a symptom of systemic problems in the nursing workforce in both the source and destination countries. If national governments and international agencies wish to respect the rights of an individual nurse to move but also wish to create an "ethical" environment in which the individual is under no pressure to leave, they must engage actively and positively in these dynamics.(p. 591)

Similarly, Bach (2003) has argued that:

> It is an indictment of governments and employers that they prefer to rely on the relatively straightforward panacea of international recruitment rather than focusing on underlying problems of pay and working conditions. Improvements in these areas would ensure increased recruitment and retention amongst the existing health sector workforce. (p. ix)

Thus, we are faced with three key policy options in Buchan and Sochalski's opinion:.

- The first option is to support improvements in pay, working conditions, scheduling, career prospects, and the security and prestige of nurses in their own countries in order to modulate
- The second option is to encourage and facilitate bilaterally or multilaterally managed flows of nurses between countries. This should also include the possibility for the nurse to return to the home country if desired. Some countries have already begun to discuss this issue.
- The third option is to institute arrangements whereby compensation flows from the recruiting country back to the source country. This could be direct or indirect financial compensation, remittances pledged from nurses, educational support as part of a donor package, or the return flow of better-trained staff. Some source countries favour financial compensation but there is little evidence of this approach being operationalized.(p. 592)

Because of Canada is sometimes viewed as a 'weigh-station' for ultimate U.S. destination, it makes our policy decision-makers somewhat more hesitant to enter into financial reciprocation agreements with source countries. It is a truly complex issue to manage health human resources while at the same time acknowledging the free movement of labour and the expenses laid out for the education of health care providers elsewhere.

5. Future Research Directions

Based on the findings from this pilot study, we are pursuing two studies with funds from the SSHRC and from the CIHR.

The first study (2006-2009) involves an examination of the experiences of internationally trained health care providers in Canada. The objectives of this study are to examine:

- the policy, the decision-making processes and regulatory environments addressing the issue of the immigration of physicians, nurses and midwives into Canada;
- the experiences of immigrant physicians, nurses and midwives who are included and excluded from practicing in Canada; and
- the factors influencing immigrant health care providers relative successful at becoming integrated into the Canadian health care system.

For each of these three case studies, data will be collected through: 1) the acquisition of key public domain policy documents from the various provider/stakeholder groups; 2) interviews to be conducted with key informants involved in the policy decision-making process and 3) experiential interviews with internationally trained physicians, nurses and midwives who have either successfully integrated into the Canadian health care system and those who have not. It involves a partnership between Dr. Bourgeault and a specialist in immigration and race relations, Dr. Victor Satzewich.

The second study funded by CIHR (2006-2010) involves a large international research team and local community decision-makers that will undertake a comparative examination of the policy context around the integration of internationally educated health care providers in Canada, the U.S., the U.K., and Australia - the key destination countries. Based on the broad literature review undertaking during this pilot study phase, it became apparent that Canada is not particularly unique among high-income countries in the extent to which it contributes to or draws upon migrant health labour or to which it is implicated in these ethical issues. The U.S., the U.K., and Australia share many features with Canada but also important differences. Comparative research recognising their distinct geographic, political and policy contexts would allow us to contrast migration policies across jurisdictions and contribute to efforts supporting a more effective, sustainable and equitable system of health care migration.

Thus, this study aims to critically examine from a comparative perspective:

- the various stakeholders involved in the migration of physicians, nurses, and midwives into and out of Canada, the U.S., the U.K., and Australia;
- the perspectives, positions, interrelations and influences of these various stakeholder groups on the framing of policy 'problems' pertaining to health care provider migration and on the overall policy process;
- the regulatory environments and broader policy contexts in Canada, the U.S., U.K. and Australia; and finally,
- the resultant policies in each of these four countries.

For each of the four countries, data will be collected through: 1) the acquisition of key public domain policy documents from the various provider/stakeholder groups; and 2) interviews to be

conducted with key informants involved in the policy decision-making process and key. These data will be analysed using the constant comparative technique of qualitative policy analysis.

Beyond our own research program, we have also been invited to participate in Health Canada's upcoming research forum entitled Setting a Research Agenda for Internationally Educated Health Care Professionals: Asking the Critical Questions which is to take place December 7, 2005 in Vancouver. As they stated in their invitation:

> The internationally educated health care provider presents several challenges to their respective regulatory bodies and associations. As highly educated immigrants they receive priority when applying to enter Canada. However, when they come to Canada, they have difficulty integrating into our health system. Integration not only includes language and cultural differences, but also a complex assessment process required to ensure the Canadian population that they have the same knowledge, skills and competencies as those already in practice. ... Federal, provincial and territorial governments have identified seven health professions (Medicine, Nursing, Pharmacy, Physiotherapy, Occupational Therapy, Medical Laboratory Technology and Medical Radiation Technology) which they believe should receive priority actions when planning for human resources in health. The International Medical Graduate Task-force identified issues that are common to all internationally educated professionals. It is Health Canada's desire to build on the work done responding to the recommendations of the IMG taskforce. Six of seven international medical graduate task force recommendations have been implemented, the seventh being a research agenda still has to be developed. Health Canada is seeking the participation of researchers from each of the seven identified health professions to develop critical research questions which address common issues. A second goal is to consider on-going or future research activity occurring in one profession, which might be transferable to one or more of the other professions. Our hope is to conclude the day having developed some critical questions, some partnerships among the researchers willing to develop the research questions and to identify the preliminary next steps including identifying specific funding sources.

Thus the funding for this research has been especially timely and will be built upon in future research endeavours.

Appendix 1

List of Relevant Websites:

National

Canadian Institute for Health Information
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_14dec2004_e
CIHI "Midwives"
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=process_download_form_e

Health Personnel Trends in Canada, 1993 to 2002

Citizenship and Immigration Canada
http://www.cic.gc.ca/english/skilled/qual-5.html

Human Resources and Skills Development Canada
http://www.hrsdc.gc.ca/en/cs/comm/hrsd/news/2004/040514.shtml

Federal-Provincial-Territorial Working Group on Access to Professions and Trades
http://www.cicic.ca/apt/apt.vol1.n1.en.asp
http://www.cicic.ca/apt/apt.vol1.n2.en.asp

Programs and Services for Immigrants
http://www.accc.ca/english/services/i-services/bt_programs.htm

The International Medical Graduate Implementation Steering Committee
http://testunix.mediaforce1.com/imgtaskforce/

Royal College of Physicians and Surgeons of Canada - International Postgraduate Medical Education
http://rcpsc.medical.org/residency/certification/img_e.php

Information for foreign-trained medical doctors
http://www.cicic.ca/professions/3112en.asp

Tips for Foreign Medical, Nursing, Healthcare and Biotechnology Professionals Looking for Work in the United States and Canada
http://www.pulsehr.com/Resources/Tips_For_Foreign_Healthcare_Professionals.htm

Canadian Nurses Association
http://cna-aiic.ca/CNA/news/releases/public_release_e.aspx?id=161
http://cna-aiic.ca/CNA/news/releases/public_release_e.aspx?id=140
http://cna-aiic.ca/cna/documents/pdf/publications/Brf_Std_Cttee_Finance_nov04_e.pdf
http://cna-aiic.ca/CNA/documents/pdf/publications/Citizenship_Immigration_e.pdf

CIHI "Nurses"

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=process_download_form_e
Health Personnel Trends in Canada, 1993 to 2002

Recruitment of Foreign Nurses
http://www.pulsehr.com/Foreign_Nurse_Recruitment.html

Information for foreign-trained registered nurses and psychiatric nurses
http://www.cicic.ca/professions/3152en.asp

Possibilities Project
http://www.possibilitiesproject.com/features/year5/sep2003/nursing_upd/nursing3.asp

Information for foreign-trained midwives
http://www.cicic.ca/professions/3232en.asp

Information for foreign-trained psychologists
http://www.cicic.ca/professions/4151en.asp

Mutual Recognition Act
http://www.cpa.ca/documents/MRA.pdf

Provincial

Ontario

Government of Ontario - Regulated Health Professions Act, 1991
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91r18_e.htm

The College of Physicians and Surgeons of Ontario
http://www.cpso.on.ca/Info_physicians/applicants/regist.htm
http://www.cpso.on.ca/Info_physicians/applicants/rpafactsh.htm

Association of International Physicians & Surgeons of Ontario (AIPSO)
www.cassa.on.ca/AIPSO

Ontario Network for Internationally Trained Professionals
http://www.onip.ca/

Ontario International Medical Graduate Clearinghouse
http://www.oimgc.utoronto.ca/

International Medical Graduates
http://www.health.gov.on.ca/english/providers/project/img/img_faq.html

College of Nurses of Ontario
http://www.cno.org/international_en/index.html

http://www.cno.org/reg/nonmemb/reg_exams.html

New registration requirements come into effect at the College of Nurses of Ontario
http://www.cno.org/new/releases/2005-01_NewRegReqs.htm

Internationally Trained Workers: Access to the nursing profession in Ontario
http://www.edu.gov.on.ca/eng/document/nr/02.03/nurse.html

Canadian Association of Midwives Ontario

http://members.rogers.com/canadianmidwives/province_ontario.html

Association of Ontario Midwives

http://www.aom.on.ca/About/Becoming_a_Midwife.aspx

Government of Ontario Opening Doors

http://www.edu.gov.on.ca/eng/general/postsec/openingdoors/apt/midwifery_fact.html

Ryerson University

http://ce-online.ryerson.ca/ce/program_sites/program_default.asp?id=2161

The College of Psychologists of Ontario
http://www.cpo.on.ca/

The Regulated Health Professions Act and the Psychology Act
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91p38_e.htm

Registration
http://www.cpo.on.ca/Registration/Psychologist/RegPsychologistMain.htm

Quebec

Immigration Quebec
http://www.immigration-quebec.gouv.qc.ca/anglais/immigration/permanent-worker/favored-training.html

Collège des médecins du Québec
http://www.cmq.org/asp/english.asp

Réglementation Loi Medicale
http://www.cmq.org/Pages/sections/college/reglemen/index.html

Canadian IMG DHCEU (Diplômé hors Canada et États-Unis) Canadian/International Medical Grads (Residents of the Province of Quebec)
http://www.med.mcgill.ca/postgrad/applicantinfo_mf_candianimg.htm

Ordre des infirmieres et infirmiers du Quebec (OIIQ)
http://www.oiiq.org/infirmieres/candidate/index.asp

For Nurses trained outside of Quebec
http://www.oiiq.org/infirmieres/diplomes/index.asp

Access to the Profession-Quebec
http://www.oiiq.org/uploads/publications/memoires/acces_profession.pdf
http://www.oiiq.org/infirmieres/diplomes/permis.asp
http://www.oiiq.org/infirmieres/diplomes/immigration.asp
http://www.oiiq.org/infirmieres/diplomes/examen_office.asp

Ordre Des Sages Femmes Du Quebec

http://www.osfq.org/ordre/index_loi.html

Canadian Association of Midwives-Quebec

http://members.rogers.com/canadianmidwives/province_quebec.html

Ordre des psychologues du Québec
http://www.ordrepsy.qc.ca/Eng/public/ordre/01_ordre.asp

Manitoba

Immigration and Multiculturalism Manitoba
http://www.gov.mb.ca/labour/immigrate/immigration/2.html

The College of Physicians and Surgeons of Manitoba
http://www.umanitoba.ca/colleges/cps/Registration/medreg.html
http://www.umanitoba.ca/colleges/cps/Registration/eicsinfo.pdf

Province of Manitoba - Medical Act
http://web2.gov.mb.ca/laws/statutes/ccsm/m090e.php

The Medical Licensure Program for International Medical Graduates (MLPIMG) will assist foreign trained physicians to obtain medical licensure to practise as primary care physicians in Manitoba.
http://www.gov.mb.ca/health/mlpimg/

Registered Nurses Act Manitoba
http://www.crnm.mb.ca/downloads/regnursesactregulweb.pdf

College of Registered Nurses of Manitoba
http://www.crnm.mb.ca/reg.php

Legislation: The *Midwifery Act*
http://www.canlii.org/mb/laws/sta/m-125/20041104/whole.html

Canadian Association of Midwives Manitoba
http://members.rogers.com/canadianmidwives/province_manitoba.html

College of Midwives of Manitoba
http://www.midwives.mb.ca/

The Psychological Association of Manitoba - Legislation: The Psychologist Registration Act.
http://www.cpmb.ca/documents/Psychologists%20Registration%20Act.pdf
Proposed by-laws
http://www.cpmb.ca/

Appendix 2

ON THE MOVEMENT OF HIGHLY SKILLED HEALTH PROFESSIONALS: A Comparative Examination of Canadian Policy regarding Health Labour Migration

Letter of Information

My name is Kim Matthews. I am a Ph.D. student working with Professor Ivy Lynn Bourgeault, a health studies researcher at McMaster University in Hamilton, Ontario. I am assisting her in conducting a study of migration of health care professionals into and out of Canada. Funding for this research comes from the Social Sciences and Humanities Research Council of Canada through their Initiative in the New Economy Skills Research Initiative. Dr. Bourgeault and I will be interviewing a variety of decision makers and health care providers and we would like to invite you to participate.

The interview will take approximately 30 minutes to one hour. The questions will largely be open-ended regarding your views and experiences with the migration of health care providers. Question areas will likely include the following:

- *a description of the role of your agency, institution or organization in this process;*
- *a description of the present state of affairs in terms of the migration of physicians, nurses, midwives or clinical psychologists;*
- *a description of the various policies that influence this situation;*
- *the identification and description of the position of various stakeholder groups; and*
- *identification of critical debates and disjunctures of policy.*

We would like to tape record the interview. The tapes will be transcribed word for word and then erased. No identifiers will be on the interview transcripts and they will be kept in a locked filing cabinet until the end of the study, at which time these will also be destroyed unless you give permission that they may be retained. Every effort will be made to maintain the confidentiality of the interview material. Unless you indicate otherwise, any material used in the publication resulting from this study will have identifying characteristics or statements omitted or paraphrased to help ensure confidentiality. Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time without consequence and the data you have provided will be destroyed if you so wish. There are no known risks to participating in this study.

This letter is yours to keep. If you have any questions about this study or your participation in it, please do not hesitate to contact Dr. Bourgeault at (905) 525-9140 ext. 23832 or email her at bourgea@mcmaster.ca. If you have any questions about the conduct of this study or your rights as a research subject you may contact the McMaster University Research Ethics Board at (905) 525-9140 ext. 23142 or srebsec@mcmaster.ca.

Thank you for your interest in this research.

Appendix 3

ON THE MOVEMENT OF HIGHLY SKILLED HEALTH PROFESSIONALS: A Comparative Examination of Canadian Policy regarding Health Labour Migration

Project Consent Form

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Please indicate (with your initials) your agreement or disagreement to each of the following requests and sign the form at the bottom. You will be provided with a copy of this form.

1. Do you agree to the taping of the interview?

YES _____ NO _____

2. Do you wish to remain anonymous in any publications or presentations of the results of the study?

YES _____ NO _____

3. May your transcript be retained after the completion of this study for the purposes of follow-up studies and comparative analyses by Dr. Bourgeault?

YES _____ NO _____

4. Do you wish to have a copy of the report emanating from this study?

YES _____ NO _____

Name of Participant (please print):
_____

Signature of Participant: _____

Date: _____

Interviewer's Initial: _____

Appendix 4

Key Informant Interview Guide
for
SSHRC INE Health Care Provider Migration Study

- Could you briefly describe the role and/or goals of your organization insofar as the migration of health care providers is concerned?

- Could you describe the present state of affairs in terms of the migration of
  - physicians
    - into Canada/province
      - how does policy differently address those internationally trained physicians who are already here and those being recruited?
      - which countries/programs are easily accepted and which are not and what are the reasons for the difference?
        - training equivalency?
        - language competency?
        - are there any plans to develop reciprocity agreements with these countries?
    - out of Canada/province
      - do you feel that the issue of physicians migrating from Canada/province is a critical issue
        - what do you feel are the major push factors?
        - what do you feel is or should be done to stem the tide of physicians leaving?
        - what do you think are the main reasons for coming back?
    - In terms of demographics (age, gender, etc.), who do you feel are the physicians most likely to immigrate to/emigrate from Canada?

  - nurses
    - into Canada/province
      - how does policy differently address those internationally trained nurses who are already here and those being recruited?
      - which countries/programs are easily accepted and which are not and what are the reasons for the difference?
        - training equivalency? e.g., diploma/degree
        - language competency?
        - are there any plans to develop reciprocity agreements with these countries?
    - out of Canada/province
      - do you feel that the issue of nurses migrating from Canada/province is a critical issue
        - what do you feel are the major push factors?

        - what do you feel is or should be done to stem the tide of nurses leaving?
        - what do you think are the main reasons for coming back?
    - In terms of demographics (age, gender, etc.), who do you feel are the nurses most likely to immigrate to/emigrate from Canada?

- midwives
    - into Canada/province
        - how does policy differently address those internationally trained midwives who are already here and those being recruited?
        - which countries/programs are easily accepted and which are not and what are the reasons for the difference?
            - training equivalency? e.g., degree
            - language competency?
            - are there any plans to develop reciprocity agreements with these countries?
    - out of Canada/province
        - do you feel that the issue of midwives migrating from Canada/province is a critical issue
            - what do you feel are the major push factors?
            - what do you feel is or should be done to stem the tide of midwives leaving?
            - what do you think are the main reasons for coming back?
    - In terms of demographics (age, gender, etc.), who do you feel are the midwives most likely to immigrate to/emigrate from Canada?

- clinical psychologists
    - into Canada/province
        - how does policy differently address those internationally trained clinical psychologists who are already here and those being recruited?
        - which countries/programs are easily accepted and which are not and what are the reasons for the difference?
            - training equivalency? e.g., doctorate
            - language competency?
            - are there any plans to develop reciprocity agreements with these countries?
    - out of Canada/province
        - do you feel that the issue of clinical psychologists migrating from Canada/province is a critical issue
            - what do you feel are the major push factors?
            - probe about lack of public funding
        - what do you feel is or should be done to stem the tide of clinical psychologists leaving?
            - what do you think are the main reasons for coming back?
    - In terms of demographics (age, gender, etc.), who do you feel are the clinical

psychologists most likely to immigrate to/emigrate from Canada?

- One commentator has noted that the migration of health care providers involves "[c]omplex and interdependent actors in multiple jurisdictions with unaligned accountabilities. Governments do one thing, educational institutions do another, and regulatory authorities do a third." As a result, we have no nationally coordinated policy for health labour immigration, and even less policy addressing the issue of health labour emigration.
    - Could you identify the key stakeholder groups and their positions in this regard and the reasons behind their positions?
    - Could you comment on where there are disjunctures of policy?
        - immigration and
        - emigration of health care providers
        - between immigration and health and provincial regulators

- Labour markets are becoming international in scope and labour mobility a requirement under international trade agreements.
    - how does this influence Canadian policy?
    - how do you think Canada compares with other jurisdictions?

- Could you comment on the ethical issues involved in both the emigration and immigration of health care providers
    - Do our policies distinguish between active recruitment and tapping into an existing resource
        - 2003 Commonwealth Code of Ethics
    - Should source countries be paid compensation for losing health care providers (to replace the costs of training)?
        - Canada did not sign on to this

Endnotes

[1] Fooks, C. (2003). Moving Towards National Resource Planning in Canada: Still Looking for a Home, CPRN/RCRPP.

[2] Bach, S. (2003). International migration of health workers: labour and social issues. International Labour Office Working Paper, Geneva.

[3] Hickey, J. P. (1995). "Why don't I send you and your wife two plane tickets....?" CMAJ **152**(11): 1865-1866.

[4] Williams, L. S. (1997). "The Road to Wisconsin." CMAJ **156**(6): 860-863.

[5] C.I.H.I. (2001). Canada's Health Care Providers http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E

[6] CIHI (2000). The Supply and Distribution of Registered Nurses in Canada.

[7] Fooks, C. (2003). Moving Towards National Resource Planning in Canada: Still Looking for a Home, CPRN/RCRPP: 7.

[8] Hickey, J. P. (1995). "Why don't I send you and your wife two plane tickets....?" CMAJ **152**(11): 1865-1866.

[9] Ryten, E., et al. (1998). "The Class of 1989 and physician supply in Canada." CMAJ **158**(6): 723-8.

[10] Williams, L. S. (1997). "The Road to Wisconsin." CMAJ **156**(6): 860-863.

[11] Barer, M. and G. Stoddard. (1991). Toward integrated medical resource policies for Canada. Report of the Conf. of Dep. Ministers of Health, Department of Ministers of Health.

[12] McKendry, R. et al. (1996). "Factors influencing the emigration of physicians from Canada to the United States." CMAJ **154**(2): 171-181.

[13] Wharry, S. (2002). "Pressure mounting to curb MD poaching by rich nations." CMAJ **166**(13): 1707.

[14] Registered Nurses Assn. of Ont. (2001). "Earning Their Return - When & Why Ontario RN's Left Canada, and What Will Bring Then Back."

[15] Joyce, R. E. and C. L. Hunt. (1982). "Philippine nurses and the brain drain." Social Science and Medicine **16**(12): 1223-1233.

[16] C.I.H.I. (2001). Canada's Health Care Providers http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E

[17] Barer, M. and G. Stoddard. (1991). Toward integrated medical resource policies for Canada. Report of the Conf. of Dep. Ministers of Health, Department of Ministers of Health.

[18] C.I.H.I. (2001). Canada's Health Care Providers http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E

[19] OMA Human Resources Committee (OHRC). (2002). "Position Paper on Physician Workforce Policy and Planning."

[20] Barer, M. and G. Stoddard. (1991). Toward integrated medical resource policies for Canada. Report of the Conf. of Dep. Ministers of Health, Department of Ministers of Health.

[21] Canadian Medical Association (2001). CMA Masterfile.

[22] Canadian Institute for Health Information. (2003). Supply, Distribution and Migration of Canadian Physicians, 2002. Ottawa, ON.

[23] Ibid.

[24] Grant, Hugh (2004). From the Transvaal to the Prairies: The Migration of South Africa Physicians to Canada. Prairie Centre of Excellence for Research on Immigration and Integration. Working Paper 02-04.

[25] Canadian Medical Association- November 22, 1999, Canadian Medical Forum Task Force on Physician Supply, http://www.cma.ca/index.cfm/ci_id/19522/la_id/1.htm

[26] Canadian Medical Association (2001). CMA Masterfile.

[27] Grant, Hugh (2004). From the Transvaal to the Prairies: The Migration of South Africa Physicians to Canada. Prairie Centre of Excellence for Research on Immigration and Integration. Working Paper 02-04.

[28] Barer, Morris L., & Webber, William A. (1999). Immigration and Emigration of physicians to/from Canada. Centre for Health Services and Policy Research UBC.

[29] Barer, Morris L., & Webber, William A. (1999). Immigration and Emigration of physicians to/from Canada. Centre for Health Services and Policy Research UBC.

[30] C.I.H.I. (2001). Canada's Health Care Providers http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E

[31] Barer, Morris L., & Webber, William A. (1999). Immigration and Emigration of physicians to/from Canada. Centre for Health Services and Policy Research UBC.

[32] Hawley, G. (2004). Canada's Health Care Workers: A Snapshot. Health Policy Research, Issue 8, May.

[33] Mason, J. (1988). Midwifery in Canada. The Midwife Challenge. S. Kitzinger. London, Pandora**:** 99-133.

[34] Bourgeault, I.L., & Benoit, C. (2004) Reconceiving Midwifery in Canada. In I. Bourgeault, C. Benoit, & R. Davis-Floyd (Eds.), Reconceiving Midwifery. Kingston/Montreal : McGill Queen's University Press.

[35] C.I.H.I. (2000). *Supply and Distribution of Registered Nurses in Canada, 1999.*

[36] Little, L. (2005). The Canadian Case. Presentation to Bellagio Institute Conference on the International Migration of Nurses. July.

[37] Joyce, R. E. and. C. L. Hunt. (1982). "Philippine nurses and the brain drain." *Social Science and Medicine* **16**(12): 1223-1233.

[38] C.I.H.I. (2004). *Supply and Distribution of Registered Nurses in Canada, 2003.*

[39] Our key informants outlined a special agreement/permit allocated to nurses from France. This facilitates their entry to Quebec and to the profession.

[40] C.I.H.I. (2004). *Supply and Distribution of Registered Nurses in Canada, 2003.*

[41] Calliste, A. (1996). "Antiracism Organizing and Resistance in Nursing: African Canadian Women." The *Canadian Review of Sociology and Anthropology* **33**(3): 361-390.

[42] Institute for Research on Public Policy (2005). NEWS RELEASE: Study Reveals Low Returns on Immigrants' Foreign Education and Experience. 8 February 2005. www.irpp.org

[43] Martin, W. (2004). *Canadian Midwifery Regulators Consortium's Research Plan for a National Midwifery Assessment Strategy*. March, College of Midwives of B.C.

[44] Brouwer, A. (1999) Immigrants Need Not Apply. The Maytree Foundation. October.

[45] According to the Report of the Canadian Task Force on the Licensure of IMGs (Feb. 2004): In June, 2002, Canada replaced the Immigration Act of 1976 with the new Immigration and Refugee Protection Act. The new legislation concentrates on skills, training and potential for successful integration into the Canadian workforce and society. It is intended to be adaptable and responsive, and to choose workers with flexible, transferable skill sets rather than specific occupational backgrounds. The Act also provides for the creation of a new landing class for certain temporary workers, including international graduates of Canadian schools with Canadian work experience who meet the selection criteria as skilled workers. The legislation has the potential to ease IMG entry into Canada, and lead to increased numbers of IMGs seeking to establish medical practice in Canada, promoting self-identification as medical professionals during the immigration process, and seeking professional integration upon arrival."

[46] Brouwer, A. (1999) Immigrants Need Not Apply. The Maytree Foundation. October.

[47] Milne, Celia (2003). In a Foreign Land, *The Medical Post*- Volume 39, Issue 15, April 15.

[48] Canadian Resident Matching Service (CaRMS). http://www.carms.ca/jsp/main.jsp

[49] Source: http://www.carms.ca/jsp/main.jsp

[50] The Collège des Médecins du Québec (CMQ) also administers certification exams in Family Medicine and other Specialties (such as Hematology & Microbiology and Infectious Diseases, which are accepted in Québec, New Brunswick, and in certain circumstances, in other provinces/territories. (source: http://www.img-canada.ca/en/licensure_overview/licensure.html). Further, to obtain recognition of equivalence of postdoctoral training, IMGs must also serve a minimum of 12 months in a postdoctoral training program in a faculty of medicine in Québec.

[51] Canadian Information Centre for International Medical Graduates. http://www.img-canada.ca/en

[52] Milne, Celia (2003). In a Foreign Land, *The Medical Post*- Volume 39, Issue 15, April 15.

[53] Canadian Information Centre for International Medical Graduates. http://www.img-canada.ca/en

[54] Canadian Medical Association- November 22, 1999, Canadian Medical Forum Task Force on Physician Supply, http://www.cma.ca/index.cfm/ci_id/19522/la_id/1.htm

[55] Canadian Information Centre for International Credentials. Information for foreign-trained medical doctors. http://www.cicic.ca/professions/3112en.asp

[56] Canadian Information Centre for International Credentials. Information for foreign-trained nurses. http://www.cicic.ca/professions/3152en.asp

[57] OIIQ (2004). *Les infirmières formées à l'étranger et l'accèss à la profession au Québec*. November

[58] Canadian Information Centre for International Credentials. Information for foreign-trained nurses. http://www.cicic.ca/professions/3152en.asp

[59] http://www.healthmatchbc.org/hmbc_nurses.asp?pageid=630

[60] According to the website of the OPQ, "in October 2000, the Order submitted a request to the Office des professions du Québec that the diploma giving access to the permit of the Ordre des psychologues du Québec be changed from a master's degree to a doctor's degree. Although the Office recently launched a consultation on this subject with various organizations concerned, it is currently impossible to say when the Order's admission requirements will be changed."
http://www.ordrepsy.qc.ca/Eng/public/inscription/05_inscription.asp

[61] *Mutual Recognition Agreement of the Regulatory Bodies for Professional Psychologists in Canada* (2001). June.

[62] College of Psychologists of Ontario. Section E: Academic Credential.
http://www.cpo.on.ca/Registration/Psychologist/RegPsychologistMain.htm

[63] OACCPP (1997). Access to Trades & Professions: Breakthroughs. Excerpts from Issue No. 3 (May 1997) http://www.skillsforchange.org/access/breakthroughs/issue_3.htm

[64] The Psychological Association of Manitoba. *Guidelines for Applicants for Registration*. http://www.cpmb.ca/documents/GUIDELINES%20FOR%20APPLICANTS%20for%20REGISTRATION

[65] Martin, W. (2004). *Canadian Midwifery Regulators Consortium's Research Plan for a National Midwifery Assessment Strategy*. March, College of Midwives of B.C.

[66] *ACCESS!* - the report of the Task Force on Access to Professions and Trades in Ontario (1990), *Immigrants Need Not Apply* (1999), *Initiatives Affecting the Labour Market Integration of Foreign-Trained Professionals and Trades Workers* (2000), *Fulfilling the Promise* (2002), *Roundtable Proceedings: Improving Access to the Professions and Trades through Prior Learning Assessment & Qualifications Recognition for Immigrants in BC* (2002), and others

[67] Yelaja, Prithi (2000). Rejected in Canada, Doctors Head South. Toronto Star-December 30, 2000.

[68] Immen, Wallace (2004) Canada urged to integrate foreign-trained MDs. The Globe and Mail- February 18, 2004.

[69] CBC News Online | September 14, 2004. Attracting skilled immigrants: The struggle to lure trained foreign workers. http://www.cbc.ca/news/background/immigration/skilledimmigrants.html

[70] AIPSO (2000). Barriers to Licensing in Ontario *for* International Physicians Report.
http://www.promptinfo.ca/AIPSOBarriers2%20Jun%2000.pdf

[71] AIPSO (2000). Barriers to Licensing in Ontario *for* International Physicians Report.
http://www.promptinfo.ca/AIPSOBarriers2%20Jun%2000.pdf

[72] Harding, Katherine (2003). 'Nursing is different here' Innovative programs help newcomers overcome the massive hurdles of Canadian practices and jargon. Wednesday, January 8, 2003.
http://globeandmail.workopolis.com/servlet/Content/fasttrack/20030108/CANURS?gateway=work

[73] http://www.netwercc.com/docs/temp/Powerpoint/INTERNATIONALLYEDUCATEDNURSESJune1_files/frame.htm

[74] Nestel, S. (1996/7). "Ontario Midwifery and the Politics of Race." *Health and Canadian Society* **4**(2): 315-341.

[75] Brouwer, A. (1999) Immigrants Need Not Apply. The Maytree Foundation. October.

[76] AIPSO (2000). Barriers to Licensing in Ontario *for* International Physicians Report. http://www.promptinfo.ca/AIPSOBarriers2%20Jun%2000.pdf

[77] From *Access to Ontario's Regulated Professions by International Candidates Research Report and Compendium* (2003) as cited in Martin, W. (2004). *Canadian Midwifery Regulators Consortium's Research Plan for a National Midwifery Assessment Strategy*. March, College of Midwives of B.C. (p. 11)

[78] https://www.mcc.ca/SelfAssessment/english/Introduction.html

[79] Eggertson, Laura (2005). News @ a glance International MDs. *Canadian Medical Association Journal* May 24, 2005; 172 (11)

[80] Eggertson, Laura (2005). News @ a glance International MDs. *Canadian Medical Association Journal* May 24, 2005; 172 (11)

[81] Canadian Press. Foreign-trained doctors, nurses get boost Tue. Apr. 26 2005 http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1114519023042_12/?hub=Health

[82] Canadian Press. Foreign-trained doctors, nurses get boost Tue. Apr. 26 2005 http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1114519023042_12/?hub=Health

[83] http://ceris.metropolis.net/Virtual%20Library/other/goldberg2/goldberg2.html

[84] http://www.regulators4access.ca/

[85] Secretariat, Council of Ontario Universities (2005). OPAS receives funding to help foreign-trained professionals upgrade skills COUNCIL HIGHLIGHTS February 2005 Issue

[86] http://www.health.gov.on.ca/english/providers/project/img/img_faq.html

[87] Canadian Press. Foreign-trained doctors, nurses get boost Tue. Apr. 26 2005 http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1114519023042_12/?hub=Health

[88] http://www.health.gov.on.ca/english/providers/project/img/img_faq.html

[89] http://www.health.gov.on.ca/english/providers/project/img/serv_agreem.html

[90] Creating Access to Regulated Employment (CARE) for Nurses Project. http://www.edu.gov.on.ca/eng/general/postsec/openingdoors/apt/care.html

[91] Government of Ontario, News Release. April 29, 2003 Ernie Eves government helps internationally trained nurses practise in Ontari. http://www.edu.gov.on.ca/eng/document/nr/03.04/nr0429.html

[92] http://www.possibilitiesproject.com/features/year5/sep2003/nursing_upd/nursing3.asp

[93] Martin, W. (2004). *Canadian Midwifery Regulators Consortium's Research Plan for a National Midwifery Assessment Strategy*. March, College of Midwives of B.C. (p. 14)

[94] http://ce-online.ryerson.ca/ce/program_sites/program_default.asp?id=2161

[95] International Midwives Pre-Registration Program (Access to Midwifery Pre-Registration Program). http://www.edu.gov.on.ca/eng/general/postsec/openingdoors/apt/midwifery_fact.html

[96] Federal-Provincial-Territorial Working Group on Access to Professions and Trades. (2001). NEWS FROM MANITOBA. APT UPDATE - Vol. 1, No. 2 - March, 2001. http://www.cicic.ca/apt/apt.vol1.n2.en.asp

[97] Federal-Provincial-Territorial Working Group on Access to Professions and Trades. (2001). NEWS FROM MANITOBA. APT UPDATE - Vol. 1, No. 2 - March, 2001. http://www.cicic.ca/apt/apt.vol1.n2.en.asp

[98] Manitoba Labour and Immigration (2004). *Summary of Activities Related to Qualifications Recognition of Highly Skilled Immigrants*, November. p. 6.

[99] Manitoba Labour and Immigration (2004). *Summary of Activities Related to Qualifications Recognition of Highly Skilled Immigrants*, November. p. 6.

[100] Milne, Celia (2003). In a Foreign Land. *The Medical Post* Volume 39, Issue 15, April 15, 2003.

[101] Government of Manitoba. Medical Licensure Program for International Medical Graduates. http://www.gov.mb.ca/health/mlpimg/

[102] Government of Manitoba. Medical Licensure Program for International Medical Graduates. http://www.gov.mb.ca/health/mlpimg/

[103] Canadian Information Centre for International Medical Graduates. *IMG Routes to Licensure in Manitoba*. http://www.img-canada.ca/en/provinces/manitoba/img-training-programs.html

[104] Manitoba announces recruitment changes for foreign-trained doctors, *Canadian Health Reference Guide*- February 6, 2003.

[105] Manitoba announces recruitment changes for foreign-trained doctors, *Canadian Health Reference Guide*- February 6, 2003.

[106] Federal-Provincial-Territorial Working Group on Access to Professions and Trades. (2001). NEWS FROM MANITOBA. APT UPDATE - Vol. 1, No. 2 - March, 2001. http://www.cicic.ca/apt/apt.vol1.n2.en.asp

[107] Groupe de travail sur l'accès aux professions et métiers réglementés (Task Force on Access to Regulated Trades and Professions) (2005). *Summary of Recommendations.* February.

[108] http://www.micc.gouv.qc.ca/publications/pdf/PlanAction20042007_summary.pdf

[109] Canadian Medical Association Physician Workforce: Executive Summary

[110] Barer, M. and G. Stoddard. (1991). Toward integrated medical resource policies for Canada. Report of the Conf. of Dep. Ministers of Health, Department of Ministers of Health.

[111] Grant, Hugh (2004). From the Transvaal to the Prairies: The Migration of South Africa Physicians to Canada. Prairie Centre of Excellence for Research on Immigration and Integration. Working Paper 02-04.

[112] Canadian Medical Association Physician Workforce: Executive Summary

[113] Canadian Institute for Health Information (2002). *Supply and Distribution of Registered Nurses in Rural and Small Town Canada, 2000*. Ottawa: Written by Roger Pitblado, Jennifer Medves, Martha MacLeod, Norma Stewart and Judith Kulig as part of the Nursing Practice in Rural and Remote Canada Study. Excerpted from: http://cranhr.laurentian.ca/faq14.html

[114] WHO (2003). *Strengthening nursing and midwifery*, report by the Secretariat, 56th World Health Assembly, Geneva.

[115] Sullivan, Patrick (2005). CMA challenges IMG "facts" before Commons committee *Canadian Medical Association Journal* March 11, 2005.

[116] Martineau, T., K. Decker, et al. (2002). Briefing note on international migration of health professionals: levelling the playing field for developing country health systems. Liverpool, Liverpool School of Tropical Medicine. P. 10

[117] Sullivan, Patrick (2005). CMA challenges IMG "facts" before Commons committee *Canadian Medical Association Journal* March 11, 2005.

[118] Sullivan, P. (2005). CMA's concern over HR issues growing, annual meeting proves. http://www.cma.ca/index.cfm?ci_id=10028212&la_id=1&topstory=1

[119] Little, L. (2005). The Canadian Case. Presentation to Bellagio Institute Conference on the International Migration of Nurses. July.

[120] Martin, W. (2004). *Canadian Midwifery Regulators Consortium's Research Plan for a National Midwifery Assessment Strategy*. March, College of Midwives of B.C.

[121] Sullivan, Patrick (2005). CMA challenges IMG "facts" before Commons committee *Canadian Medical Association Journal* March 11, 2005.

[122] Cesa, Frank (2004). International Medical Graduates: A Case Study. *Health Policy Research*- Issue 8, May 2004.

[123] According to a CMAJ (2002, 166(2); 232) article, "Salesman succeeds in bringing MD recruits to BC.", "Maurice Leblanc has already brought pharmacists to British Columbia from his native South Africa, and now he's doing the same thing with physicians. LeBlanc, who has lived in Mackenzie, a town of 6000 in northern BC, for a decade, traveled to South Africa in 1999 to find pharmacists for his business. When 4 of the town's 5 family doctors left the town last winter, the former salesman approached Dr. Jennifer Rice, medical director of the Northern Interior Regional Health Board in Prince George, and offered to travel to South Africa to recruit FPs. He asked for $3000 to help defray his travel expenses; Rice, who was used to paying recruitment companies $7500 for each doctor they recruited readily agreed. ... He did his homework carefully, building up a list of contacts and pinpointing the cities where he was most likely to find potential recruits. During the three weeks he met with 72 doctors and returned to Canada with 20 resumes of well-qualified candidates. Rice was "absolutely thrilled". Six of the doctors are currently going through official procedures to immigrate and will be coming to the region, and Rice is directing the others elsewhere.

[124] Cesa, Frank (2004). International Medical Graduates: A Case Study. *Health Policy Research*- Issue 8, May 2004.

[125] Silas, L. (2004). *Slow the exit Speed the entry*. Pre-budget Submission, Standing Committee on Finance, Hon. Massimo Pacetti, MP, Chair House of Commons, Ottawa, Ontario, November 2004.

[126] Dauphinee, W. Dale (2005). Physician Migration to and from Canada: The Challenge of Finding the Ethical and Political Balance Between the Individual's Right to Mobility and Recruitment to Underserved Communities. *Journal of Continuing Education in the Health Professions* 25(1):22-29.

[127] Bueckert, Dennis. Doctor's exodus stirs shortage fear *The Vancouver Sun* May 11, 1995.

[128] Chamberlain, Art. New doctors fleeing south, U of T prof says Medical brain drain blamed on lack of respect. *The Toronto Star* September 24, 1997.

[129] Ryten, E. et al. (1998). "The Class of 1989 and physician supply in Canada." CMAJ **158**(6): 723.-9. Ryten, E. et al. (1998). "The Class of 1989 and physician supply in Canada." CMAJ **158**(6): 723-8.

[130] Ma P.C. et al. (1997). "Intention to relocate to the United States." Canadian Family Physician. **43**:1533-9.

[131] Ryten, E. et al. (1998). "The Class of 1989 and physician supply in Canada." CMAJ **158**(6): 723.

[132] Canadian Institute for Health Information. (2003). Supply, Distribution and Migration of Canadian Physicians, 2002.

[133] McKendry, R. et al. (1996). "Factors influencing the emigration of physicians from Canada to the United States." CMAJ **154**(2): 171-181.

[134] C.I.H.I. (2001). Canada's Health Care Providers. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E.

[135] McKendry, R. et al. (1996). "Factors influencing the emigration of physicians from Canada to the United States." CMAJ **154**(2): 171-181.

[136] C.I.H.I. (2005). Supply, Distribution and Migration of Canadian Physicians, 2004.

[137] CMA disputes report number of doctors rising. *The National Post*- August 10, 2001.

[138] It is also interesting to note that 75% of duplicate registrations are found in Ontario.

[139] Buchan, J. , Parkin, T., & Sochalski, J. (2003). International Nurse Mobility: Trends and Policy Implications.

[140] Secondary registrations identify RNs that are living outside of Canada or RNs employed (or living) in a Canadian jurisdiction different from the province/territory of registration.

[141] Little, L. (2005). The Canadian Case. Presentation to Bellagio Institute Conference on the International Migration of Nurses. July.

[142] Loefler, I. J. (2001). "Medical Migration." *Croatian Medical Journal* **42**(5): 504-505.

[143] McKendry, R. et al. (1996). "Factors influencing the emigration of physicians from Canada to the United States." *CMAJ* **154**(2): 171-181.

[144] Joyce, R. E. and C. L. Hunt. (1982). "Philippine nurses and the brain drain." *Social Science and Medicine* **16**(12): 1223-1233.

[145] C.I.H.I. (2001). *Canada's Health Care Providers*. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E.

[146] Bilodeau, H., et al. (2001). "Qu'en est-il de l'emigration des medicins quebecois?" Cahiers de Soc. et de Demograph. Med. **41**(2): 239-261.

[147] Webb, R. J. (1997). "Shades of greener grass." Canadian Family Physician **43**: 1483-1485.

[148] Kasperski, J. (2000). "Too Many Hours, Too Much Stress, Too Little Respect" Ontario College of Family Physicians- July 19, 2000.

[149] Harper, T. (1998) Ottawa blamed for doctor exodus- Cutbacks trigger a brain drain, CMA charges *The Toronto Star*- June 10, 1998.

[150] Gray, Charlotte (1999). How bad is the brain drain? *CMAJ* October 19, 1999; 161 (8), 1028-9.

[151] Hugh Grant & R. Oertel (1997) The Supply and Migration of Canadian Physicians, 1970-1995: Why We Should Learn to Love an Immigrant Doctor. *Canadian Journal of Regional Science*: Spring/Summer 1997.

[152] Gray, Charlotte (1999). How bad is the brain drain? *CMAJ* October 19, 1999; 161 (8), 1028-9.

[153] Gray, Charlotte (1999). How bad is the brain drain? *CMAJ* October 19, 1999; 161 (8), 1028-9.

[154] Sibbald Barbara (2002). The nursing crisis: "Physicians should ponder what this will mean" CMAJ, September 3, 2002; 167 (5) http://www.cmaj.ca/cgi/content/full/167/5/535

[155] Registered Nurses Assn. of Ontario (2001). "Earning Their Return - When & Why Ontario RN's Left Canada, and What Will Bring Then Back."

[156] Sibbald Barbara (2002). The nursing crisis: "Physicians should ponder what this will mean" CMAJ, September 3, 2002; 167 (5) http://www.cmaj.ca/cgi/content/full/167/5/535

[157] Buchan, J., Parkin, T., & Sochalski, J. (2003). *International Nurse Mobility: Trends and Policy Implications*: WHORCNICN.

[158] Orzack, L. (1998). Professions and World Trade Diplomacy: National Systems and International Authority. In Olgiati et al Professions, Identity, and Order in Comparative Perspective. Onati: Institute for International Study of the Sociology of Law.

[159] Bach, S. (2003). International Migration of Health Workers: Labour and Social Issues. Paper prepared for the Sectoral Activities Department, International Labour Office, July 2003.

[160] http://www.pulsehr.com/Resources/Tips_For_Foreign_Healthcare_Professionals.htm#Canadian%20Nurses:%20Going%20to%20the%20United%20States

[161] Aiken, L. H. et al. (2004). "Trends in International Nurse Migration." Health Affairs **23**(3): 69-77.

[162] Bach, S. (2003). International Migration of Health Workers: Labour and Social Issues. Paper prepared for the Sectoral Activities Department, International Labour Office, July 2003.

[163] Orzack, L. (1998). Professions and World Trade Diplomacy: National Systems and International Authority. In Olgiati et al Professions, Identity, and Order in Comparative Perspective. Onati: Institute for International Study of the Sociology of Law.

[164] Webb, R. J. (1997). "Shades of greener grass." *Canadian Family Physician* **43**: 1489.

[165] Gray, Charlotte (1999). How bad is the brain drain? *CMAJ* October 19, 1999; 161 (8), 1028-9.

[166] The College of Physicians and Surgeons of Ontario. Registration Process. http://www.cpso.on.ca/Info_physicians/applicants/regist.htm

[167] http://www.gov.mb.ca/health/nurses/annualreport.html

[168] Buchan, J., & Sochalski, J. (2004). The migration of nurses: trends and policies. *Bulletin of the World Health Organization, 82*(8), 587-594.