BRAIN DRAIN, BRAIN GAIN AND BRAIN WASTE

Programs Aimed at Integrating and Retaining the Best and the Brightest in Health Care

ABSTRACT

This article looks at recent efforts to better coordinate and integrate health care providers trained abroad. The findings are based on a pilot study of physicians, nurses, midwives and psychologists who have immigrated into Canada. The article traces some of the demographic and policy contexts related to health labour migration.

Although it was common to lament the health care "brain drain" from Canada throughout the 1990s (Hickey 1995, Williams 1997), it is important to note that we are by far a greater importer than exporter of health labour. Indeed, Canada has relied heavily on internationally trained providers in part to help solve shortages in rural and remote under-serviced areas and in urban subspecialties (Barer and Stoddard 1991, CIHI 2001, OHRC 2002). At the same time, we hear of numerous accounts of internationally trained providers not being able to practice their profession. One of the staples of recent Canadian news writing has become the story of highly educated professionals driving taxis or performing other type of deskilled labour. The deskilling of immigrants is also a recurring trend in the scholarly and policy literatures. This contradicts immigration policies that strive to seek the "best and the brightest."

Where does this disconnect arise? One commentator has argued that 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," (Fooks 2003). As a result, we have had no nationally coordinated policy for health labour immigration. Efforts have been recently made to address these issues. New specifically targeted efforts have highlighted the importance of the associated problems of lost labour and potential solutions to the current or projected shortages of several kinds of health care providers.

In this article, I discuss some of the recent efforts undertaken to better coordinate and integrate health care providers who have been trained abroad.[1] The cases I present are based on a pilot study of the migration of physicians, nurses, midwives and psychologists into Canada. The purpose of this pilot study was to: 1) examine the demographic and policy contexts surrounding the migration of physicians, nurses, and midwives; 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 involved examining, the flow of physicians, nurses, and midwives into and out of Canada through available datasets and published documents, then linking these flows to the policies of professional regulatory bodies and government departments (e.g., immigration, health, human resources) at the national and provincial or state level through the analysis of relevant policy documents and key informant interviews.

Health care professionals on the move

Health care workers have long been nationally and internationally mobile, yet there has been relatively little comparative analysis of policy's influence on their migration patterns nor of policy responses to their movement. An examination of the process and impact of current health care provider migration policy is of critical importance because labour markets are becoming international in scope and because labour mobility under international trade agreements is often a requirement (Fooks 2003). This has increased both the speed and extensiveness of migration. 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 (Bach 2003).

Clearly, the flow of providers into (as well as out of) Canada is intricately linked to key policy decisions that have been made both historically and most recently (Barer and Stoddard 1991, CIHI 2001, OHRC 2002). In the case of medicine, throughout most of the 1970s, roughly one-third of our

IVY LYNN BOURGEAULT

Ivy Lynn Bourgeault is an Associate Professor of Sociology and Health Studies at McMaster University. She is also the Canada Research Chair in Comparative Health Labour Policy.

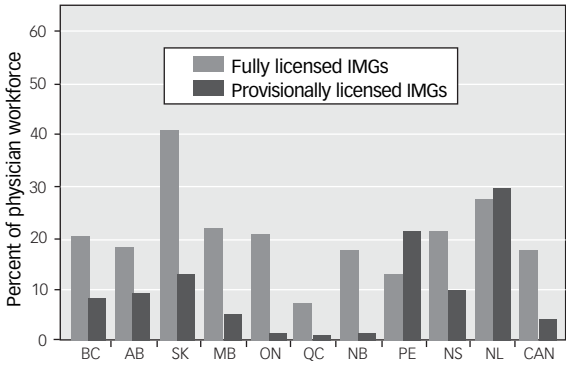
physicians were international medical graduates (IMGs) but this has most recently dropped to 23%; this downward trend may reflect limits on the number of post-graduate training spaces available as well as other factors (CIHI 2003). More recently, according to the Canadian Medical Association (2001), the number of IMGs recruited has increased quite dramatically from 388 in 1993 to 790 in 1997 (CMA 2001). A recent list of recommendations from the College of Physicians and Surgeons of Ontario (2004) to deal with the shortages of physicians in that province specifically calls for "expanding the number of assessment and training positions for international medical graduates."

In terms of the source of immigrant physicians, the majority had graduated from medical schools in the United Kingdom or Ireland. In 1985, 35% of immigrant physicians were graduates of medical schools in the UK or Ireland, which had fallen to just over 5% by 2000. Now the primary source of IMGs who make it into the system is South Africa; South African-trained IMGs accounted for 24% of those who entered in 2000, up from 9% in 1985 (CIHI 2001).

IMGs usually have to complete an extensive licensing procedure before being able to practice medicine in Canada; this includes passing several standardized exams and often two to six more years of postgraduate medical training, to which they have limited access (CIHI 2001). Exceptions are 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 IMGs to meet the needs of under-serviced areas, sometimes through temporary licenses (see Figure 1). As a long-term policy solution to the shortages of physicians in particular areas, however, the use of IMGs has been questioned. There is some evidence showing that immigrant health care providers usually do not remain in rural areas without some form of coercive intervention (such as through return of service agreements), and often "leak" into the overall geographically unrestricted Canadian physician supply (Barer and Stoddard 1991).

Though we know a fair bit about immigrant physicians, less is known about the immigration of other health care providers in Canada. We do know that in the 1950s and 1960s, many nurses from Britain, particularly those with advanced training in midwifery, were recruited by Health Canada to serve in northern outposts (Mason 1988). Both tighter immigration policies and a change in Health and Welfare Canada policy in the late 1970s and early 1980s required that all pregnant women residing in isolated and under-populated northern areas of Canada travel to urban hospitals located in the south to deliver their babies. This led to an overall reduction in the number of immigrant nurse-midwives practising in remote areas of Canada (Bourgeault et Benoit 2004). Unfortunately, unlike the case for medicine, we do not have readily available demographic data to describe these trends.

Figure 1: Temporary and permanent medical licenses by province[2]



More recently, the overall percentage of internationally educated nurses (IENs) has remained relatively steady over the last five to ten years. Specifically, in 2003, 7.3% of all nurses working in Canada were internationally trained, up from 6.8% in 1999 (CIHI 2000). There has, however, been a slight increase in the recruitment of foreign-trained nurses in some provinces and territories – notably in British Columbia, Ontario, Saskatchewan and the Northwest Territories – in the face of impending shortages.

Nurses from the Philippines have been one of the primary sources of immigrant nursing labour in Canada as it is elsewhere,[3] but nurses from the UK represent an equal proportion (26%) (Joyce and Hunt 1982, Little 2005), with nurses from the United States (7%) and Hong Kong (6%) representing smaller groups. Demographically, foreign-trained nurses in the current workforce are, on average, more than five years older than Canadian-trained nurses (49.4 years to 44.1 years) (CIHI 2004). We also know that immigrant nurses, particularly those of colour, occupy the lowest echelons of the profession (Calliste 1996).

Although initially the migration of midwives was bound up with the migration of nurses, 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 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. Midwifery is interesting to examine because of its newness, its strong linkages to foreign training, and its internationally unique entry to practice requirements (a baccalaureate, while in most countries, midwives are trained in vocational institutions or at a level equivalent of community college). Preliminary research suggests that this credential may increase the burden on internationally trained midwives (ITMs) who are not university-trained (Nestel 1996/97).

Policy efforts

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 number of layers of organizations involved in the integration process and the lack of communication between stakeholders. In response to these concerns, some of the key partnerships that have emerged in the new programs to reduce barriers have been between these various organizations, including government and professional bodies at the national and provincial levels. These efforts have prioritized foreign credential recognition by moving towards a system of "one-stop" information sources as well as towards the centralization or national coordination of integration processes.

Foreign credential recognition as a priority

The Advisory Committee on Health Delivery and Human Resources (ACHDHR) is a federal/provincial/territorial committee that reports to the Conference of Deputy Ministers of Health. One of the initiatives undertaken by the ACHDHR 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 2002 to address the integration of IMGs into the Canadian health care system. The goal of the Canadian Task Force on Licensure of International Medical Graduates was to "develop strategies to aid in the integration of qualified internationally trained physicians to the Canadian physician workforce" (ACHDHR 2004, 6). Some of its key recommendations were to increase the capacity to assess and prepare IMGs for licensure, and to work toward the standardization of licensure requirements. These and other recommendations are in the process of being addressed largely through the recently announced funds to Health Canada (discussed below). 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.

Canada has relied heavily on internationally trained providers in part to help solve shortages in rural and remote under-serviced areas and in urban subspecialties.

The Foreign Credential Recognition (FCR) program was established in 2003 within the federal department of Human Resources and Social Development Canada (HRSDC) as one of the key components of the Government's 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). In concert with the efforts of the ACHDHR and the FCR program, a series of programs and projects were announced in 2004 and 2005 by federal government agencies including HRSDC, Citizenship and Immigration Canada (CIC) and Health Canada to address international medical graduates, internationally educated nurses and, to a lesser extent, internationally trained midwives.

Medicine

In March 2004, HRSDC announced it would provide $341,050 in funding to the Medical Council of Canada (MCC) 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."

Effective integration of IMGs has remained high on the policy agenda with the announcement of a $75 million plan by Health Canada and CIC just one year later, to be implemented over five years. The goal is to integrate up to 1,000 physicians, 800 nurses and 500 other health care professionals into the Canadian workforce. One of the programs – again run by the MCC – was a National Credential Verification Agency, which would "create both a one-stop process to assess credentials and a national registry of graduates." (Eggertson 2005) There were also funds to make the MCC's evaluation exam available in electronic form to make it more accessible. An Internet portal (www.IMG-Canada.ca) was also established and hosted by the Association of International Physicians and Surgeons of Ontario.

Nursing

In March 2004, HRSDC, through its FCR Program, also announced funds $545,145 for a 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 IENs. Some of the key recommendations included: 1) the establishment of a national assessment service to create an evidence-based standardized approach to the assessment of IENs; 2) the establishment of nationally standardized and flexible bridging programs to ensure IENs have the competencies required to meet Canadian nursing standards, and; 3) the development of a central Website specific to IENs to access complete, clear and easily understood information related to immigration and nursing licensure/registration (CNA 2005).

Midwifery

In 2003, HRSDC, through its Prior Learning 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). 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 objective is to increase access by internationally educated midwives to the profession by building upon the high degree of similarity in professional requirements and standards across the country to create an efficacious inter-jurisdictional process (CMRC 2005). Thus far, the NAS has: 1) approved the development of a pan-Canadian Website for internationally educated applicants; and 2) approved the development of pan-Canadian expertise and a credential evaluation database with the purpose of creating standardization wherever possible.

Conclusion

In sum, there have been numerous task forces, working groups and joint government-profession committees, which 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. 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. To date, some action has been taken towards this kind of centralization thus easing the integration process with the help of public funding and support.

An interesting finding arises from a comparative analysis between medicine and midwifery on one hand, and nursing on the other. Specifically, the latter profession has, in most provinces, two different levels of regulatory status: Registered Nurses and Licensed Practical Nurses. 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.

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Notes

[1] Internationally educated health care providers (IEHPS) in the Canadian context are largely those trained outside of Canada and the United States.

[2] From Audas, Ross and Vardy 2005.

[3] The Philippines, it is argued, has a government-sponsored policy of producing nurses for export despite having a shortage of nurses.