INTEGRATING INTERNATIONALLY EDUCATED HEALTH PROFESSIONALS INTO CANADA'S HEALTH CARE WORKFORCE

by

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Abstract

In this study I examine the barriers to integration faced by international health professionals in Canada and initiatives used to facilitate positive labour outcomes for immigrants trained in the health professions. Canada is experiencing a shortage of health professionals, yet internationally educated nurses and doctors experience lower employment rates than those educated in Canada. This indicates that internationally educated health professionals are not integrating successfully into Canada's health care workforce. I examine the immigration and integration policies of Australia, New Zealand, and the United Kingdom, and I find that they have several main characteristics in common. Based on these findings, I propose policy options that address the lack of integration of immigrant health professionals in Canada. I then evaluate these alternatives based on a set of criteria, and I recommend integrating credential recognition into the federal immigration process.

Keywords: Skilled Worker migration; Internationally Educated Health Professionals; Internationally Educated Nurses; International Medical Graduates; immigration; labour market integration; Canada

Executive Summary

This study examines the barriers to labour market integration faced by internationally educated health professionals and the initiatives used to facilitate positive labour outcomes for these immigrant professionals in Canada. The research focuses primarily on registered nurses and general practitioners because of the shortages of health professionals in these fields. It is estimated that by 2016, the nursing shortage will be as high as 100,000, while 14% of Canadians will be without a family physician. Through analysing the barriers and the programs perceived to mitigate the barriers, I identify policy options that can facilitate the integration process.

One of Canada's key strategies to overcome the shortage of health professionals is to encourage the economic immigration of health professionals to Canada through the federal Skilled Worker program. As of June 2010 skilled applicants are only considered if they are in one of 29 in-demand occupations, ten of which are health occupations such as family physicians, and registered nurses. Despite this policy initiative, however, it is estimated that nurses and doctors educated overseas have a higher unemployment rate than those educated in Canada.

Research shows that by 2001 only 22% of Indian nurses, 22% of Filipino nurses, and 25 Chinese nurses were employed. The employment rates for doctors were even worse with only 19% of Indian doctors, 3% of Filipino doctors, and 4% of Chinese doctors being employed. These outcomes are troubling when compared to the total inflow (22,854) of nurses and doctors to Canada between 1996-2001.

The primary research methodology in this capstone is a case study of Australia, New Zealand and the United Kingdom. These countries were chosen because their government structure and culture are similar to that of Canada, and they also regulate health professionals. I

identify four characteristics to determine the best practices to assess and integrate overseas health professionals into the health care workforce: immigration policy, health policy jurisdiction, credential recognition, and knowledge evaluation and programs. Based on the case study analysis, I identify and analyse the following policy options: 1) integration of credential recognition into the federal immigration process, 2) increased access to bridging programs, and 3) development of an occupational English test for health occupations. The first policy option is a preventive option intended to select those applicants who will quickly find employment in Canada, while ensuring equity for those originating from non-English speaking and developing countries through the provision of foreign aid for nursing and medical programs. The second policy is a remedial policy that addresses the need for additional training when assessment of international health professionals indicates a deficiency in medical knowledge and skills. Finally, the third policy is also a remedial policy intended to addresses the barrier of English language proficiency in the health care environment.

Cost, effectiveness, key stakeholder acceptability, legal feasibility, and horizontal equity are the criteria used to evaluate each policy option. The study concludes by recommending that credential recognition is integrated into the federal immigration process. This policy is low in cost and addresses three of the most important barriers to employment faced by internationally educated health professionals: language proficiency, credential recognition, and competency gaps. Also, because applicants are required to undergo assessment prior to arrival, and because they must demonstrate a high level of language proficiency, they are presented with a more realistic depiction of working in a regulated occupation in Canada. Finally, through the provision of foreign aid, the policy also addresses the issue of exclusion of health professionals from countries that may not have health training that meets Canadian standards.

To my parents

Thank you for your courage, sacrifice, and hard work, without which all of this would not be possible.

And to Tom

For your love, support and encouragement every step of the way.

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Glossary

CaRMS	Canadian Resident Matching Service
CIC	Citizenship and Immigration Canada
CIHI	Canadian Institute for Health Information
CPSBC	College of Physicians and Surgeons of British Columbia
CRNBC	College of Registered Nurses of British Columbia
IEHP	Internationally Educated Health Professional
IEN	Internationally Educated Nurse
IMG	International Medical Graduate
LCP	Live-in Caregiver Program
OECD	Organisation for Economic Co-operation and Development

1: Introduction

Canada is experiencing a shortage of health professionals, particularly doctors and nurses. It is estimated that roughly 14% of Canadian adults do not have a family physician (Dumont et. al., 2008), while the Canadian Nurses Association projects the registered nurse shortage to be as high as 100,000 by 2016 (Little, 2007). The United States is also facing a shortage of health professionals. According to Dumont et. al. (2008), analysts are concerned that Canadian doctors and nurses will emigrate to the US where financial incentives are greater and jobs are more plentiful, thus further compounding Canada's health professional shortage. One strategy to overcome the shortage of health professionals employed by Canada is to encourage the economic immigration of health professionals to Canada. In 2008, Citizenship and Immigration Canada decreased the amount of federal skilled worker applications because of Canada's current labour market needs; as of June 2010 applicants are only considered if they are in one of 29 in-demand occupations, ten of which are health occupations such as specialist physicians, family physicians, dentists, pharmacists, registered nurses, and psychologists. Despite this policy initiative, it is estimated that people educated as doctors in other countries have a significantly lower unemployment ratio of almost 70% when compared to Canadian educated doctors. Internationally educated nurses account for only 7% of the total registered nurse workforce in Canada and the unemployment ratio for overseas medical professionals is more noticeable than for other skilled professionals. This creates the problem that *not enough internationally educated health professionals are integrating successfully into Canada's healthcare workforce*.

This capstone will examine the barriers to integration faced by international health professionals in Canada and initiatives used to facilitate positive labour outcomes for immigrants trained in the health professions. Analysing the barriers and the programs, which are perceived to

mitigate the barriers, helps to identify policy options that facilitate the integration process. The research question addressed is: What are the existing barriers that prevent internationally educated health professionals from entering the healthcare workforce and what policies exist to help surmount the barriers?

The capstone begins by outlining Canada's immigration policy and the programs under which internationally educated health professionals immigrate to Canada. It also describes the migration trends of internationally educated health professionals. Next, the capstone shows the employment rates for internationally educated health professionals residing in Canada. From this, the discussion progresses to examine the barriers to employment and current federal and provincial initiatives to address the barriers. The primary methodology to answer the research question is a case study of three countries whose government structure and culture are similar to that of Canada, and who also regulate their health professionals. Based on the case study analysis, the following policy alternatives are identified and analysed: integration of credential recognition into the federal immigration process, increased access to bridging programs, and development of an occupational English test for health occupations. The capstone concludes by recommending that credential recognition is integrated into the federal immigration process.

2: Canada's Immigration Policy for Health Professionals

Canada is an immigration country. Immigration policy has been used historically not only as a nation-building tool, but also as a way to respond to the country's prevalent economic needs. Reitz (2005) points out, this is partly because of Canada's small population size and its low fertility rate and argues that future labour-force growth will arise from immigration. This section outlines the main features of Canada's immigration policy specifically focusing on policies for health professionals.

2.1 Immigration Policy – a Solution for Labour Shortages

Historically, the most significant phases of Canadian economic development were during the agricultural and industrial periods. In response to the economic needs of the time, Canada recruited immigrant agricultural workers, and construction and manufacturing labourers to fill labour shortages. Until the 1960s, Canadian immigration policy also focused on immigrants from western and northern Europe. Western European immigrants were perceived to settle and assimilate more easily because of similar "values and norms" to that of Canadian society (Somerville and Walsworth, 2009). Following the industrial phase and up to the present, Canada evolved toward a service and knowledge economy. And in 1967, Canada's immigration policy underwent a significant shift with the introduction of the point system.

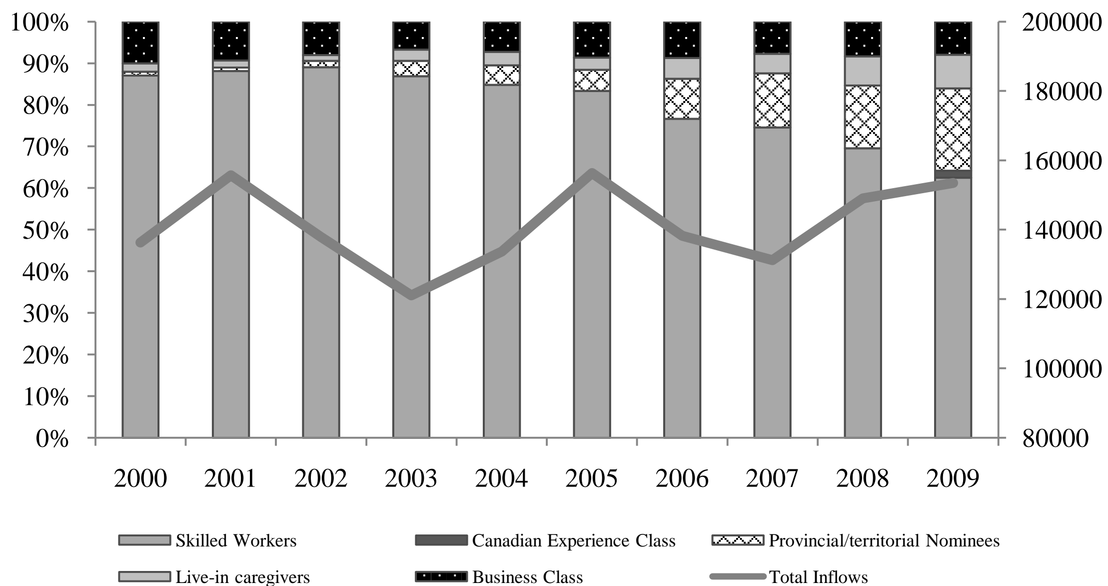
The point system shifted immigration policy from constraint on countries of origin to selecting skills by assigning applicants points based on education and work experience. The point system is theoretically underpinned by human capital theory, which suggests that, a worker's education, skills, and job experience will be reflected in their earnings (Reitz, 2005).

The Immigration Act of 1976 continued the new tradition of recruiting skilled workers by introducing four main classes of immigration. First, the independent class consisting of individuals applying for landed-immigrant status of their own initiative; second, the humanitarian class comprised of refugees; third, the family class including immediate family, parents, and grandparents of individuals already residing in Canada; and fourth, the assisted relatives class comprised of distant relatives who are sponsored by family members in Canada (CIC, 2000). In 2002, the *Immigration and Refugee Protection Act* (IRPA) updated the points system and defined three basic categories of immigrants: Family, Economic and Refugee. Since IRPA was introduced, an applicant requires 67 out of 100 points to be admitted to Canada. The applicant is awarded up to 25 points for educational credentials, 24 points for knowledge of an official language, 21 points for work experience, and up to 10 points each for age, adaptability and arranged employment. With the point system and the introduction of the Economic Class of immigration, Canada seeks to attract professionally trained, university-educated immigrants from diverse countries (Mullally and Wright, 2007). The Economic Class has since been renamed the Federal Skilled Worker Class.

Since 1995, the Federal Skilled Worker Class is the largest immigrant class accounting for about 50% of all immigrants permanently entering the country (DeVoretz, 2006). Within this class, applicants are further divided into categories, depending on whether they are skilled workers, Entrepreneurs, Self-employed, Investors, Provincial/Territorial nominees, or part of the Canadian Experience class. Immigrants can also enter Canada to fill labour shortages through the Temporary Foreign Worker Program (TFW). Provincial/Territorial nominees and Live-in Caregivers enter Canada through the TFW. One requirement of this program is that applicants must have an offer of employment. Figure 1 shows that from 2000 to 2009, most applicants enter as Skilled Workers, then as Provincial/Territorial nominees, and finally as Live-in Caregivers. The figure also shows that since 2005, the share of immigrants entering Canada through the

Skilled Worker program has been decreasing, while Provincial/Territorial nominees and particularly those entering through the Live-in Caregiver program have been steadily increasing. If the applicants in the Provincial/Territorial nominee program work in a regulated profession, then they must already have a professional licence, certification, work experience, and language proficiency that will enable them to work in their field shortly upon entering Canada. Often, employers use this immigration class to nominate workers who have already integrated into the workforce. Live-in Caregivers also enter Canada with secured employment for a maximum of two years. After the two-year period has passed, they become eligible for permanent residency, which may be a reason why applications in this class have increased (Kalaw and Gross, 2010).

Figure 1: Economic Class Immigrants from 2000-2009



Source: CIC (2009)

On June 26, 2010, Canada announced that it was adjusting its immigration plan to increase the number of permanent economic immigrants. In particular, Citizenship and Immigration Canada (CIC) anticipates accepting more federal skilled workers and provincial nominees, in order to emphasize economic recovery and reduce the federal skilled worker backlog (CIC, 2010a). The criteria for eligibility under the Federal Skilled Worker Class also

changed. Applicants must now either have a job offer, or they must have experience in one of the *29* in-demand occupations.[1] The government identified the 29 occupations based on labour market information and through consultations with provinces, territories, stakeholders and the public (CIC, 2010c). Of these 29 occupations, ten are health occupations: specialist physicians, general practitioner and family physicians, dentists, pharmacists, physiotherapists, registered nurses, medical radiation technologists, dental hygienists and dental therapists, licensed practical nurses, and psychologists. The following section discusses in detail the immigration policies for internationally educated health professionals (IEHPs).

2.2 Definitions

This capstone examines the integration of internationally educated nurses (IENs) and internationally educated medical doctors, referred to as international medical graduates (IMGs), into Canada's health care workforce. The terms IEN and IMG can denote Canadian citizens who completed nursing or medical schools abroad and return to practice in Canada and; those who immigrate to Canada from overseas. Also, in Canada there are several levels of nursing and different types of medical specialization. This capstone will only look at registered nurses and family physicians that immigrate to Canada from overseas with the intent to work in their occupation. Unless otherwise specified, they will be referred to as nurses, doctors, overseas nurses and overseas doctors.

2.3 Canada's Immigration Policy for Health Professionals

The Skilled Worker and the Provincial/Territorial Nominee programs are the most used for recruiting health professionals to solve labour shortages. The Live-in Caregiver program is also a source overseas nurses, even though they are not permitted to work in their professions while being part of this initiative.

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[1] See Appendix A for complete list.

Under the Skilled Worker Program for health occupations, applicants must either already have a job offer, or be experienced in the health occupation and demonstrate language proficiency by passing the International English Language Testing System (IELTS) "General Training" exam. Their application is then assessed using the points system for permanent residency. The goal of the skilled worker program is to "bring in quickly the people Canadian employers need to supplement the domestic labour supply" (CIC, 2010b). CIC offers a self-assessment tool so that immigrants can evaluate their skills and potential of practicing their profession in Canada. Somerville and Walsworth (2009) point out, however, that the federal government may recognize an applicant's credentials by awarding them more points for their education, but once the migrant lands in Canada their labour market participation is largely dependent on the province and their regulatory bodies. They further mention that often, provincial regulatory bodies and associations do not recognize credentials from foreign countries.

The Provincial Nominee program gives provinces and territories the authority to nominate individuals who meet their unique social and economic needs for permanent residency. Most applicants already work in Canada but want to become permanent residents. They must first apply to the province where they have the genuine intent to settle, after which they must submit a separate application to CIC for further evaluation. Applicants must also pass a medical exam and a criminal check, and submit proof that they have enough funds to support themselves and their dependents while in Canada. Each province has a separate agreement with the federal government, however, and not every province explicitly identifies health occupations in its labour needs. Furthermore, the program is employer driven in the majority of provinces and territories, as identified in Table 1, and requires a joint application from the prospective immigrant and their Canadian employer. Employers must also prove to the government that they could not find anyone locally or nationally to fill the position. Once the application is submitted, prospective

immigrants may be granted a temporary worker visa if they do not have one already while the application for permanent residency is being processed (CIC, 2010d).

The Live-in Caregiver Program (LCP) does not directly target health professionals, but many overseas nurses, particularly from the Philippines, enter Canada through this initiative. The goal of the LCP is to provide live-in care for children, seniors or people with disabilities, without supervision and in private households (Dumont et. al., 2008). Live-in caregivers work under temporary work visas, but they are eligible to apply for permanent residency after two years or 3900 hours of authorized full-time employment (CIC, 2010e). They must complete these requirements within four years of arriving in Canada. If the live-in caregiver is a nurse, he or she is not permitted to pursue nursing registration while being a part of the LCP because the program is designed to provide full-time live-in care for households in need of the extra support; as a result many nurses in the program find it difficult to transition into nursing in Canada.[2] The LCP, however, is not intended to recruit nurses. The education requirement is the completion of high school (or its equivalent), but 91.9% of participants in the program have a college or university degree; Kalaw and Gross (2010) argue that based on the characteristics of the participants in the LCP, most live-in caregivers may be eligible to apply under the point system for permanent immigration, which has a long wait time, but the LCP is a more attractive option because the wait time is only two years. This indicates that more likely, overseas nurses who want to become Canadian permanent residents use the Live-in Caregiver Program at the risk of losing their skills.

[2] From "Journey to Greener Pastures: Oral Histories of Migrant Filipino Nurses in Canada," presented by Charlene Ronquillo, Ph.D. Candidate, University of Toronto, at the Health Worker Migration to Canada: Histories, Geographies, Ethics Conference, University of British Columbia, September 30, 2010.

Table 1: Provincial and Territorial requirements for the Provincial Nominee Program

Province	**Health Occupations**	**Description of Requirements**
British Columbia	Yes	Nurses and physicians must be recruited through Health Match BC. Nurses must be registered or eligible for registration. Physicians must have worked in BC for at least 9 months and received a positive assessment from a supervising physician.
Alberta	No	…
Saskatchewan	Yes	Provincial nomination is available only to those who have been working in the province for at least 6 months on a temporary work permit.
Manitoba	Not specifically	Professionals must have a licence, certification, work experience and language proficiency to begin work in selected fields shortly after arriving in Canada.
Ontario	Not specifically	Must have appropriate Ontario registration if work in a regulated profession, and must have an offer of permanent employment in a skilled occupation.
New Brunswick	No	…
Nova Scotia	No	…
Prince Edward Island	Yes	Health professions are listed under the *Skilled Labour Shortages* category. Applicants must first secure a full-time position and meet all registration criteria before being able to apply.
Newfoundland and Labrador	No	…
Yukon	No	…
Northwest Territories	No	…

Source: CIC (2010)

2.4 Migration Trends of Internationally Educated Health Professionals

There is a lack of reliable data on health professional migration. Some countries consistently collect statistics, while others do not, and the methods for data collection vary, thereby making quantitative analysis difficult. In Canada, the Canadian Institute for Health Information (CIHI), Statistics Canada, and some regulatory bodies collect data on internationally educated health professionals. Not all Statistics Canada datasets on IEHPs are publicly available, and regulators in British Columbia do not collect data.[3] Internationally, the Organization for Economic Cooperation and Development (OECD) and the World Health Organization (WHO) collect and disseminate data on international health workers. Below is a discussion of the available statistics and trends in health worker migration, beginning by illustrating Canada's position with respect to other countries, and then followed by Canadian data.

Figure 2 shows that 7% of nurses, and 22% of doctors in Canada are from overseas, but in comparison to other countries that rely on immigration to contribute to their nation's economic development, such as Australia, Ireland, the United States, the UK and New Zealand, Canada ranks lower.[4]

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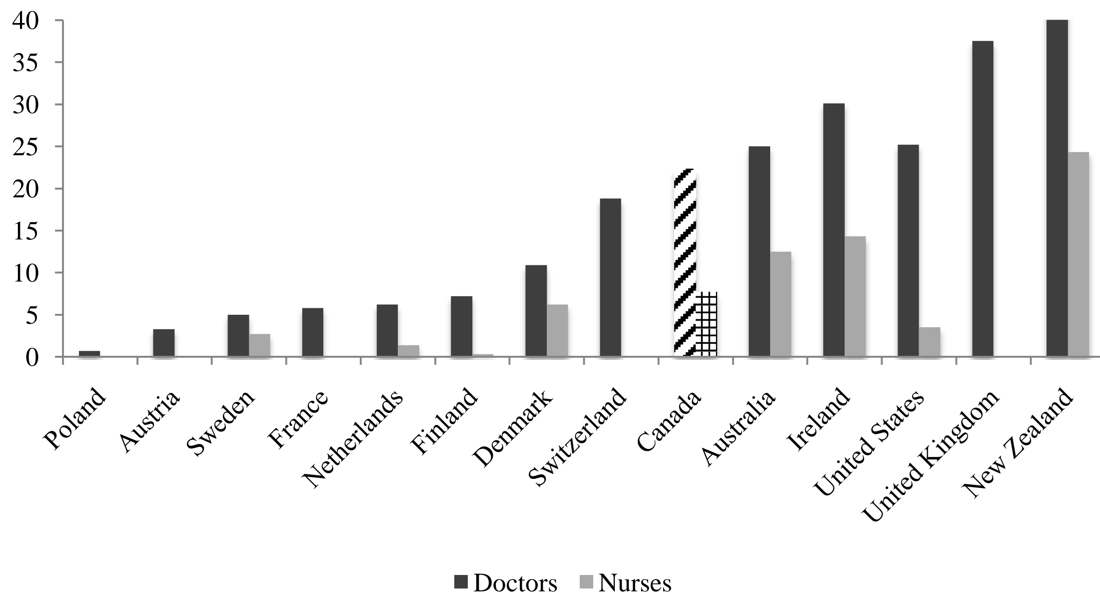
[3] The Longitudinal Survey of Immigrants to Canada (LSIC) collects information about immigrants' intended profession in Canada, but I was unable to find data for analysis, and published reports do not delineate health professionals as a category. Furthermore, when the survey does ask about highest level of education attained, the following option is given for health professionals: "Degree in dentistry, medicine, veterinary medicine, optometry, law or theology" (Statcan, 2007).

[4] Although Dumont et. al. (2008) caution that the data was obtained from professional registers and should be considered with care.

Figure 2: Share of overseas doctors and nurses in selected OECD countries, 2005



Source: Adapted from Dumont et. al. (2008)

Overseas nurses and doctors often engage in brain circulation.[5] For example Philipino nurses first migrate to the United Arab Emirates, the US, or the UK.[6] From there, they are either recruited by organizations such as Health Match BC, or they enter through one of Canada's immigration programs. Their length of stay in Canada is unknown; it is likely, however, that some will return to their home country. Canadian recruiters indicate that they almost never accept registered nurses directly from a developing country, only through developed countries such as the UK or US.[7] Of the nurses recruited from the UK, only half were British born, the remainder were from India or Africa. Despite their work experience in the UK, a country thought to be similar to Canada with respect to education, culture and language, nurses found

[5] The movement of skilled workers across three or more states (DeVoretz, 2006).

[6] This paragraph is based on "Policy Roundtable on Internationally Educated Nurse Recruitment, Migration & Integration to British Columbia, Canada," presented by Jean Carne, RN, Operations Leader, St. Paul's Hospital BC, at the Health Worker Migration to Canada: Histories, Geographies, Ethics Conference, University of British Columbia, September 30, 2010.

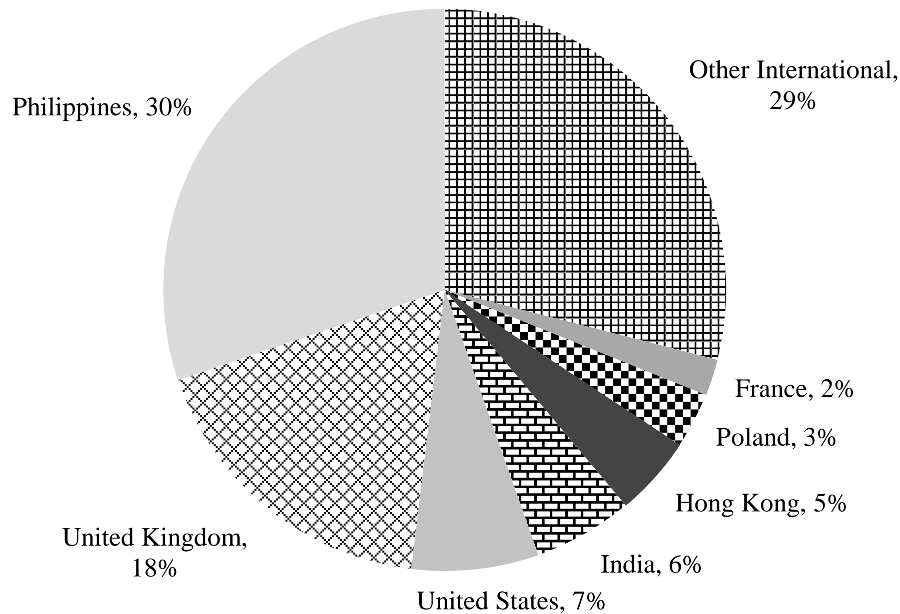
[7] Ethical recruitment was cited as the reason for only recruiting from the UK or US. Because of increasing concern over the brain drain from developing countries that are also experiencing nursing shortages, countries such as Canada are making a more conscious effort to recruit only from developed nations.

transitioning to the Canadian workforce difficult. Recruiters also noted that even though Canada is relying less on overseas doctors in the proportional sense, many are here now, and they face labour market integration barriers.

In Canada, the Canadian Institute for Health Information (CIHI) reports that in 2008, overseas nurses made up 7% of Canada's nursing workforce. This is a slight increase from 2004, when they accounted for 6.7% of the workforce (CIHI, 2009b). These statistics, however, only account for nurses who were successful in obtaining credential recognition and registration. The actual stock of overseas nurses in Canada may be greater as regulatory bodies only collect statistics on applicants who continue the registration process and not the ones who "drop-out," or do not pursue the nursing profession in Canada.

As shown in Figure 3, the four main countries of origin for overseas nurses in Canada are the Philippines (30%), the United Kingdom (18%), the United States (7%), and India (6%). Provincially, the highest concentrations of overseas nurses in the workforce in 2008 were in British Columbia (15.8%), followed by Ontario (12.3%) and Alberta (9.6%).

Figure 3: Overseas Nurses in the Workforce, by Country of Graduation, 2008



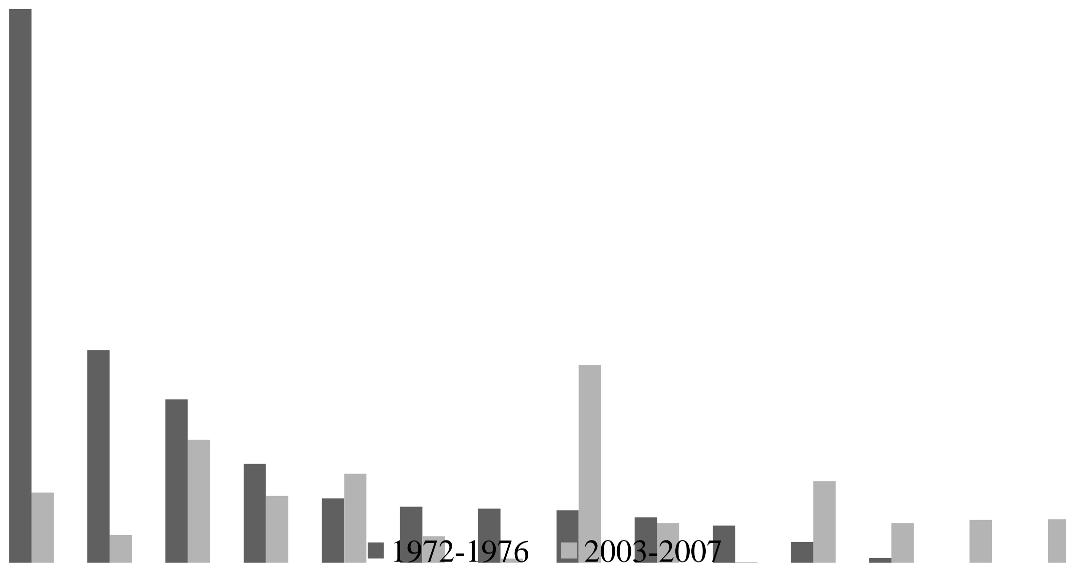
Source: CIHI (2010)

Overseas doctors, on the other hand, make up a larger share of the Canadian workforce than overseas nurses. CIHI (2009a) reports that in 2008, overseas doctors accounted for 24.9% of Canada's family physician stock, and overseas specialists accounted for 21.5% of the specialist physician stock. Since 1978, the share of overseas doctors has declined by 7 percentage points, and the share of overseas specialists by 8.2 percentage points. Since 2002, however, more overseas doctors than specialists work in Canada. It must be stated that the data only shows those who have been successful at integrating into the Canadian health workforce. The actual number of overseas doctors residing in Canada but not practicing their profession is unknown.

The main countries of origin for doctors shifted between 1972-1976 and 2003-2007 (see Figure 4). The UK and Ireland were the main sources of doctors to Canada between 1972 and 1976, but between 2003 and 2007, the UK was replaced by South Africa as the top source country. The decreased share of overseas doctors in the latter period could be because credentials

from developing countries are less likely to be recognized by Canadian regulatory bodies. Figure 4 also illustrates the drop in the amount of doctors entering Canada between the two periods, which could point to a policy shift between 1976 and 2003.

Figure 4: Number of International Medical Graduates in Canada from Selected Countries, 1972 to 1976 and 2003 to 2007



Source: Adapted from CIHI (2009a)

In summary, the share of overseas nurses and doctors in Canada has changed over time. Recently, most originate from developing countries, and are likely to face integration barriers. The next section examines in more depth the employment rates of internationally educated health professionals in Canada.

3: Employment Rates for Internationally Educated Health Professionals

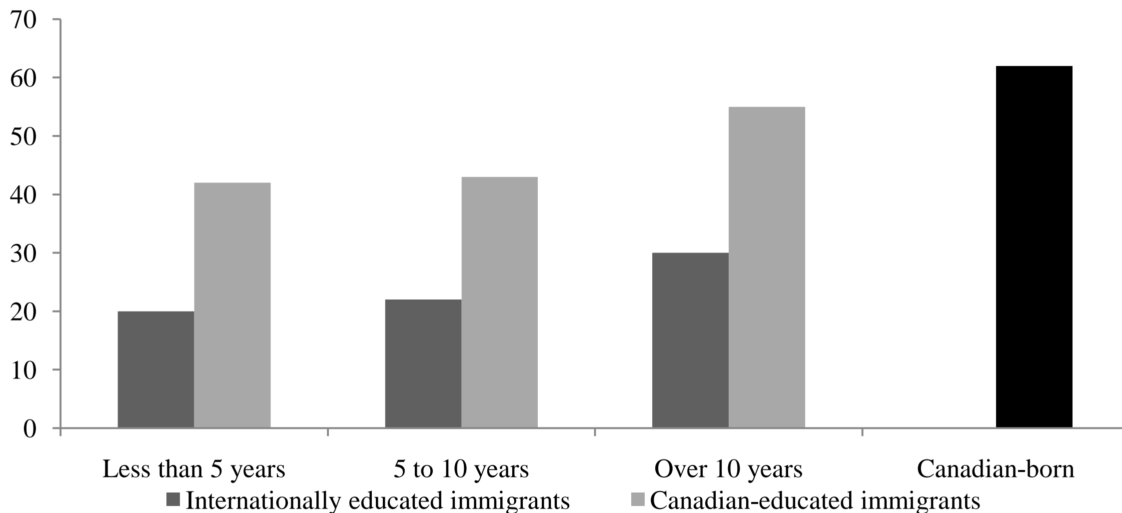
This section begins by examining employment rates of skilled workers who immigrated to Canada, and then it looks at health occupations as a group.

Despite efforts to recruit skilled workers from countries with similar cultures, education, and language as Canada, many immigrants do not find work in their professions after settling in Canada.[8] In 2006, immigrants with a degree in a regulated occupation who studied outside of Canada had a higher unemployment rate than Canadian educated immigrants with similar degrees (7% vs. 4.2%). The difference in unemployment rates was even larger between Canadian born immigrants who studied outside of Canada and Canadian educated immigrants. The *match rate* is used to assess immigrants' integration levels into the Canadian workforce. It is derived by dividing the total number of people working in the occupation by the total number of people whose studies would lead them to work in the occupation (Zietsma, 2010). The match rates between immigrants and the Canadian born are calculated to illustrate that skilled workers in a regulated field of study do not readily gain employment in Canada. Figure 5 illustrates that an immigrant's length of residency in Canada does not improve the match rate if he/she was internationally educated, compared to Canadian-educated. Internationally educated immigrants, who reside in Canada for over ten years, only had a 30% match rate in their regulated profession. Canadian-educated immigrants who reside in Canada for over ten years, however, had the highest match rate at 55%, and are the closest to the Canadian-born population match rate of 62%. In general, getting a Canadian education in a regulated occupation increases an immigrant's probability of employment in a regulated profession.

[8] Section 3 is based on Zietsma (2010)

Finally, provincially there is a high variance in match rates between internationally educated immigrants and the Canadian-born. Quebec, British Columbia, and Ontario, had the lowest match rates for 2006 with 19%, 22%, and 24% respectively. These provinces also have the highest proportions of recent immigrants, who are the least likely to be working in regulated professions because of the time it takes to meet all professional requirements and secure employment. These provincial match rates might reflect immigrants who are beginning the registration process but who still face significant barriers preventing them from accessing regulated professions.

Figure 5: Match rates by length of stay in Canada

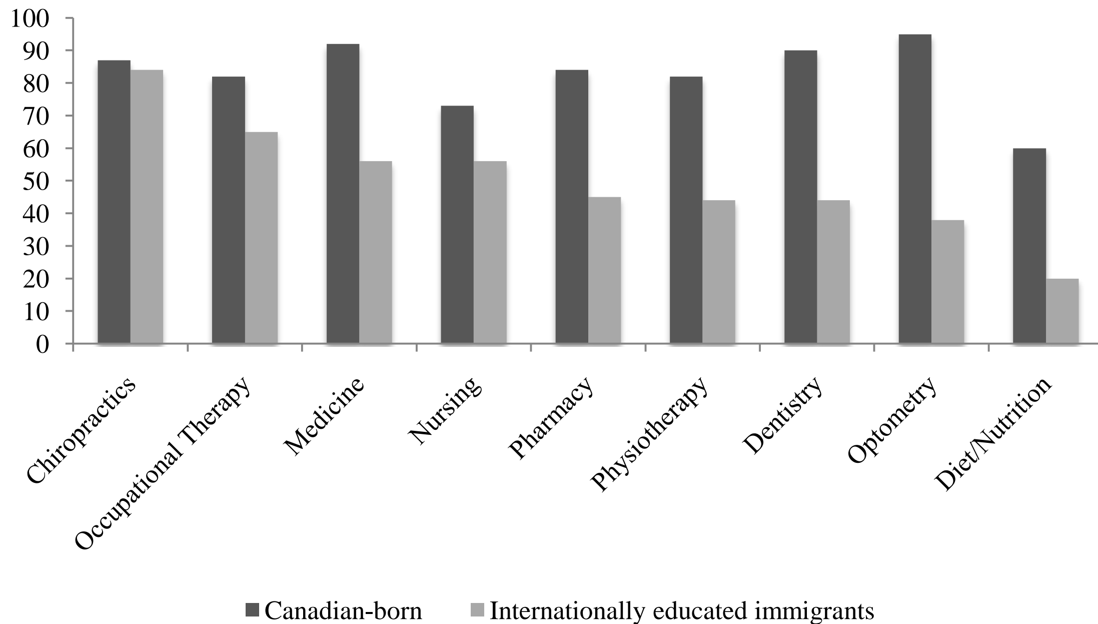


Source: Adapted from Zietsma (2010).

For internationally educated health professionals, the 2006 match rates were also markedly lower than for the Canadian-born. As Figure 6 illustrates, IEHPs had the highest percentage gaps in optometry (57), and dentistry (46). Those employed as chiropractors had the lowest percentage gap. The low match rates indicate that internationally educated health professionals are less likely to find employment in their occupation. The data for health professionals, however, does not take into consideration important factors such as country of

origin, length of residence in Canada, or language ability upon arrival, and it does not look at the length of time it took overseas health professionals to fulfil all the occupational requirements to gain employment in the regulated health occupations.

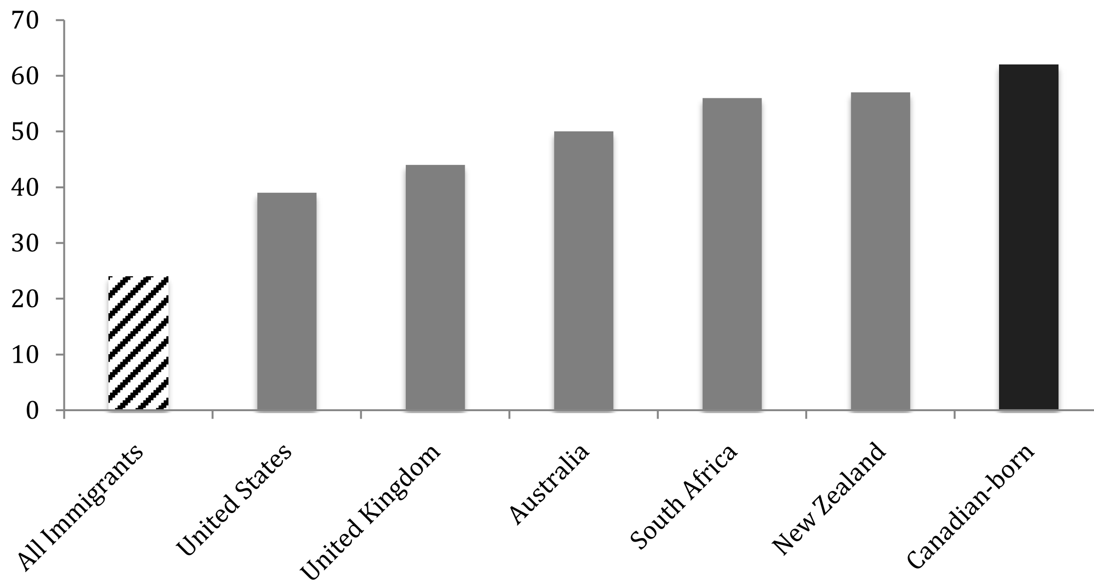
Figure 6: Match rates in health occupations



Source: Adapted from Zietsma (2010).

Zietsma (2010) does, however, look at countries of origin of internationally educated immigrants who have training in a regulated profession. Figure 7 illustrates that immigrants educated in countries with similar education systems and language of instruction to Canada like New Zealand and South Africa, have higher match rates than immigrants educated in other countries.

Figure 7: Match rates of immigrants from North America and the Commonwealth



Source: Adapted from Zietsma (2010).

Hawthorne (2008) examines the labour market outcomes of overseas nurses and doctors immigrating to Canada by country of birth. She finds that by 2001 only 22% of Indian nurses, 22% of Filipino nurses, 25% of Chinese nurses, and 32% of European nurses were employed. Doctors also fared poorly in 2001: only 19% of Indian doctors, 3% of Filipino doctors, 4% of Chinese doctors, and 8% of European doctors were employed. Hawthorne notes that these outcomes are upsetting when compared to the total inflow (22,854) of nurses and doctors to Canada between 1996-2001 and attributes the employment rates to a low demand for health occupations during this period (Canada was experiencing a recession) and rigorous regulatory requirements.

In summary, immigrants educated outside of Canada in a regulated profession are less likely to work in the same occupation in Canada, and internationally educated immigrants from developing countries are the least likely to work in their occupation in Canada when it is regulated.

4: Barriers to Employment

Overseas nurses and doctors who immigrate to Canada through the Skilled Worker Class face four key barriers to employment in regulated occupations. This section analyses each of the barriers in more detail.

4.1 Language, Communication and Culture

Language limitations are cited as one of the most important barriers for those who want to practice in a regulated health occupation in Canada. Because the top countries of origin for health occupations are not English speaking, nurses and doctors often do not meet the language requirements upon arrival in Canada. Older immigrants are also less likely to be proficient in English (Williams and Baláž, 2008). Regulatory bodies and employers point out that language limitations can lead to errors in documentation, which in turn may impact patient safety, as well as pose a legal liability for professionals and their employer (Jeans et. al., 2005).

In the medical field communication is essential, especially when dealing with an emergency situation. In critical moments, the medical staff must be quick to act and this involves communicating the problem and what procedures must be executed and by whom. Those who are not fluent or who have difficulty understanding what is being explained quickly may not have time to react appropriately and patient safety may be impacted. The language barrier may also cause the development of low self-confidence, which in turn may impact patient care (Williams and Baláž, 2008). For example, Williams and Baláž (2008) found that Philipino nurses working in the UK found communication to be an obstacle when learning from their UK colleagues; they were reluctant to ask clarifying questions when they did not understand something because this led to the perception by UK nurses that they did not have the required skills. This, in turn led to

the development of low self-confidence in the overseas nurses further compounded by their inability to ask questions. Consequently, patient safety can be impacted negatively if an overseas nurse cannot understand or clarify a medical order. Lack of language fluency may thus lead to communication barriers between overseas nurses, doctors and other health care staff, and patients and their families.

Communication, however, is not limited to the technical structure of language. Language also conveys the socio-cultural dimension of a country's society. Certain phrases, jargon, and word meaning may have a different cultural connotation than their explicit meaning. Being unable to understand certain socio-cultural cues that patients are communicating in relation to their symptoms may hamper the diagnosis and treatment thereby affecting the quality of care and patients' safety. Communication can also be non-verbal. Non-verbal communication is intricately tied to the country's culture and its subtleties can also take a long time to learn. In some cultures for example, maintaining eye contact is considered rude, but in Canada, not maintaining eye contact is considered rude. Responding inappropriately to a patient can lead to negative experiences and health outcomes. Because Canada is a diverse society, patients represent distinct ethnicities and sensitivity to their unique non-verbal communication is important in determining their medical care. Both Canadian and overseas nurses and doctors can experience the non-verbal communication barrier, but regulatory bodies place emphasis on adapting to the Canadian culture therefore, this barrier is more prominent for immigrant health professionals (Jeans et. al., 2005).

IEHPs also experience cultural barriers to the practice of medicine in Canada. I define "culture" as a set of shared values, practices, attitudes and beliefs that characterize a community of people. In cultures where care is directed exclusively by physicians and other senior health care providers, nurses may lack professional independence. In Canada, nurses are mandated to make decisions and take action based on their assessment of the needs of patients; sometimes this

requires questioning the physicians' and other health care providers' authority. Thus, transitioning to an independent practice may be an arduous task (Jeans et. al., 2005). Similarly, doctors accustomed to exercising their authority are unlikely to transition well into the Canadian system where other staff and patients may question their medical treatment. IEHPs also face cultural differences in scope of practice, the diseases and medical problems that must be treated, and patient expectations. Scope of practice in Canadian family medicine includes obstetrics, hospital work, emergency care, and psychiatry, but these scopes may not be included in general medicine in some countries; furthermore, because psychiatry may not be in an overseas doctors scope of practice, when a patient exhibits symptoms of a mental illness like depression, the doctor may not prescribe the appropriate treatment or can misdiagnose (VanAndel, 2009). Padela and Punekar (2008) give an example of patient expectations in a vignette of a female Muslim patient who was upset and was refusing examination and treatment after being dressed in a hospital gown by male staff and approached by a male physician who wanted to perform a physical exam; she preferred female health staff because of her cultural and religious beliefs. Doctors who do not have experience with patients from other cultures may not realize the distress and potential negative health outcomes that may result from culture-specific expectations.

Regulatory bodies and employers are aware of the impact that lack of language fluency, communication and culture can have on patient safety and care, which is why regulatory bodies require that overseas applicants successfully complete a language test before their application is evaluated (Baumann et. al., 2006). Many withdraw from the application process because they are unable to obtain the required score, or because their lack of language fluency prevents them from completing the application (Jeans et. al., 2005). British Columbia's registered nursing and medical regulatory bodies accept scores from five language tests (see Table 3). The main criticisms of the language tests, however, are that they do not address the socio-cultural dimension of language, and that they do not test the applicants' knowledge of medical

terminology or vocabulary that is appropriate for health care (Baumann et. al., 2006). Only the Canadian English Language Benchmark Assessment for Nurses (CELBAN) incorporates medical and health care vocabulary and is specifically based on nurses' communication requirements in a variety of health care settings. The CELBAN, however, is the most expensive language exam, and therefore the least likely to be chosen by nurses (Baumann et. al., 2006). Another criticism of the exam is that the accepted scores are too low, which means that the exam does not ensure effective communication for safe practice (Jeans et. al., 2005). Gaining complete language fluency, however, can take years and it could be argued that the best way of achieving fluency is through practice and the use of specialised vocabulary. IEHPs could thus benefit more from being allowed to train or practice in the health care setting once they have achieved the required level of fluency.

Table 2: English Language Tests Accepted in British Columbia

English Test	Description	Minimum Passing Score	Cost (CAD)	IEN/ IMG
IELTS	International English Language Testing System – tests speaking, listening, reading and writing for general proficiency. Only the academic version of the exam is accepted.	IEN: 6.5, and 7 on speaking section. IMG: 7 on all components	$285	IEN and IMG
TOEFL - iBT	Test of English as a Foreign Language Internet Based – tests listening and reading comprehension, knowledge of grammar structure and writing ability for general proficiency at the university level.	IEN: Combined 60 26 for speaking component. IMG: Combined 95, and 25 for speaking	$200	IEN and IMG
TOEFL/TSE	Test of English as a Foreign Language/Test for Spoken English – tests listening and reading comprehension, knowledge of grammar structure and writing ability for general proficiency at the university level. Computer and paper based. The TSE is a complement to the TOEFL and tests for oral communication. (The TSE has been discontinued as of March 2010, but scores from tests taken prior to this date will be valid until 2012)	Computer – 213 Paper – 550 TSE – 50	$200	IEN
MELAB	Michigan English Language Assessment Battery – tests listening, reading and writing, and speaking if requested at an advanced English level. Offered in Toronto.	Combined – 83 Spoken – 3	$250-$290[A]	IEN
CELBAN	Canadian English Language Benchmark Assessment for Nurses – tests listening, speaking, reading and writing ability. Assesses English language capability within the nursing context. Contains vocabulary that is appropriate to nursing and health care.	Speaking – 8 Listening – 9 Reading – 8 Writing – 7	$320	IEN

Source: IELTS (2010); TOEFL (2010); MELAB (2010); CELBAN (2010)
A: partial tests can be taken and cost less.

4.2 Racism

Racism can also act as a barrier to employment for overseas nurses and doctors, and must be acknowledged. The devaluing of education and work experience of immigrants seeking professional registration in Canada might be partly attributed to racial differences. For example, Ogilvie et. al. (2007) argues that because credential assessment in regulatory bodies is not transparent, it can be concluded that in some cases, the devaluation of education is based on discrimination. Overseas nurses who are visible minorities are also less likely to gain professional registration and employment, and research in Toronto indicates that discrimination is most likely when a nurse from a minority group speaks with a noticeable accent (Ogilvie et. al., 2007). Foster (2008) also notes that the devaluation of international credentials in medicine affects visible minorities more than others. Although racism is an important and substantial issue, it is not the purpose of this capstone, therefore it will not be explored in more detail.

4.3 Institutional

Institutional barriers represent obstacles to IEHPs that are outside their control such as characteristics of the health care system, access to a residency position, and Canadian employer's willingness to hire immigrant professionals with provisional registration.

First, an IEHP's successful integration into the Canadian health care system also depends on the characteristics of their home country's health care system. If the system has poor resources and lacks modern advances in practice and technology, then regardless of their education and experience, they will face integration barriers in Canada (Jeans et. al., 2005). IEHPs who come from a less developed health care system might need to complete a nursing or medical degree in Canada or undergo additional extensive training.

Second, the most significant institutional barrier for overseas doctors is accessing a residency position. The number of residencies offered to overseas doctors through the Canadian

Resident Matching Service (CaRMS) is small in comparison to the demand (Boyd and Schellenberg, 2007). CaRMS matches applicants to an entry-level postgraduate position in one of Canada's 17 medical schools. The process takes place over two rounds; the first round is open to overseas applicants, the second round is for Canadian and overseas applicants who were not matched to one of their top three choices during the first round. In 2010 there were 229 dedicated positions for overseas doctors, but only 212 positions were filled. This is a decrease from 2009 (CaRMS, 2010). Out of 1497 overseas applicants participating in the process in 2010, 1223 (82%) of them remained unmatched to a residency position (CaRMS, 2010). In comparison, 10% of the total positions for Canadian medical graduates (CMG) were not matched. Overseas doctors compete with Canadian graduates for residency positions, and usually Canadian graduates are considered first.

British Columbia offers 19 IMG first round residency positions, 13 in Family Medicine and 6 in Specialties, which are posted on CaRMS and offered through the International Medical Graduate of British Columbia Program (IMG-BC). The IMG-BC program is funded through the provincial government and is based at St. Paul's Hospital in Vancouver. Only the programs' top 35 candidates are invited to take part in a clinical assessment, after which they are eligible to apply for one of the 19 residency positions offered at St. Paul's (IMG-BC, 2010). It is unknown what happens to the IMGs who are not matched to a residency in Canada. Some may choose to leave the profession, or downgrade to a lower level medical occupation, while others may keep trying to secure a residency in subsequent years (Foster, 2008).

Third, Canadian employers are unwilling to hire immigrant health professionals with a provisional licence. Many nurses face difficulties in meeting the Canadian work experience requirement because employers interpret the term "supervise" to mean that the nurse must be constantly in the presence of a higher-ranking nurse. In fact, they are permitted to work as part of

the team and do not require constant monitoring.[9] They also face the risk of being hired into marginal positions that Canadian nurses do not want to fill.

4.4 Credential Recognition

Credential recognition is another significant barrier to employment in Canada's regulated health occupations.[10] Overseas nurses and doctors who obtained their medical education in the Middle East, Asia or Eastern Europe need to have their training program evaluated and approved in Canada (Health Canada, 2005). The assessment of credentials ensures that the medical education received outside of Canada is comparable to Canada's system and that applicants' education and experience measures to the same standards. In Canada, provincial regulatory bodies are responsible for credential recognition through funding and programs for assessment. Some regulatory bodies outsource the credential assessment to third parties, which may have developed a separate evaluation procedure. The result is an inefficient and inconsistent system of evaluation across provinces, which results in unreliable information being provided to applicants regarding assessment results and subsequent courses of action.

The credential recognition process is particularly daunting for nurses because Canada has four separate nursing designations. In some countries there is only one designation and nurses new to the Canadian system may not know which regulatory body to apply to. They may also submit applications to multiple regulators within the country but because Canada does not have national standards for assessment this results in duplicated evaluations and costs. Many applicants are surprised to find that either their education has not been recognized or that they need to undergo additional training before their application is processed further.

[9] From "Policy Roundtable on Internationally Educated Nurses," panel discussion presented at the Health Worker Migration to Canada: Histories, Geographies, Ethics Conference, University of British Columbia, September 30, 2010.

[10] This section is based on Jeans et. al., (2005) unless otherwise indicated.

Regulators also require several original documents from the home country such as current registration, course transcripts, diplomas and certificates from programs of study, etc. Different countries' bureaucratic systems can make this process cumbersome and in some instances the required documents cannot be retrieved. Also, nurses and doctors originating from non-English speaking countries, must obtain translation and notarisation copies which are costly. As a result, despite passing language tests, many overseas professionals are unable to provide original documents, and to complete the application process.

To meet Canadian equivalency nurses must be trained as generalists and must have a baccalaureate degree in nursing. If equivalency cannot be determined, they are sent to a third party for competency testing. Nurses who are not trained at the baccalaureate level, or who lack experience in general medicine, need to complete the degree within a certain timeframe or complete additional training; this results in an added cost for the nurses. Once nurses overcome these hurdles they are permitted to write the Canadian Registered Nurse Examination as the final step to receiving a full licence to practice nursing.

Doctors' medical degrees must be listed with either the International Medical Education Directory (IMED) or the World Health Organization (WHO) to be approved in Canada (Boyd and Schellenberg, 2007). The doctor must then submit their credentials to the Medical Council of Canada's Physician Credentials Repository (PCRC) for verification (PCRC, 2011). The applicants' credentials are then verified to ensure that the education received abroad is equivalent to Canadian medical graduates' training; this entails both theoretical and clinical education, where medical school students interact with patients under the supervision of a licensed and trained physician. Once the documents are verified, the PCRC stores the documents in a repository from which they may be forwarded to provincial and territorial regulators. The provincial regulatory body retains the responsibility for recognizing the credentials. The number

of doctors who fail to have their credentials recognized in Canada, however, is unknown (Foster, 2008).

Prior to 1999, the College of Physicians and Surgeons of British Columbia (CPSBC) grouped countries into two categories: Category I were the Commonwealth English-speaking countries; Category II, all other countries. Doctors who belonged to Category I were easily able to practice medicine in British Columbia because their credentials were automatically recognized, and they had three years to write all entrance exams while being permitted to practice under a temporary licence in a rural setting. Doctors in Category II were required to repeat post-graduate medical training in Canada, or in a Category I country. In 1999, the Human Rights Commission of British Columbia ruled that the distinction between the two categories was discriminatory (BCHRC, 1999). Since then the College has removed the categories (CPSBC, 2010). The College reframed the requirements stating that if an overseas doctor completed post-graduate training in an accredited and approved program, rather than country, and the training was adequately long, they may be granted provisional licensure prior to completing the required exams (CPSBC, 2010).

The IMG must also successfully pass the Medical Council of Canada Evaluating Examination (MCCEE), which is a test of general medical knowledge in the main medical disciplines. The exam tests entry-level competencies of medical graduates about to start their first year of supervised postgraduate training. This exam is also a prerequisite for subsequent tests where doctors must demonstrate clinical competency, knowledge, skills and attitudes (MCC, 2010). The applicant must then complete a Canadian two-year family medicine residency or a 5-6 year specialist residency before being able to obtain full licensure to practice in Canada. Provided that the IMG successfully completes the residency and passes all the relevant exams, the overseas doctor can be granted full licensure by the regulatory body.

4.5 Competency Gaps

Regulatory bodies and third party credential assessors are sometimes unable to determine if the applicants' education and skills meet Canadian standards. Regulators then require applicants to undergo a competency assessment (Jeans et. al., 2005). The Substantially Equivalent Competency Assessment in British Columbia aims to evaluate nurses' entry-level professional knowledge, skills and abilities (CRNBC, 2010). The College of Registered Nurses of British Columbia (CRNBC) must refer the applicant for the assessment, and it is used as a complement to credential recognition when paper documentation is not enough to determine a nurse's entry-level competencies. Kwantlen Polytechnic University is responsible for administering the assessments. The results are forwarded to the CRNBC, who then determines if the nurse must undergo extensive educational upgrading, or additional training. They may be eligible for Provisional Registration while completing the conditions identified in the competency assessment. Under Provisional Registration, overseas nurses must complete 250 hours of supervised work. However, the employment requirement is not applicable to new Canadian graduates who are assumed to have the required competencies. Nurses are then required to pass the Canadian Registered Nurse Exam. Passing the exam is also viewed as a potential barrier for entry to practice by IENs. It tests competencies of entry-level nurses (CNA, 2010). Most overseas nurses, however, are already specialized in a nursing area because of years of work experience in their home country. As a result, they may have forgotten the general knowledge and skills that are acquired in an education program.

Overseas doctors' competency gaps are assessed through the Medical Council of Canada's clinical exam. Candidates, however, are not advised of areas that require further training if they do not pass the exam. Successful completion of the exam permits doctors to move onto the next step of the registration process, which is completing a Canadian residency position.

The applicant may be required to undergo additional clinical assessments, however, before being deemed eligible to apply to a particular province's residency position.

In summary, the barriers faced by IEHPs, especially those from developing and non-English speaking countries are substantial and sometimes may be insurmountable. The next section examines Canadian initiatives that address these barriers.

5: Canadian Initiatives to Address Barriers to Employment

Both the federal and provincial governments have developed initiatives to address the barriers faced by internationally educated health professionals and this section highlights the most significant programs.

5.1 Federal Initiatives

At the federal level there are four main programs: Health Canada's IEHP initiative, the Foreign Credential Recognition Program (FCRP), and the Working in Canada website.

The IEHP initiative (IEHPI) began in 2005 with the objective of increasing the supply of health professionals into the Canadian health care system. It receives annual funding of $18 million, which is distributed to provinces and territories, to build on the progress of programs and supports already developed by stakeholders, and to advance a uniform approach to integration. The federal government works in collaboration with the provincial and territorial governments, health regulators, post-secondary institutions, and professional associations to meet these goals (Health Canada, 2010). This has the potential of significantly reducing inefficiencies and duplications of procedure. Also, the initiative allows provinces and territories to continue administering needed programming; the precise distribution of the funding is unknown.

The Foreign Credential Recognition Program is another form of federal funding to provinces, territories, regulatory bodies, education institutions, and employers for the implementation of credential recognition projects. Part of the program is the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, which specifically targets the barriers to credential recognition. The goal of the program is to streamline credential recognition so that professionals working in health occupations are informed within a year of

whether or not their credentials will be recognized for work in Canada. It develops pre-arrival services so that potential immigrants can begin the credential assessment process prior to arriving in Canada (HRSDC, 2009). In 2010 nurses and occupational therapists were targeted, and in 2011 it will focus on physicians and dentists (HRSDC, 2011). The greatest challenge is to develop a pan-Canadian approach to credential recognition since each province and regulatory body has a different method of assessment and different standards for professional practice.

The Working in Canada website is an initiative that aims to provide information about the job market, licensing and registration requirements, skills and education needed, and which institutions to contact for regulated occupations. The website offers information on 520 occupations, including health occupations, so that immigrants are aware of what will be required of them if they wish to work in their occupation. The website is only offered in English and French, which assumes that most potential immigrants are proficient enough in either language to understand the information presented. Furthermore, it assumes that all immigrants have equal access to a computer.

All the federal initiatives are a positive start to addressing the barriers faced by IEHPs, but there needs to be more evaluation to assess whether the initiatives are achieving their objectives. Naturally, it will take time to see the effects, as all initiatives are fairly new. The next section examines how British Columbia in particular is working to provide integration resources for IEHPs.

5.2 Provincial Initiatives

Skills Connect, Health Match BC, and bridging programs are the main provincial initiatives targeted to internationally educated health professionals.

Skills Connect is a comprehensive program that offers services for immigrants to upgrade their skills, receive Canadian credentials, and access financial and language assistance, career

planning, and job leads. It receives $23.4 million in funding from the federal, and provincial governments. Part of the program is dedicated to the health care sector, particularly to the health occupations under the Work BC action plan to address skills shortages. Skills Connect assists IEHPs in upgrading their qualifications, finding work and mentoring prospects, and helps to overcome language barriers (Skills Connect, 2009). However, these services are only available to those with permanent residence status, who have arrived in Canada within the last five years, have intermediate English language skills, and are unemployed, underemployed or are not working at a level that uses their experience and knowledge (Skills Connect, 2009). IEHPs who are in the process of immigrating or are waiting for their permanent residency status, or who require new credentials or extensive language upgrading are excluded from the program.

Health Match BC is a health care recruitment service funded by the provincial government. Services are free and extend to physicians and nurse, and other health professionals. Health Match BC helps IEHPs navigate through the registration, licensing and immigration process, assists in finding employment based on interests and skills, and provides access to employers (Health Match BC, 2009). Health Match BC, however, is not a service for immigrant health professionals who require additional language or education training, it only facilitates transition into the Canadian health care workforce.

The use of bridging programs for nurses is becoming a standard for successful integration into the health care workforce. Kwantlen Polytechnic University's bridging program is the only one provided in the province. It is full-time, offered twice a year, and provides nurses with the knowledge, skills and Canadian clinical experience necessary to work in the Canadian health care setting. Nurses must pay for their tuition, textbook, and travel expenses (Kwantlen Polytechnic University, 2010). Only those referred by the CRNBC can gain access to it. There do not appear to be any bridging programs for overseas doctors other than the IMG-BC program, which offers assistance to those in the process of acquiring a residency position.

The programs developed at the provincial level are mainly geared toward IEHPs who have sufficient language capacity and skills and credentials that do not require a lot of upgrading. There is, however, not enough assistance for those who face greater challenges in overcoming the barriers to integration into the Canadian health care workforce.

In summary, although there are government and educational initiatives underway in Canada to address the barriers to integration for IEHPs, the majority of the programs are either in the early stages of development and implementation, or they only target a specific group of IEHPs – those who do not require substantial assistance and resources to integrate into the Canadian workforce.

6: Policy Problem and Key Stakeholders

The background analysis leads to the definition of the following policy problem: not enough internationally educated health professionals are integrating successfully into Canada's health care workforce.

The stakeholders affected by this problem are internationally educated health professionals, Canadian health professionals, federal and provincial governments, regulatory bodies, education institutions and the public. Immigrant health professionals' suffer from delayed labour market integration and deskilling. Canadian health professionals work with and provide mentoring to overseas health professionals. The federal government is responsible for the immigration policy that encourages skilled workers to migrate to Canada; therefore it is in its interest to choose applicants who will fully contribute to the economy. Provincial governments often bear the burden of financing education programs that help overseas nurses and doctors overcome the barriers to employment. Regulatory bodies, on the other hand are the gatekeepers to entry into the profession in Canada and they are also mandated to protect the public. Education institutions are the ones responsible for creating programs that will bridge overseas professionals into the labour market. Finally, those overseas health professionals who are successful at integrating into the labour market will treat the public. The rest of my capstone identifies ways to successfully integrate overseas nurses and doctors into Canada's health care workforce, and proposes policies that reach this goal.

7: Methodology

The objective is to answer the following question: what are the best practices to address the barriers to labour market integration for immigrant health professionals? To determine which initiatives facilitate positive labour outcomes for immigrants trained in the health professions, I use two methodologies. Case study analysis is my primary methodology, and I examine how three countries successfully facilitated the integration of internationally educated health professionals into their health care workforce. The information for my case studies is drawn from academic literature and government reports and websites. My secondary methodology uses analytical studies to determine the impact of the case study practices. This section describes each case study used in the primary methodology and presents the analysis framework to identify best practices.

7.1 Case Study Selection

I selected three countries that share similarities with Canada, namely a public health care system, a shortage of nurses and physicians, and reliance on immigration to relieve shortages of skilled labour; they are Australia, New Zealand, and the United Kingdom. All three countries have developed policies to address the barriers to integration of immigrant health professionals; however, they have chosen different approaches. Below is a brief description of the common characteristics of these case studies.

Immigration falls under the jurisdiction of the federal (Australia), national (New Zealand), or central (UK) government. All three countries have a permanent skilled worker category, and a temporary worker category where employer sponsorship is required. All three countries also use a point system for assessing applicants' suitability for residency. Also, as part

of the immigration process, all case studies required nurses and doctors to prove English language proficiency and receive credential recognition prior to entry. Like Canada, these countries also attract overseas health professionals from the Philippines, India, South Africa, Pakistan, and non-English speaking countries. Furthermore, health professionals are regulated at the national level.

Australia and New Zealand represent the best practices for successfully integrating health professionals. Since Australia changed its immigration policy in 1996, overseas health professionals who arrived between 1996 and 2001 integrated well into the labour market; an average of 61% found employment in their field within the first five years of arrival (Hawthorne, 2006). New Zealand's health and community service is the largest employer of health professionals (27%; Wallis, 2006). In 2010, overseas nurses made up 25% of the workforce (NCNZ, 2010); in 2009, overseas doctors constituted 41% of the New Zealand health care workforce (MCNZ, 2009).

The UK represents a slightly different case for integrating overseas health professionals. In December 2010, the UK closed the Highly Skilled Worker category to overseas applicants because highly skilled workers from the European Union could fill vacant labour positions through the free mobility agreement within the EU without requiring visas. Therefore, since then only EU nationals can permanently migrate to the UK under the EU freedom of movement directive. In 2008, only 9% of overseas nurses were registered for practice. This is a decline from 2004 when 41% of registered nurses were from overseas (NMC, 2008). In 2011, only 25% of registered doctors were from overseas (GMC, 2011). Clearly the competition from free mobility policy made integration policies difficult to run.

7.2 Evaluation Framework

Four characteristics are used to determine the best practices to assess and integrate overseas health professionals into the health care workforce: immigration policy, health policy jurisdiction, credential recognition, and knowledge evaluation and programs.

Table 3: Evaluation Framework

Characteristic	**Measurement**
Immigration Policy	*Jurisdiction level:* Who has jurisdiction over immigration? *Targeting health professionals:* Is there special consideration given to health professionals? *Admission Criteria:* What criteria are used to admit skilled immigrants? *Permanent and Temporary Programs:* What program is used by health professionals to enter the country? Is there a list of approved occupations?
Health Policy Jurisdiction	Who is responsible for regulation of health occupations? Who administers and funds integration programs for health occupations?
Credential Recognition	*Jurisdiction for assessment:* • Who has jurisdiction over credential assessment? • Is there a central agency that is responsible for credential assessment? *Requirements:* • Is assessment conducted based on country of origin or curriculum of medical program? • Are health professionals required to undergo additional examinations as a requirement for licensure?
Knowledge Evaluation and Programs	*Language*: • How is language fluency tested? • What are the acceptable test scores? • Are there programs that specifically assess language ability of health professionals? • Are there preparatory programs for internationally educated health professionals? *Culture*: • Is culture in medical practice a barrier for health professionals? Are there programs that address it? *Technical knowledge*: • Are health professionals required to undergo additional training/education in the destination country? If so, how long is the additional training? • Are there special programs specifically for international health professionals, such as bridging programs?

For immigration policy I look at four aspects: jurisdiction, whether the policy targets health professionals, admission criteria, and permanent and temporary programs. For health policy

jurisdiction I examine who is responsible for regulation, and who administers and funds integration programs. Under credential recognition I explore who assesses credentials and what requirements must be met. Finally, for knowledge evaluation and programs I look at three components and initiatives: language, culture, and technical knowledge.

8: Case Study Analysis

In this section I analyse each case study by examining the characteristics identified in Table 3. A summary of the results for nurses is provided in Table 4, and for doctors in Table 5[11].

Table 4: Case Study Evaluation for Nurses

Variable	Detail	Case Studies		
		Australia	New Zealand	UK – Pre 2010
Immigration Policy	*Jurisdiction level*	Federal	National	Central
	Targeting health professionals Yes/No	Yes	Yes	Yes
	Admission Criteria	*Permanent*: Points assessment *Temporary*: Visa assessment	*Permanent*: Points assessment. *Temporary*: Visa assessment.	*Permanent*: Points assessment. *Temporary*: Points assessment.
	Permanent Programs	General Skilled Migration category	Skilled Migrant Category	Highly Skilled Workers Tier 1 (General)
	Temporary Programs	Long-term Visa 457	Work to Residence	Sponsored Skilled Worker category - Tier 2 (General)
Health Policy Jurisdiction	*Level*	*Federal*: Australian Nursing and Midwifery Council (ANMC) Nursing and Midwifery Board of Australia (NMBA)	*National*: Nursing Council of New Zealand 21 District Health Boards (DHBs) and District Health Boards New Zealand (DHBNZ)	*Central*: Nursing and Midwifery Council
	Training for IEHPs	Bridging programs funded and run through nursing institutions	No bridging programs	No specific programs. Overseas Nurses Programme administered through education institution.

[11] For detailed case study of nurses see Appendix B; for doctors see Appendix C.

Table 4. Case Study Evaluation for Nurses (continued)

Variable	Detail		Case Studies		
			Australia	New Zealand	UK – Pre 2010
Credential Recognition	*Jurisdiction for assessment*		Federal: Australian Nursing and Midwifery Council (ANMC)	National: New Zealand Qualifications Authority (NZQA) and Nursing Council	Central: Nursing and Midwifery Council (NMC)
	Requirements	Target	Overseas nurses seeking pre-migration recognition in permanent or temporary category	Overseas nurses seeking registration	Overseas nurses seeking registration
		Gaps	If cannot assess credentials must undergo competency test to prove skills.	If cannot recognize credentials must undergo competency test. May need to undergo more training.	All applicants must undergo the 20-day Overseas Nurses Programme (ONP)
Knowledge Evaluation and Programs	*Target Group*		Overseas nurses	Overseas nurses	Overseas nurses
	Language	Test	IELTS: min score of 7 OET: grade B or A	IELTS: min score of 7 OET: grade B	IELTS: min score of 7
		Program	IELTS: preparatory material OET: preparatory material	IELTS: preparatory material OET: preparatory material	IELTS: preparatory material.
	Culture	Test	No test.	No test.	No test.
		Program	Online material addressing cultural differences and practices for doctors and general public, can be useful for nurses.	No program. Suggest mentor program.	No program.
	Technical knowledge	Test	Competency based assessments (CBA)	Competency assessment	Competency assessment
		Program	CBA incorporated in bridging programs.	If gaps in training then must undergo additional training	Only the ONP is offered. Receive a mentor in the program.

Source: Hawthorne, 2001; Hawthorne, 2002; ANMC, 2010; ANMC, 2009; Iredale, 2009; Metropolis, 2003; DOHA, 2008; DIAC, 2010; OET, 2007; Zurn and Dumont, 2008; NCNZ, 2011; Narasimhan et. al., 2006; Manchester, 2007; MOH, 2009; INZ, 2011; NMC, 2010; NurseInfo, 2007; Buchan et. al., 2008; UKBA, 2011.

Table 5: Case Study Evaluation for Doctors

Variable	Detail	Case Studies		
		Australia	**New Zealand**	**UK – Pre 2010**
Immigration Policy	*Jurisdiction level*	Federal	National	Central
	Targeting health professionals Yes/No	Yes	Yes	Yes
	Admission Criteria	*Permanent:* Points assessment *Temporary:* Visa assessment	*Permanent:* Points assessment.	*Permanent:* Points assessment. *Temporary:* Points assessment.
	Permanent Programs	General Skilled Migration category	Skilled Migrant Category	Highly Skilled Workers Tier 1 (General)
	Temporary Programs	Long-term Visa 457: recruited into "Districts of Workforce Shortage."	Work to Residence	*Sponsored Skilled Worker category Overseas Qualified Doctors taking the PLAB test.*
Health Policy Jurisdiction	*Level*	*Federal*: Australian Medical Council (AMC).	*National*: Medical Council of New Zealand. The District Health Boards New Zealand (DHBNZ)	*Central:* General Medical Council (GMC).
	Training for IEHPs	No funding or endorsement of bridging programs.	"Ready for Work" Training Program developed by the Ministry of Health.	The Foundation Year 1 Programme
Credential Recognition	*Jurisdiction for assessment*	*Federal*: Australian Medical Council (AMC)	*National*: New Zealand Qualifications Authority (NZQA) and Medical Council	*Central*: General Medical Council
	Requirements Target	Overseas doctors.	Overseas doctors.	Overseas doctors.
	Gaps	If not recognized, must complete knowledge and clinical examinations.	If not recognized must pass US Medical Licensing Examination, and then also pass the NZ Registration Examination.	All must complete the Professional and Linguistic Assessments Board (PLAB). If pass granted full licensure.

Table 5. Case Study Evaluation for Doctors (continued)

Variable	Detail		Case Studies		
			Australia	New Zealand	UK – Pre 2010
Knowledge Evaluation and Programs	*Target Group*		Overseas doctors	Overseas doctors	Overseas doctors
	Language	Test	IELTS: 7 on all four components. OET: grade A or B in all four components.	IELTS: 7.5 on speaking and listening, and 7.0 on reading and writing.	IELTS: minimum score of 7 on all components in single sitting.
		Program	IELTS: preparatory material. OET: preparatory material.	IELTS: preparatory material.	IELTS: preparatory material.
	Culture	Test	No test.	No test.	No test.
		Program	Online tool for cultural education.	No specific program.	No specific program.
	Technical knowledge	Test	Competency based assessments.	Competency based assessments.	Competency based assessments.
		Program	Bridging programs.	"Ready to Work" program.	No bridging programs.

Source: Iredale, 2009; AMC, 2010; DIAC, 2010; Hawthorne, 2008; CETU, 2010; DOHA, 2008; OET, 2007;Zurn and Dumont, 2008; MCNZ, 2010; Narasimhan et. al., 2006; MOH, 2011; GMC, 2010; Buchan et. al., 2008; BMA, 2008; UKBA, 2011.

8.1 Best Cases

This sub-section examines the Australian and New Zealand case studies.

8.1.1 Immigration Policy

Australia targets overseas nurses and doctors through skilled migration to compensate for high emigration rates of Australian nurses and doctors, which began in the early nineties. Between 1995 and 2000, around 41,000 nurses arrived on a permanent or temporary basis (Hawthorne, 2001); and between 1991 and 2000, around 22,000 doctors entered Australia on a permanent or temporary basis (Iredale, 2009). The influx of immigrant health professionals prompted growing concern over deskilling and the lack of integration of these professionals into Australia's labour market. In response, Australia changed its immigration policy in the late 1990s by incorporating language and occupational skill testing as part of the immigration process.

Health professionals can obtain permanent residency through the General Skilled Migration category. However, only those who obtain pre-recognition of their credentials and prove their English language ability are eligible for this category. Applicants are assessed through the points test, and a minimum of 60% [12] is required to pass. Furthermore, nurses and doctors are awarded up to 15 additional points because these occupations are in demand (Iredale, 2009). The Long-term Visa (457) is available for nurses and doctors who do not have full registration. It allows health professionals to work in Australia temporarily for up to four years. Employers must sponsor workers and the occupation must be on the list of approved occupations. Visa applications receive priority processing if these conditions are met. Immigrating under the temporary program exempts doctors from writing additional licensing exams in Australia, and they are recruited specifically into "Districts of Workforce Shortage"; thus, they are restricted to work in areas of need. The Long-term Visa pathway is often a route to permanent immigration

[12] Refer to Appendix D for a country comparison of points assessment.

because it provides professionals with Australian work experience, and allows them to meet all regulatory requirements necessary to apply under the General Skilled Migration category.

The path to permanent immigration in New Zealand is through the Skilled Migrant category. If the health occupation is listed on the Long-Term Skill Shortage List, then the application is fast-tracked. To qualify for skilled migration health professionals must score at least 38% on the points test. Those who obtain 53%, however, are automatically selected. Additional points are given to health professionals who are already registered with a New Zealand regulatory body, and whose occupation is listed on the shortage list. Also, applicants can be awarded bonus points for New Zealand work experience (see Appendix E), if they have an employment offer in a rural or high need region, or have a minimum of two years general work experience (Zurn and Dumont, 2008). Another important category for health professionals is Work to Residence. This is a temporary program for health professionals who have an employment offer and New Zealand registration. After two years, health professionals may either renew the work permit or transfer to permanent residency (Zurn and Dumont, 2008).

8.1.2 Health Policy Jurisdiction

Australia established the Australian Nursing and Midwifery Council (ANMC) and the Australian Medical Council (GMC) at the federal level to be responsible for creating a national approach to nursing and doctor regulation[13]. The nursing and medical boards merged the separate state and territory regulatory boards into one organization (NurseInfo, 2007; DHA, 2010). This merger streamlines processes and professional standards to allow easy movement of professionals across the country. These boards also approve standards for nursing and medical education, but bridging programs are run and funded through nursing and medical institutions.

[13] Since 2010, the responsibility for registration, however, lies with the Nursing and Midwifery Board of Australia and the Medical Board of Australia, which were established through the National Registration and Accreditation Scheme.

New Zealand also has a nationalized approach to nursing and medical regulation through the Nursing and Medical Councils of New Zealand. The country is divided into twenty-one District Health Boards (DHBs), funded by the Ministry of Health, which coordinate policies and introduce a common approach to workforce planning and recruitment. The Ministry of Health also developed the *Ready to Work* training program for doctors who do not have New Zealand work experience. The program introduces them to the New Zealand health care system through classroom teaching and ward experience (MOH, 2011). Other than this program, however, the Ministry of Health no longer provides bridging programs for nurses or doctors (CETU, 2010). Additional training is undertaken at nursing and medical institutions.

8.1.3 Credential Recognition

The Australian Nursing and Midwifery Council (ANMC) and the Australian Medical Council (AMC) have jurisdiction over credential recognition for overseas nurses and doctors applying to either the permanent or temporary immigration program. To determine the equivalency of credentials during the immigration process, the Department of Immigration and Citizenship collaborates with these bodies (DIAC, 2010). They formally review and approve foreign schools that are deemed equivalent to Australian education institutions. Applicants from approved schools do not need to undergo additional assessment because their credentials are automatically recognized. Therefore, nurses immigrating from the UK, the United States, Canada, Singapore, Hong Kong, and the EU are exempt from undergoing additional competency based assessments in order to prove their skills for registration in Australia (ANMC, 2010). Doctors immigrating from the UK, the United States, Canada and New Zealand are exempt from additional medical or clinical examinations to become registered in Australia (AMC, 2010). Overseas nurses and doctors whose credentials are not recognized, must undergo competency based assessments and examinations. The AMC is also implementing a new pathway for recognition that will replace the clinical exam with a workplace performance assessment that will

permit doctors to demonstrate their clinical ability in a real Australian health care environment (AMC, 2010).

Health professionals applying to immigrate to New Zealand must undergo two separate credential assessments. The New Zealand Qualifications Authority assesses foreign credentials for immigration purposes (NZQA, 2011), whereas the Nursing Council of New Zealand and the Medical Council of New Zealand assess credentials for registration purposes. There is no direct link between these authorities. The Nursing Council assesses applications on an individual basis, and if the credentials are not recognized, the Council may require the nurse to undergo competency assessment, or a competence programme before granting registration (NCNZ, 2011). The Medical Council, on the other hand, grants provisional licences to doctors who have practiced for at least three years in a comparable health system such as Canada, the UK, the US, and the EU countries. Applicants from all other countries must pass the US Medical Licensing Examination to prove their medical knowledge, as well as the New Zealand Registration Examination to demonstrate their clinical ability.

8.1.4 Knowledge Evaluation and Programs

The IELTS academic exam is the standard test for English language proficiency for health professionals in both countries. The lowest acceptable score is 7 on all four components, and doctors must attain this score in the first sitting. Furthermore, doctors in New Zealand must score at least a 7.5 on the speaking and listening components. Australia and New Zealand also accept scores from the Occupational English Test (OET), which was specifically designed for health professionals. In both countries, nurses must pass the OET with a minimum B grade in all four components. The OET for doctors is only accepted in Australia, however, with a minimum B grade to pass. Beyond preparatory material for the IELTS and English as a Second Language classes, there are no specific language programs for health professionals. The OET provides access to sample tests and preparatory material for the exam, and it lists several independent

institutions that offer preparatory programs, but it does not endorse any of them. The onus is on the health professional to ensure they have the proper English language skills for safe practice prior to immigration.

Although cultural knowledge is recognized as a barrier to medical practice for health professionals, only Australia has developed online information materials geared specifically towards physicians and the general public. Specifically, it is recognized that English language proficiency is not always the solution to remove cultural barriers (DHA, 2008). Tolerance of cultural diversity therefore is emphasized for both overseas, and Australian trained physicians. The online tool for doctors deals with cultural and medical issues in the Australian medical workforce, including communication styles, professional ethics, and the health care system (DHA, 2008). In addition, cultural awareness training is often provided through an employer's orientation program but is not incorporated into a bridging program. In New Zealand, overseas doctors must prove their cultural competence in a program administered through one of the approved practice settings (MCNZ, 2010).

Regarding technical knowledge in both countries, nurses and doctors are required to have training in a program that is approved in length,[14] must have theoretical and practical training in generalist medicine, be able to use modern technology, and be competent to practice at a level equivalent to new graduates. Both countries, rather than only rely on written exams and credentials, moved to a competency assessment where health professionals demonstrate their skills and knowledge. This takes into consideration not only their knowledge but also their experience. If competency gaps are identified, they must undergo either additional training at an approved institution, a supervised practice placement (like the "Ready to Work" training program for New Zealand doctors), or undergo a bridging program. Only doctors with provisional

[14] Nurses must hold a bachelor level degree.

registration in New Zealand, however, are eligible for the *Ready to Work* program, otherwise no other bridging programs are available for health professionals.

8.2 The UK

This section examines the United Kingdom case. The discussion does not consider European Union nationals because they are exempt from immigration procedures and they receive automatic recognition of their credentials under EU law. It covers policies in place until 2010.

8.2.1 Immigration Policy

The United Kingdom specifically implemented a policy of international recruitment as part of a staffing strategy used to solve its nursing and physician shortages. Overseas health professionals could immigrate under one of two categories – the Highly Skilled Worker category (Tier 1 of the points system) for permanent residency, or the Sponsored Skilled Worker category (Tier 2 general of the points system) for temporary immigration.

Those applying for permanent residency do not require an offer of employment, but applicants must demonstrate that they are highly skilled, proficient in English, and can support themselves in the UK. Under the temporary immigration program, however, applicants must have a job offer from a licensed sponsor, their occupation must be on the Tier 2 (General) occupational shortage list, and they must be issued a valid certificate of sponsorship, which is obtained if the applicant scores a minimum of 67% on the points test (Home Office, 2010). The awarded points must include 10 points for English language skills and 10 points for proof of financial support while living in the UK; overseas applicants under this category are not allowed to claim state benefits while working in the UK. The result of the recruitment policy was that by 2005, around 32% of doctors and nurses were from outside the UK and the European Union (Buchan et. al., 2008). In 2006, however, registered nurses were taken off the occupational

shortage list except for nurses specializing in surgery and neonatal intensive care (Buchan et. al., 2008). The shortage list also lists physicians specializing in anaesthetics, paediatrics and general medicine.

8.2.2 Health Policy Jurisdiction

The UK registers nurses and doctors at the central level through the Nursing and Midwifery Council and the General Medical Council. The Department of Health operates on the central level and is responsible for workplace management, funding of the National Health Service, and for setting policies like the international recruitment policy. Beyond this scope, however, there are no specific programs for overseas health professionals that are developed or funded by the Department. The Overseas Nurses Programme and the Foundation Year 1 programme are developed and run through approved education institutions.

8.2.3 Credential Recognition

In the UK, the Nursing and Midwifery Council and the General Medical Council have central jurisdiction over credential recognition. Assessment for nurses is based on the country of origin, rather than the nature of the training program (Buchan et. al., 2008). All overseas nurses must complete the Overseas Nurses Programme and once they pass the program they are automatically granted registration and can enter the labour market. The Medical Council assesses doctors' qualification based on the medical program completed. Overseas doctors must also pass the Professional and Linguistic Assessments Board (PLAB) exam to prove their medical knowledge and skill before being granted either full or provisional registration and licensure to practice (GMC, 2011). Doctors applying for full registration with a licence to practice must also prove that they completed an acceptable internship; those who need to complete an internship but pass the PLAB exam are granted provisional registration and licence to practice (GMC, 2011).

8.2.4 Knowledge Evaluation and Programs

The UK requires overseas nurses and doctors to prove their English language ability before their applications are assessed. The IELTS is the only recognized language exam for health professionals. Applicants must pass with a minimum of 7 on all four components, and doctors must achieve this in one sitting. Culture is recognized as a barrier to medical practice, especially when working in a team setting, in patient management, and communication. Nurses become acquainted with the health care system and culture of practice through the Overseas Nurses Programme (NMC, 2010); doctors who hold provisional registration and licence to practice are made familiar with the health care system and culture through the Foundation Year 1 program (GMC, 2010). Beyond this, however, there are no other online tools or programs that specifically address cultural awareness.

The UK does not offer bridging programs for health professionals except for the twenty-day Overseas Nursing Program where their competency is assessed through a nursing institution. If they are lacking skills, especially clinical skills, they may be required to undergo an additional supervised placement, but it is their own responsibility to find the placement. The NMC strongly encourages overseas nurses not to come to the UK until they have secured a placement in the nursing program because spaces are limited. Overseas doctors are assessed through the Professional and Linguistic Assessments Board (PLAB) exam. Doctors who have not completed an acceptable internship in their home countries are required to enter the Foundation Year 1 program to fulfil this requirement. Registration and licensing is granted to both overseas nurses and doctors once they pass the competency assessments.

8.3 Summary of Findings

The three case studies have several important similarities with regard to each country's approach to integration of international health professionals into the labour market. To ensure positive employment outcomes for immigrant skilled workers, two types of policies are used in

the case studies: preventive policies to address the problem of integration *before* immigrants enter the country, and remedial policies that address the problem once immigrants are in the country (Svizzero and Tisdell, 2002). Below I discuss the key findings from the case studies which are characteristics present in two or all of the case studies, as well as the initiatives that are recognized as the most effective.

- ❖ Finding 1: To prevent poor labour market outcomes, need to recognize that credentials should be recognized prior to immigration.

All three case studies allocated bonus points for occupations on occupational shortage lists. Two of the case studies gave bonus points for obtaining registration before immigrating to the country. One case study also used a collaborative approach between the Department of Immigration and the Councils responsible for credential assessment and registration for nurses and doctors. Also, all of the case studies complete credential recognition at the national level. This creates a streamlined immigration process and provides international health professionals with a realistic expectation of their ability to enter the destination country's labour market, before they make the commitment to migrate. One case study even eliminates the requirement for re-training in the destination country if credentials are approved prior to immigration.

Hawthorne (2006) conducted a statistical analysis based on the 2001 Australian Census, which indicated that labour market outcomes for recently arrived skilled immigrants improved by 50% since the immigration policy's transformation. By 2001, 73% of UK nurses, 66% of Indian nurses, 63% of South African nurses, 49% of South Asian nurses, and 52% of Chinese nurses were working in their occupation. The results were equally high for doctors, with 66% Indian, 59% Hong Kong, and 57% Taiwanese doctors working in their field. These employment rates were achieved within five years of arriving in Australia.

- ❖ Finding 2: Acknowledged the need for strong level of language proficiency before arrival.

All case studies increased the acceptable scores to 7 on the IELTS for both doctors and nurses immigrating to their country. Accepting only the IELTS creates consistency and equity among international health professionals. One case study developed the Occupational English Test for health professionals to assess their ability to speak English and communicate in a health care setting. This is a significant step in addressing the barriers to language and communication faced by international health professionals.

An Australian analysis of the occupational test data showed that 33% of doctors and 67% of nurses were turned away at the point of entry. The results also showed that those who did gain entry succeeded in gaining immediate employment (Hawthorne, 2005). Using an occupational English test can thus create faster positive labour market outcomes for overseas health professionals.

- ❖ Finding 3: Recognise gaps in technical knowledge.

All case studies shifted to competency based assessments for international health professionals. Those whose credentials are not recognized or who have identified gaps in their training complete a bridging program. Bridging programs that offer work experience in the country's health care system are seen as particularly effective because they help the international health professional meet the country's work experience requirement.

A case study of the overseas nurses' labour market outcomes in Australia shows that between 1988/1989 and 1994/1995, only 29% of those who arrived from non-English speaking countries were recommended for immediate registration. Subsequent survey analysis showed that after the introduction of bridging programs, nurses who passed registration exams increased from 55% to 86% in the New South Wales, and up to 95% in the Victoria regions (Hawthorne, 2002). Furthermore, up to 95% of nurses received full registration upon completion of a three-month course (Hawthorne, 2002). Most success was noted in programs that facilitated clinical

placements, and not where nurses and doctors were responsible for finding programs willing to accept them. In New Zealand, for example, nurses must negotiate an instruction agreement with an education institution and notify the Nursing Council of the arrangements. These findings show that explicitly recognising gaps in technical knowledge can improve labour market outcomes significantly.

Although nurses and doctors undergo different training programs, they face the same need to overcome gaps in their training; therefore, analysis regarding technical knowledge should consider these two occupations together.

- ❖ Finding 4: Recognise the need for more information.

All three case studies recognize that culture is an important barrier for health professionals working in countries with diverse societies where appropriate responses are required, but only one case study developed an online tool that addresses cultural awareness specifically for health professionals. The responsibility for ensuring cultural competence, however, lies with the employer. There are no evaluative studies of this tool. It can also be surmised that although culture presents a barrier to practice, it is not a barrier to labour market outcomes.

8.4 Implications for Canada

There are several differences between the case studies and Canada in their approach to integration of internationally educated health professionals. Although Canada uses the points system for assessment of applicants in the Skilled Worker Class, the case study countries go further by first, requiring that international health professionals obtain credential recognition and an English language assessment as part of the immigration process, and second, by giving bonus points to candidates who meet these requirements. Canada does not have a unified federal approach for credential assessment. Each provincial regulatory body and province is responsible

for developing its own criteria for assessment. Also, there are no language tests designed specifically for health professionals; only the CELBAN, which is an option in British Columbia, is available, and only for nurses. Finally, Canada does not have online resources for cultural awareness targeted at health professionals. Canada, however, does address finding number 3, the gap in technical knowledge.

The differences between the characteristics of Canada's approach and the characteristics of the three case studies lead to possible policy options, which are discussed in the next sections.

9: Policy Objectives, Criteria and Measures

This section describes the long-term and short-term policy objectives required to address the barriers to labour market integration for immigrant health professionals, and it explains the criteria and measures used for analysing the proposed policy options.

9.1 Policy Objectives

I identify short and long-term objectives to help select feasible policy alternatives and to guide my evaluation of them. For this study, the short-term is defined as occurring within five years of policy implementation, and long-term as occurring within ten years of implementation.

There are two long-term objectives:

1. Raise the employment rate of internationally educated health professionals to 60% after 5 years of arriving in Canada.
2. To avoid deskilling because of non-immediate recognition of foreign training and ensure rapid full integration of overseas nurses and doctors.

To achieve the long-term objectives, short-term goals concentrate on minimizing barriers for overseas health professionals specifically, language, institutional, credential recognition, and competency gaps.

9.2 Criteria for Analysis

I selected five criteria to evaluate which policy option will best achieve the above objectives. They are: cost, effectiveness, key stakeholder acceptability, legal feasibility, and horizontal equity. For each criterion I define a benchmark, which corresponds to a rating of high, medium or low. Every rating receives a score; a policy rated high receives a score of 3, one rated medium receives a score of 2, and a low rating receives a score of 1. The acceptability criterion

has three components which are weighed equally, thereby allowing stakeholders to choose which is more important and viable for them; the final score for acceptability is the average of the three components. The total score is then calculated to rank the policy options. The policy with the highest score is recommended at the end of the analysis. Table 6 summarizes the criteria and measures used for analysis.

Table 6: Criteria and Measures

Criteria	Definition	Measurement	Benchmark	Score
Cost				
Cost of implementation	Financial cost for implementing the policy	Cost of employees and resources needed to implement the policy	< $699,000………………	High (3)
			Between 700,000 and 799,000…………………..	Medium (2)
			> 800,000………………..	Low (1)
Effectiveness				
Minimization of barriers to employment	How well the policy decreases the barriers to employment for overseas health professionals	Number of barriers addressed through policy • Language • Institutional • Credential Recognition • Competency Gaps	4 barriers are addressed…	High (3)
			2-3 barriers are addressed.	Medium (2)
			0-1 barrier is addressed….	Low (1)
Key Stakeholder Acceptability				
Acceptability among federal and provincial governments	Who will be responsible for administering the policy?	The extent to which the policy is supported by both levels of government	Support by both levels of government………………	High (3)
			Support by one level of government………………	Medium (2)
			No support from either level of government……	Low (1)
Acceptability among regulatory bodies	How well does the policy address the mandate to protect the public and ensure all professionals meet standards?	The extent to which the policy is supported by regulators	All regulators support the policy……………………	High (3)
			Only two regulators support the policy………	Medium (2)
			Only one, or no regulator supports the policy………	Low (1)

Criteria	Definition	Measurement	Benchmark	Score
Acceptability among education institutions	The level of involvement of key education institutions	Do education institutions need to create or alter programs for overseas health professionals?	Program already exists, nothing needs to be added…………………….. Program exists, but need to add training modules… Program does not exist, need to create one………	High (3) Medium (2) Low (1)
Acceptability among Canadian health professionals	The extent to which the policy is supported by Canadian health professionals because it addresses key components to working with IEHPs	The policy addresses • Technical skills • Language • Canadian Medical Culture	Addresses all 3 components…………….. Addresses only technical skills and language……… Addresses only technical skills……………………..	High (3) Medium (2) Low (1)
Acceptability among the public	The extent to which the policy is supported by the Canadian public because it addresses key components to being treated by IEHPs	The policy addresses • Professional skills • Cultural awareness • Transparency in assessment	Addresses all 3 components…………….. Addresses only professional skills and cultural awareness………. Addresses only professional skills………..	High (3) Medium (2) Low (1)
Legal Feasibility				
Legislative Requirement	Can the policy be implemented within the current legislation?	Extent to which the policy fits into the current legislative framework	Within current legislation………….. Requires legislative amendment………….. Requires new legislation…………..	High (3) Medium (2) Low (1)
Horizontal Equity				
Equity among the various health occupations	Does the policy have positive impacts for all health occupations?	Equal access to all health occupations	Applicable to all health occupations...................... Only applicable to nurses and doctors……………….. Applicable to only one health occupation………..	High (3) Medium (2) Low (1)

Cost: The cost of each policy option is the number of additional employees and resources needed to implement the policy. There may be a one-time setup cost for each alternative, but I only evaluate the annual operational cost of each because this is what is necessary to sustain the policy in the long run. The benchmark for cost is based on the Government of Canada's funding to the College of Nurses of Ontario for the implementation of two provincial projects aimed at helping overseas nurses enter the labour market. The college received $776,000 (HRSDC, 2010). Using this sum as the benchmark assumes that the Government of Canada would extend the same funding to British Columbia for policy implementation.

Policies where the annual cost of hiring additional employees and developing resources is greater than $800,000 are considered low and assigned a value of 1. Those between $700,000 and $799,000 are considered medium and assigned a value of 2, and those that cost less than $699,000 are deemed high and assigned a value of 3.

Effectiveness: This criterion assesses how well the policy decreases the barriers to labour market integration for overseas health professionals. The measure is the number of barriers addressed through the policy. A policy that considers all 4 barriers (ie: language, institutional, credential recognition, competency gaps) is rated high and assigned a value of 3. One that addresses 2-3 barriers is rated medium and assigned a value of 2, and an alternative that addresses only one, or no barriers is rated low and assigned a value of 1.

Key Stakeholder Acceptability: The policy analysis must consider the acceptance of five groups of key stakeholders: the federal and provincial governments, regulatory bodies, education institutions, Canadian health professionals, and the public in Canada. The federal government has jurisdiction over immigration policy, therefore any policy alternative that considers changes to immigration requirements will need the approval of the federal government. Provincial governments hold jurisdiction over health care provision and funding of education, hence policies affecting these areas will require approval from the province. Furthermore, any policy that is

national in scope will require coordination of both levels of government. An alternative has high acceptability (value = 3) if both levels of government support it, medium acceptability (value = 2) when only one level of government supports it, and low acceptability (value = 1) if neither level of government supports the policy.

The regulatory bodies' acceptance of the policy alternative is also essential because their primary mandate is to protect the public through the establishment of medical standards practiced by licenced professionals. Health professionals wishing to practice in any province must meet these standards and obtain registration from the regulator. Therefore, policies that are perceived to lower the standards of practice already in place are unlikely to be accepted, whereas policies that adhere to the standards or improve upon them will be more likely to gain approval. If all health regulators support the policy than it will be rated high and assigned a value of 3; if only two regulators support it than it will be rated medium and assigned a value of 2; and, if only one, or no regulator supports it, then it will be rated low and assigned a value of 1.

Education institutions are important stakeholders because they develop and administer competency based assessments and training programs for overseas health professionals. Education institutions' acceptability is measured based on the need to create a new program or to add training modules to a program already in place. If a program is already in place and nothing needs to be added, then the policy has high acceptability and the assigned value is 3. If a program already exists but it needs to be modified with a training module, then the policy has medium acceptability and its assigned value is 2. If a new program needs to be created than the acceptability is low and the assigned value is 1.

Canadian health professionals are also important stakeholders because they work with overseas health professionals. Their acceptability is measured by the likelihood of their support for a policy that would increase the number of immigrant health professionals working in the Canadian health care setting. It addresses the following key components: technical skills,

language and Canadian medical culture. If all components are addressed then it has high acceptability and is assigned a value of 3. If only technical skills and language are addressed, then the policy is rated as medium and assigned a value of 2. If only technical skills are addressed, it is rated as low and assigned a value of 1.

Finally, acceptance from the Canadian public is also essential because immigrant health professionals treat them. The Canadian public is diverse and comprises of those whose roots are long established in Canada, those from many different ethnic backgrounds, and those who are recent immigrants. Their acceptability is measured by the extent of support for a policy that would increase the number of overseas health professionals practicing in the Canadian health care workforce. It addresses the following key components: professional skills, cultural awareness, and transparency in assessment. If all three components are addressed, then it is rated as high and assigned a value of 3. If only professional skills and cultural awareness are addressed then it is rated medium and assigned a value of 2; finally if only professional skills are addressed, then it is rated low and assigned a value of 1.

Legal Feasibility: This criterion evaluates the difficulty of implementing a policy within the IRPA. It is measured on the degree to which the policy fits into the legislative framework. If a policy is within the current legislation, then it is highly feasible and assigned a value of 3; if it requires a legislative amendment than it is moderately feasible and assigned a value of 2. A policy that requires new legislation has low feasibility and is assigned a value of 1.

Horizontal Equity: This criterion addresses health occupations other than nursing and medicine like pharmacists, dentists, occupational therapists etc. All immigrant health professionals potentially face the same barriers to labour market integration; therefore the evaluation must consider the policy's impact on these occupations. Equity is measured by the ability of other health occupations to adopt the policies into the context of their practice. High equity (value = 3) means that the policy applies to all health occupations; medium equity (value =

2) means that the policy applies only to nurses and doctors, and low equity (value = 1) means that the policy applies to only one health occupation.

10: Policy Options and Analysis

This section suggests and evaluates three policy options based on the criteria and measures outlined above. Section 10.4 summarizes the policy analysis.

10.1 Policy Option 1: Integrate Credential Recognition into the Federal Immigration Process

This policy follows the preventive approach. Applicants under the Skilled Worker category will be required to receive credential recognition as part of the immigration process. Citizenship and Immigration Canada will collaborate with a national credential registry body, which will assess the applicant's knowledge and skills, and determine if there is a need for further training before moving to Canada. As part of this process, applicants will also be required to prove their English language proficiency for practice in the health care environment. Presently, they must only demonstrate a pass on the IELTS General Training exam, which is below the standard required for professional practice. The required pass for health occupations will be raised, to at least a score of 7 on the IELTS Academic exam. Applicants would be asked to submit all required documentation from within their home country, thus avoiding delays. Physicians already have the Physicians Credential Registry of Canada (PCRC) that can perform this task, but nurses will need to establish a national credential recognition body. This can be accomplished using the PCRC as an example. Up to 10 additional points will be assigned for credential recognition. Canada will also contribute in foreign aid to help offset the cost of additional training for potential immigrants who do not gain credential recognition prior to immigration. Finally, to address the issue of the lack of information prior to immigration, the Working in Canada website will be translated into the languages of the principal immigrant countries.

Cost: This policy does not require additional immigration personnel because the credential recognition bodies will be responsible for providing assessments. Because the PCRC already exists and receives annual funding, it will not be incorporated into the cost calculation. In 2005, the Ministry of Health provided $1,403,601 over four years, or $350,000 per annum, to Manitoba to simplify assessment processes (Health Canada, 2006). Because an initiative to standardize provincial credential recognition for nurses is already underway nationally, this amount can be added to complete the establishment of a national nursing credential recognition body. Therefore, the total annual cost for integrating credential recognition into the federal immigration process will be $350,000.

Foreign aid funding will be based on CIDA's "Strengthening Higher Education Stakeholder Relations in Africa" project, which allocated $2.2 million over three years ($733,000 per annum) for the improvement of university programs (CIDA, 2010). Since Africa is already receiving foreign aid, it will not be included in the cost calculation. Foreign aid will be extended to Asia, particularly India, China, and the Philippines, because overseas health professionals from these countries experience the lowest employment rates in Canada as shown in Section 3. Because the African foreign aid is for all university training, not only health, the funding for Asia will be divided by 1/3[15] to reflect only the costs of upgrading courses in health occupations. Therefore, the annual cost for foreign aid to Asia will be $240,000.

Translating the Working in Canada website is a one-time fixed cost, hence it will not be included in the cost calculation. The total annual operating cost for this policy is $590,000, which is below the cost benchmark, therefore the policy rates high (value = 3).

Effectiveness: Only applicants whose credentials are recognized and who meet language proficiency requirements will be granted permanent residency in the Skilled Worker Class.

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[15] This number is chosen arbitrarily and a more precise evaluation of the policies should include a calculation of the number of immigrants that would need to be trained in Asia, and the number of courses that would be needed to upgrade their technical and cultural skills.

Those who need to undergo additional training because of insufficient knowledge and skills, can complete this training before arriving in Canada, or by immigrating as a student with the intent of completing a nursing or medical program here, thus addressing the competency gaps barrier. This policy does not, however, address institutional barriers such as, Canadian work experience. This policy ranks medium (value = 2) because it only addresses three barriers to employment.

Key Stakeholder Acceptability: This policy is likely to receive support from both the federal and provincial governments. The change to immigration policy will be small because credential recognition bodies will be responsible for assessment. The federal government has also shown its commitment to minimizing the barrier to credential recognition, therefore, it is likely to support the next step of incorporating this process into the immigration procedure. Provincial governments will also support the policy because it reduces the need of additional funding for bridging programs since eligible applicants will meet the education, skill and language requirements for their occupation before arrival. This policy ranks high for acceptability (value = 3) for provincial and federal governments.

All regulatory bodies will support the policy because it adheres to the standards of professional practice, reduces inefficiency in the assessment process, and encourages qualified professionals to seek registration. Furthermore, nursing regulators across Canada have already begun collaboration on developing common approaches to foreign credential recognition and creating a database of all approved programs to create a faster assessment process. Therefore, they are likely to support the next step of creating a national credential recognition body, similar to the PCRC. The policy ranks high (value = 3) for regulatory bodies.

Education institutions will support the policy because it does not require changes or additions to existing programs for immigrant health professionals. Costs to education institutions for additional training would also be offset to CIDA through foreign aid aimed at improving university nursing and medical programs in developing countries. This policy could also

potentially generate revenue for these institutions if health professionals arrived on a student visa to upgrade their skills, and they could simplify their bridging programs. Therefore the policy ranks high (value = 3) for education institutions.

Canadian health professionals would support the policy because it would ensure that only those who are qualified and meet all education, registration, and language requirements immigrate to Canada and gain entry into the health care workforce. The training programs in their home countries, that will be made possible through the provision of foreign aid, would also include a module on Canadian health care system and culture. This would decrease communication barriers between Canadian and immigrant professionals working in the same health care team. It would also decrease the amount of time Canadian health professionals need to spend to mentor and help overseas health professionals adapt to the workplace, thus improving working relationships. An increase in overseas health professionals would also decrease the workload of Canadian health care staff who are overburdened because of the nursing and physician shortages. Therefore the policy ranks high (value =3) for Canadian health professionals.

The Canadian public is likely to support this policy option. Some of the public would support the policy because it ensures that only qualified health professionals immigrate to Canada, therefore the quality of care is less likely to be compromised. Also, because the policy favours those who are likely to enter the labour market quickly, it reduces the need for bridging and language courses, which are in part funded by taxes paid by the public; therefore a decrease in integration programs would result in a distribution of tax revenue to other programs and services that are important to the public. Some of the public, however, could support the policy because it reduces barriers for those immigrating from developing and non-English speaking countries through the provision of foreign aid to develop training courses in health. Recent Canadian immigrants from developing countries who may not have English language fluency that

enables them to access Canadian health care, or effectively communicate their symptoms to an English speaking health professional, would benefit from culturally sensitive health care provided by overseas health professionals. Furthermore, because of the establishment of national credential recognition bodies that would have clear and unified standards, and because international training programs would be developed along Canadian standards, there would be transparency and consistency in the assessment of credentials. This would lead to a fairer assessment process, and might reduce the perception of discrimination amongst the public and overseas health professionals. The policy thus ranks high (value =3) for the Canadian public.

The average for stakeholders is thus 3 or high.

Legal Feasibility: The legislation will need to incorporate a provision for credential recognition in the IRPA, and there will be a need for an information sharing agreement between CIC and the credential recognition body. Finally, an amendment will be required to allocate the ten bonus points. The policy thus ranks medium (value = 2).

Horizontal Equity: This policy is highly equitable (value = 3) because it can be extended to all health occupations.

10.2 Policy Option 2: Increased Access to Bridging Programs

This policy is a remedial policy, which addresses the need for additional training when assessment of international health professionals indicates a deficiency in medical knowledge and skills. For example, British Columbia runs only one program, twice a year, through Kwantlen Polytechnic University for overseas nurses. St. Paul's Hospital offers only thirteen residency positions for the top 35 overseas doctors who complete the IMG-BC Program; this means that only 37% of overseas doctors can apply for a BC residency position. This policy will add a third round of Kwantlen's program and add 8 residency positions, which will allow 60% of overseas doctors to apply. These bridging programs will familiarize health professionals with the

Canadian health care system, prepare for licensing exams, and connect them with employers through supervised work placements. Raising tuition for bridging programs to offset costs to government and education institutions responsible for running them is also a possibility, but this can potentially create another barrier for those who cannot afford high tuition, therefore this option does not include higher tuition rates.

Cost: The Kwantlen bridging program offers ten courses over three semesters. Three of the courses are theory related, and three are experience related. The theory and experience courses will require one additional professor each (total 2 professors). One course is the practicum, therefore, an additional employee will not be assigned to teach it. This leaves three courses that will each require an additional professor. In total, to run a third iteration of the bridging program will require 5 additional staff. According to Kwantlen University's Collective Agreement (2007), full-time faculty members earn $84,896 per annum. The total annual cost for teaching an additional iteration is: $84,896 x 5 = $424,480. St. Paul's Hospital will need to hire two more professors to accommodate 8 more residents (4 residents per professor). According to Statistics Canada (2010), a full medical professor at the University of British Columbia earns $154,346 per annum. The total annual cost of hiring two more professors is: $154,346 x 2 = $308,692.

The provincial government funds residents' salaries over the course of their post-graduate training. According to the Collective Agreement (2006-2010), the average annual resident salary is $51,371 (PAR-BC, 2006). The total cost for admitting 8 more residents is: $51,371 x 8 = $410,968.

The cost for the policy is: $424,480 + 308,692 + 410,968 = $1,144,140. This is multiplied by 2.5[16] to make the policy proportionate for the rest of Canada, therefore the total cost

[16] 2.0 accounts for British Columbia and Ontario, which receive the largest proportion of new immigrants, and 0.5 accounts for the remaining provinces in Canada.

for the policy is: $2,860,350. This is greater than the cost benchmark, therefore the policy rates low (value = 1).

Effectiveness: Professionals whose credentials are not completely recognized can gain full recognition once they pass a bridging program. These programs also provide training in knowledge and skills that the applicant is lacking. Finally, they address institutional barriers by providing access to Canadian work placements, residencies, and an orientation to the health care system. Language proficiency, however, is not specifically addressed through this option because it is a prerequisite for participation in the program. This policy rates medium for effectiveness (value = 2) because it only addresses three barriers to labour market entry.

Key Stakeholder Acceptability: Only the federal government supports it because the policy does not require its involvement. The provincial government is unlikely to approve of the policy because it requires increased funding to Kwantlen University, and funding for the eight residency positions at St. Paul's Hospital. Therefore, the policy rates medium (value = 2) for government acceptability.

Regulatory bodies would support the policy because it would ensure that applicants meet professional standards, thereby ensuring public safety. Regulators from other health occupations will also support the policy because it can be adapted to their professional requirements, and it ensures that qualified professionals are working in diverse health teams. The policy rates high (value = 3) for regulatory acceptability.

Kwantlen University would need to add training modules to their program if its frequency increased. It would also need to hire additional instructors to run the program three times a year. St. Paul's Hospital would also need to hire additional staff to accommodate eight more doctors. This involves more administration and coordination. Therefore education institutions have medium acceptability (value = 2).

Canadian health professionals would support this policy because it would ensure that overseas nurses and doctors will meet professional standards and will be acquainted with the Canadian health care system and culture through class work and through work placements; this means that they will be likely to practice safely, and will require less orientation and mentoring from Canadian health professionals when they enter the workforce. Therefore the Canadian health professionals have high acceptability (value = 3).

The Canadian public will support the policy because it will ensure that overseas health professionals have the necessary training and orientation in the Canadian health care system that is required for safe practice. Those who would prefer to receive health care from a professional that is of the same ethnic and linguistic background would also support this policy because it would increase the amount of overseas professionals from diverse backgrounds. Also, there would be transparency in the type of training received by overseas health professionals, and it would become less likely that they could be discriminated against based on their country of origin. Therefore, this policy rates high for Canadian public acceptability (value = 3).

The average for the stakeholder acceptability is 2.6, therefore the policy rates medium.

Legal Feasibility: No amendments are required to increase the frequency of programs, or the amount of residency spaces. This policy, thus rates high (value = 3) for legal feasibility because it would operate within the current legislative framework.

Horizontal Equity: This policy rates medium (value = 2) for equity because it only applies to nurses and doctors. Expanding the policy to other health occupations would cost more, therefore other health occupations could not easily adopt it.

10.3 Policy Option 3: Develop an Occupational English Test for Health Occupations

This policy option is a remedial policy that addresses the barrier of English language proficiency in the health care environment. The Canadian English Language Benchmark Assessment for Nurses is already available. This policy would extend the assessment to doctors. It will require the development of preparatory classes and materials on language and communication in the Canadian health care context. Furthermore, this policy can be extended to other health occupations in the future.

Cost: The CELBAN is administered through Kwantlen University. To extend the exam to doctors, I estimate that six additional staff would be required to administer the test for Canada. In 2009 the annual wage for persons employed in Education was $45,643; multiplied by six, employing additional assessors would cost $273,858 annually. Development of preparatory classes and material for doctors would cost $79,279; this is how much the federal government awarded the Canadian Language Benchmarks for developing competency tools for English as a second language (PWGSC, 2010). The total cost for this policy will be: $273,858 + $79,279 = $353,137. The total cost is less than $699,000 annually, therefore it ranks high (value = 3).

Effectiveness: This policy ranks low (value = 1) on effectiveness because it only addresses language proficiency.

Key Stakeholder Acceptability: Both federal and provincial governments will support the policy because the framework for developing language assessments is in place, it will only require expansion to other health occupations with minimal additional funding and coordination from the federal and provincial governments. Therefore it ranks high (value =3) for government acceptability. All regulatory bodies will also support the policy because it reinforces the requirement for strong English language skills in the health care environment, therefore it ranks high (value = 3). Education institutions will need to add training modules for physician specific

medical terminology, therefore the policy rates medium (value = 2). Canadian health professionals will only partially support this policy because it only ensures that overseas nurses and doctors will have the English language proficiency to communicate effectively in the health care environment; it does not address technical skill or knowledge of the Canadian health care system and culture, therefore the policy rates low (value = 1). The Canadian public will also only partially support this policy because it only ensures that overseas health professionals can communicate effectively with them and with other members of the health care team to coordinate care; it does not ensure that overseas health professionals have the necessary professional skills or cultural awareness needed to provide quality care, and there is no transparency with regard to their training or assessment of it, therefore the policy rates low (value = 1). Overall, this policy ranks medium for acceptability, with an average value of 2.

Legal Feasibility: This policy rates high for legal feasibility because it would operate within the current legislative framework. No amendments are required to develop new language modules.

Horizontal Equity: This policy rates medium (value = 2) for equity because it is only extending occupation specific language testing to doctors.

10.4 Evaluation Summary

Table 7 summarizes this policy analysis using the three policy options and the established criteria and measures.

Table 7: Policy Evaluation Matrix

	Policy Option 1:Integrated Credential Recognition	**Policy Option 2: Access to Bridging Programs**	**Policy Option 3: Occupational English Test**
Cost			
Implementation Cost	High 3	Low 1	High 3
Effectiveness			
Minimized barriers to employment	Medium 2	Medium 2	Low 1
Stakeholder Acceptability			
Federal and Provincial Government Acceptability	High 3	Medium 2	High 3
Regulatory Body Acceptability	High 3	High 3	High 3
Education Institution Acceptability	High 3	Medium 2	Medium 2
Canadian Health Professionals' Acceptability	High 3	High 3	Low 1
Canadian Public Acceptability	High 3	High 3	Low 1
Average	3	2.6	2
Legal Feasibility			
Legislative Requirement	Medium 2	High 3	High 3
Horizontal Equity			
Health Occupation Equity	High 3	High 2	High 2
Total (out of 15)	**13**	**10.6**	**11**

10.5 Policy Recommendation

The recommended policy based on the policy evaluation is the Integration of Credential Recognition into the Federal Immigration Process. This policy received the highest total value. Implementation costs for this policy are low, which makes it attractive. Also, it addresses three of the most important barriers to employment faced by internationally educated health professionals: language proficiency, credential recognition, and competency gaps. Furthermore, because applicants are required to undergo assessment prior to arrival, and because they must demonstrate a high level of language proficiency, they are presented with a more realistic depiction of working in a regulated occupation in Canada. Through the provision of foreign aid, the policy also addresses the issue of exclusion of health professionals from countries that may not have health training that meets Canadian standards. As a result, only strong candidates, who achieve the long-term policy objective of entering the labour market, will be selected.

11: Conclusion

Despite Canada's shortage of health professionals and the policy initiative aimed at filling it through the economic immigration of overseas nurses and doctors, internationally educated health professionals arriving in Canada face four key barriers to labour market integration: language, institutional, credential recognition and competency gaps. In this capstone I explored initiatives that could help overcome these barriers and successfully integrate overseas health professionals. Through a case study analysis of Australia, New Zealand and the United Kingdom I discovered that successful integration into the labour market is possible. After detailed analysis I proposed three policy options for Canada: integrating credential recognition into the federal immigration process, increasing access to bridging programs, and development of occupational language testing for health professionals. Using a set of criteria and measures, I analysed each policy and concluded that integrating credential recognition into the federal immigration process would best address the labour market outcomes of overseas health professionals coming to Canada.

Shortcomings of the study are that it only examines the nursing and medical profession, but other health occupations likely face the same barriers to labour market integration. Future studies should examine the labour market outcomes of all health professionals. As well, an evaluation of the programs and initiatives currently underway should be conducted to ascertain what is, and is not, working in Canada. Ensuring positive employment outcomes for overseas health professionals will require a commitment and collaboration of all key stakeholders.

Appendices

Appendix A: Canada’s In-Demand Occupation List

0631	Restaurant and Food Service Managers
0811	Primary Production Managers (Except Agriculture)
1122	Professional Occupations in Business Services to Management
1233	Insurance Adjusters and Claims Examiners
2121	Biologists and Related Scientists
2151	Architects
3111	Specialist Physicians
3112	General Practitioners and Family Physicians
3113	Dentists
3131	Pharmacists
3142	Physiotherapists
3152	Registered Nurses
3215	Medical Radiation Technologists
3222	Dental Hygienists & Dental Therapists
3233	Licensed Practical Nurses
4151	Psychologists
4152	Social Workers
6241	Chefs
6242	Cooks
7215	Contractors and Supervisors, Carpentry Trades
7216	Contractors and Supervisors, Mechanic Trades
7241	Electricians (Except Industrial & Power System)
7242	Industrial Electricians
7251	Plumbers
7265	Welders & Related Machine Operators
7312	Heavy-Duty Equipment Mechanics
7371	Crane Operators
7372	Drillers & Blasters – Surface Mining, Quarrying & Construction
8222	Supervisors, Oil and Gas Drilling and Service

Appendix B: Detailed Nurse Case Study

Variable	Detail	Case Studies		
		Australia	New Zealand	UK – Pre 2010
Immigration Policy	*Jurisdiction level*	Federal	National	Central
	Targeting health professionals Yes/No	Yes	Yes	Yes
	Admission Criteria	*Permanent:* Points assessment at point of entry. +15 points because occupation in demand. *Temporary:* Visa assessment.	*Permanent:* Points assessment. Additional points for occupations recognized prior to arrival and that are on shortage list; if listed on shortage list immigration is facilitated. *Temporary:* Work permit assessment.	*Permanent:* Points assessment. *Temporary:* Points assessment.
	Permanent Programs	General Skilled Migration category. Need pre-recognition of credentials and prove language proficiency before entering Australia. Non-English speakers have low immediate recognition rate.	Skilled Migrant Category. Need at least 100 points, if 140 automatically accepted. Priority given to those with NZ experience and qualifications (must be registered, or eligible to register, with NZ Nursing Council). Must have job offer or minimum 2 yrs work experience.	Highly Skilled Workers Tier 1 (General). Do not need an offer of employment but must demonstrate that highly skilled, proficient in English, and can support oneself while living in the UK.

Variable	Detail	Case Studies		
		Australia	New Zealand	UK – Pre 2010
	Temporary Programs	Long-term Visa 457 for those who don't have full registration. Employer sponsored, occupation must be on approved occupation list. Can work for up to 4 yrs. Visa applications receive priority processing if occupation on list. Temporary migration is pathway to permanent migration for those with good education.	Work to Residence: For those who have offer of employment and NZ registration. After two years can renew work permit or transfer to permanent residency.	Sponsored Skilled Worker category. Must have job offer from a licensed sponsor, and occupation must be listed on Tier 2 (General) occupational shortage list. If applicant scores minimum of 70 points on the test, then receive a valid certificate of sponsorship. Tier 2 lists: surgery and neonatal intensive care for nursing.
Health Policy Jurisdiction	*Level*	*Federal*: Australian Nursing and Midwifery Council (ANMC), administers national approach to nurse regulation. Nursing and Midwifery Board of Australia (NMBA): since 2010 responsible for registration. Established through National Registration and Accreditation Scheme to be responsible for registering nurses in all of Australia, and for accrediting education institutions across the country to streamline process and allow for easy movement of professionals from one region to another.	*National*: Nursing Council of New Zealand, national nursing regulator. Ministry of Health provides funding on national level to the 21 District Health Boards (DHBs) who are responsible for planning, purchasing, and provision of health care. The District Health Boards New Zealand (DHBNZ) coordinates the DHBs' policy, and introduces common approach to workforce planning and recruitment.	*Central:* Nursing and Midwifery Council, national nursing regulator. Department of Health is responsible for workplace management, funding of the National Health Service (NHS), and setting health workforce policies (ie: international recruitment policy).

Variable	Detail		Case Studies: Australia	New Zealand	UK – Pre 2010
	Training for IEHPs		Does not provide funding or special programs for overseas nurses. Bridging programs are funded and run through nursing institutions.	Ministry of Health no longer provides bridging programs for nurses.	No specific programs for overseas nurses. Overseas Nurses Programme is administered through approved education institution.
Credential Recognition	*Jurisdiction for assessment*		Federal: Australian Nursing and Midwifery Council (ANMC)	National: New Zealand Qualifications Authority (NZQA) assesses credentials for immigration purposes only. Nursing Council of New Zealand provides professional registration. No link to NZQA.	Central: Nursing and Midwifery Council (NMC)
	Requirements	*Target*	Overseas nurses seeking pre-migration recognition in permanent or temporary category. UK, US, Canada, Singapore, Hong Kong and EU nurses are exempt from additional competency based assessments for purpose of credential recognition. Must hold bachelor level degree in generalist nursing; ability to practice at level of new Australian graduate.	Overseas nurses seeking registration with the Nursing Council. Australian nurses are exempt because of reciprocal registration agreement. Applicants must complete program that is similar in content and length to a NZ nursing degree. English language competence is a minimum standard before the application is assessed.	Overseas nurses seeking registration with the NMC. EU nationals are automatically recognized because of mutual recognition of qualifications directive.
		Gaps	Non-English speakers require more time to receive credential recognition; rejected because of a lack of research on calibre of nursing programs in source countries, not because they had lack of training. Those	Assessed on individual basis. Applicants' whose credentials are not recognized must undergo competency based assessment, and if needed a competency	Assessment based on country of origin, do not consider academic level equivalency. All applicants must undergo the 20-day Overseas Nurses

Variable	Detail		Case Studies		
			Australia	**New Zealand**	**UK – Pre 2010**
			whose credentials cannot be assessed must undergo competency assessments to prove skills.	programme before being granted registration. May need to undergo additional training at a NZ nursing institution.	Programme (ONP). Most nurses need more than 20 days to complete, and to successfully pass.
Knowledge Evaluation and Programs	*Target Group*		Overseas nurses	Overseas nurses	Overseas nurses
	Language	*Test*	IELTS: minimum score of 7 on all components. OET: grade B or A in all components.	IELTS: minimum score of 7 on all components. OET: grade B in all areas.	IELTS: minimum score of 7 on all components. Nurses from Australia, New Zealand, the US, and Canada must also pass.
		Program	IELTS: preparatory material. OET: preparatory material and sample tests; independent institutions offering preparatory programs for exam but none are endorsed by the organization.	IELTS: preparatory material. OET: preparatory material and sample tests; independent institutions offering preparatory programs for exam but none are endorsed by the organization.	IELTS: preparatory material. Otherwise no special English language classes for health professionals.
	Culture	*Test*	No test, but recognized need for bilingual and bicultural nursing professionals because of Australia's diversity. Especially important in context of health care.	No test for cultural awareness, but recognition that cultural understanding is important especially in a diverse society and in health care context.	No test for cultural awareness. Recognize that cultural differences can act as barrier to practice especially with respect to patient management and when working in a team setting.

Variable	Detail		Case Studies		
			Australia	New Zealand	UK – Pre 2010
		Program	None specifically for nurses. Online material addressing cultural differences and practices for doctors and general public, can be useful for nurses as well. Cultural awareness is provided in employer orientation programs, not in bridging program.	No program. Suggestion from overseas nurses practicing in NZ that a mentor program would be useful in guiding through the basics of life in NZ.	No program. Receive introduction to the UK health care system through the 20-day ONP.
	Technical knowledge	*Test*	Competency based assessments (CBA) adopted as policy in 1986.	Competency assessment through recognized nursing institution.	Competency assessment through nursing institution (20-day ONP).
		Program	CBA incorporated in bridging programs. Bridging programs very successful – by mid 1990s after a 3 month course applicants had 90-95% pass rates on exams and received full registration.	If gaps in training then must undergo additional training in NZ; for example through a Competency Programme or through additional course work. Applicant must negotiate the instruction agreement with a Department of Nursing and notify the Nursing Council of the arrangements.	Only the ONP is offered. Through the program receive a mentor, but success depends on nurses' relationship with the mentor. In addition to the ONP, may need to undergo an additional supervised placement to gain clinical experience. Their own responsibility to find an open space (limited space).

Source: Hawthorne, 2001; Hawthorne, 2002; ANMC, 2010; ANMC, 2009); Iredale, 2009; Metropolis, 2003; DOHA, 2008; DIAC, 2010; OET, 2007; Zurn and Dumont, 2008; NCNZ, 2011; Narasimhan et.al., 2006; Manchester, 2007; MOH, 2009; INZ, 2011; NMC, 2010; NurseInfo, 2007; Buchan et. al., 2008; UKBA, 2011.

Appendix C: Detailed Doctor Case Study

Variable	Detail	Case Studies		
		Australia	**New Zealand**	**UK – Pre 2010**
Immigration Policy	*Jurisdiction level*	Federal	National	Central
	Targeting health professionals Yes/No	Yes	Yes	Yes
	Admission Criteria	*Permanent:* Points assessment at point of entry. +15 points because occupation is in demand. *Temporary:* Visa assessment	*Permanent:* Points assessment. Additional points for occupations recognized prior to arrival and that are on shortage list; if listed on shortage list immigration is facilitated.	*Permanent:* Points assessment. *Temporary:* Points assessment.
	Permanent Programs	General Skilled Migration category. Only for doctors who obtained full medical registration. Must pass licensing exams and complete 2 yr internship under supervision of Australian doctor.	Skilled Migrant Category. Need at least 100 points, if 140 automatically accepted. Priority given to those with NZ experience and qualifications (must be registered, or eligible to register, with NZ Medical Council). Must have job offer or minimum 2 yrs work experience.	Highly Skilled Workers Tier 1 (General). Do not need an offer of employment but must demonstrate that highly skilled, proficient in English, and can support oneself while living in the UK.
	Temporary Programs	Long-term Visa 457: employer sponsored, doctors recruited offshore and do not need to pass	Work to Residence: For those who have offer of employment and NZ registration. After two	Sponsored Skilled Worker category. Must have job offer from a licensed sponsor, and

Variable	Detail	Case Studies		
		Australia	**New Zealand**	**UK – Pre 2010**
		exams; recruited into "Districts of Workforce Shortage". Employment location is restrained by the visa (into "Areas of Need")	years can renew work permit or transfer to permanent residency.	occupation must be listed on Tier 2 (General) occupational shortage list. If applicant scores minimum of 70 points on the test, then receive a valid certificate of sponsorship. Tier 2 lists: anaesthetics, paediatrics, and general medicine for physicians. *Visa for Overseas Qualified Doctors taking the PLAB test:* visa granted for up to 6 months, must prove that can financially support and accommodate oneself during this time, and that can pay for round-trip travel.

Variable	Detail	Case Studies		
		Australia	**New Zealand**	**UK – Pre 2010**
Health Policy Jurisdiction	*Level*	*Federal*: Australian Medical Council (AMC), national medical regulator.	*National*: Medical Council of New Zealand national medical regulator. Ministry of Health provides funding on national level to the 21 District Health Boards (DHBs) who are responsible for planning, purchasing, and provision of health care. The District Health Boards New Zealand (DHBNZ) coordinates the DHBs' policy, and introduces common approach to workforce planning and recruitment.	*Central:* General Medical Council (GMC), national medical regulator. Department of Health is responsible for workplace management, funding of the National Health Service (NHS), and setting health workforce policies (ie: international recruitment policy).
	Training for IEHPs	Does not provide funding or endorsement of the available bridging programs. Bridging programs are in preparation for AMC exams; run through education institutions.	"Ready for Work" Training Program developed by the Ministry of Health; for doctors who do not have NZ work experience. Combines classroom teaching with ward experience and introduction to NZ health care system. Those who have provisional registration can access the program. Otherwise no other	No bridging or training programs. The Foundation Year 1 Programme administered through approved education institution.

Variable	Detail		Case Studies		
			Australia	New Zealand	UK – Pre 2010
				bridging programs offered.	
Credential Recognition	*Jurisdiction for assessment*		*Federal*: Australian Medical Council (AMC)	*National*: New Zealand Qualifications Authority (NZQA) assesses credentials for immigration purposes only. Medical Council of New Zealand provides professional registration. No link to NZQA.	*Central*: General Medical Council
	Requirements	*Target*	Overseas doctors. UK, US, Canada, and New Zealand doctors acquire advanced standing towards registration and are exempt from additional medical or clinical examinations required for registration. They must however, complete a workplace based performance assessment while working under supervision.	Overseas doctors. Provisional licence can be obtained by those who practiced for at least 3 yrs in comparable health system: Australia, Canada, US, Austria, Belgium, Denmark, Finland, France, Germany, Italy, Norway, Ireland, Sweden, Switzerland, the Netherlands, and the UK. Doctors with provisional licence work under supervision for up to 2 yrs.	Overseas doctors. EU nationals can automatically practice in the UK because of mutual recognition of qualifications directive. Overseas doctors must verify credentials on the Avicenna Directory for Medicine, and then receive recognition from the GMC.
		Gaps	Those whose credentials are from schools that have not been formally reviewed and approved by the AMC must complete knowledge and clinical	Those whose credentials are not from a comparable health system must pass US Medical Licensing Examination (Part 1: knowledge, and Part 2: clinical	All overseas doctors must complete the Professional and Linguistic Assessments Board (PLAB) exam to prove medical knowledge and skill. If pass

Variable	Detail		Case Studies		
			Australia	**New Zealand**	**UK – Pre 2010**
			examinations. A new pathway for recognition is being implemented, the workplace performance assessment (would replace clinical exam but not knowledge exam), which tests performance in actual work environment.	skills), and then also pass the NZ Registration Examination to show clinical ability. From there can either receive provisional registration.	the exam and have completed appropriate internship then granted full licensure. If need to complete an internship, then granted provisional licensure to practice.
Knowledge Evaluation and Programs	*Target Group*		Overseas doctors	Overseas doctors	Overseas doctors
	Language	*Test*	IELTS: minimum score of 7 on all four components. OET: minimum grade A or B in all four components.	IELTS: minimum 7.5 on speaking and listening, and 7.0 on reading and writing.	IELTS: minimum score of 7 on all components in single sitting. Must complete before sitting the PLAB.
		Program	IELTS: preparatory material. OET: preparatory material and sample tests; independent institutions offering preparatory programs for exam but none are endorsed by the organization.	IELTS: preparatory material. Otherwise no special language programs for health professionals.	IELTS: preparatory material. No special language programs for health professionals.
	Culture	*Test*	No test. Recognize the need for cultural awareness because of Australia's diversity; English language proficiency not always sufficient to remove cultural barrier.	No test. Recognition that culture can be a barrier to medical practice, but no test developed. The MCNZ's policy on accreditation states that "must have cultural	No test. Recognition that cultural is important. But more concern about doctors conforming to UK standards of communication and health care.

Variable	Detail		Case Studies		
			Australia	New Zealand	UK – Pre 2010
				competence."	
		Program	Online tool for cultural education developed by DHA: covers cultural and medical issues in the Australian medical workforce, including communication styles, professional ethics and the Australian healthcare system. Online resource on cultural diversity available for all health professionals through Queensland Government	No specific program. Doctors working under supervision through the provisional licence become familiar with NZ culture; a senior colleague then assesses their performance.	No specific program. Doctors, receive cultural orientation to the health care system through the Foundation Year 1 program; but only doctors who need to upgrade their skills enter the program.
	Technical knowledge	*Test*	Competency based assessments. Must meet standards expected of new Australian graduates. Medical knowledge as well as clinical experience are required and are tested by the AMC exams. Those whose basic medical qualifications are not recognized must undergo testing.	Competency based assessment through the NZ Registration Examination. Must meet standards expected of new NZ medical school graduate.	Competency based assessment through the PLAB test. Must meet the standards expected of a new medical graduate. Those who did not complete an acceptable internship (residency) overseas may be granted the provisional licence and enter the Foundation Year 1 program.
		Program	Bridging programs that prepare	Those who have provisional	There are no bridging

Variable	Detail		Case Studies		
			Australia	New Zealand	UK – Pre 2010
			for AMC exams are available through education institutions. Applicants' responsibility to find suitable program. Critiques that need more bridging programs.	registration can access the "Ready to Work" program. Otherwise no other bridging programs offered. Otherwise may need to undergo further training at a NZ medical institution.	programs. Only those who have yet to complete an internship are eligible for the Foundation Year 1 program. Passing the PLAB automatically makes them eligible for registration and licensing.

Source: Iredale, 2009; AMC, 2010; DIAC, 2010; Hawthorne, 2008;CETU, 2010; DOHA, 2008; OET, 2007; Zurn and Dumont, 2008; MCNZ, 2010; Narasimhan et. al., 2006; MOH, 2011; GMC, 2010; Buchan et.al., 2008; BMA, 2008; UKBA, 2011.

Appendix D: Country Comparison of Points Assessment

Selection Factor	Australia	New Zealand	UK	Canada
Education	60	65	15	25
Proficiency in English	25	n/a*	10	24
Experience	10	60	n/a	21
Age	30	30	n/a	10
Arranged employment in destination country	20	60	50	10
Adaptability	55	50	35	10
Total	200	265	110	100
Pass Mark	120	100	75	67

Source: DIAC, 2010; INZ, 2010; UKBA, 2010; CIC, 2009
**English language proficiency is considered a basic requirement, therefore points are not awarded.*

Appendix E: New Zealand Bonus Points

Conditions	Bonus Points
Skilled Employment	
In an identified future growth area	10
In an area of absolute skills shortage	10
In a region outside Auckland	10
Partner has a skilled job or job offer	20
Work experience in NZ	
1 year	5
2 years	10
3 or more years	15
Work experience in an identified growth area	
2 to 5 years	5
6 or more years	15
Work experience in an area of absolute skills shortage	
2 to 5 years	10
6 or more years	15
Qualifications	
2yrs full-time study in NZ	5
Recognized basic NZ qualification (trade qualification, diploma, bachelor etc.)	5
Recognized post-graduate NZ qualification (Masters or Doctorate)	10
Qualification in identified future growth area	10
Qualification in an area of absolute skills shortage	10
Partner holds a recognized qualification	20

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