Ethical Recruitment and Integration of Internationally Educated Health Professionals in Canada

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INTRODUCTION

Health professionals have long been nationally and internationally mobile. However, because labour mobility is a requirement under international trade agreements, labour markets have become truly global in scope.[i] This has increased the speed and extent of migration and highlighted the consequences, including severe shortages of staff and skills in many of the countries from which health professionals migrate.[ii] In response, the Global Health Workforce Alliance developed the *Global Code of Practice on the International Recruitment of Health Personnel*, which the Human Resources for Health Office of the World Health Organization (WHO) adopted at the 63rd World Health Assembly in May 2010. The new code addresses the ethical recruitment practices and non-discriminatory integration of internationally educated health professionals (IEHPs) into the health care systems of their destination countries.

In this paper, we examine the ethical recruitment and integration of IEHPs, drawing upon the case study of Canada. We focus specifically on the recruitment and integration of international medical graduates (IMGs) and internationally educated registered nurses (IENs). As noted in a companion contextual report,[iii] the role of IEHPs has been intricately connected with human resources for health (HRH) policy in Canada. During periods of perceived shortages, there has been recruitment of IEHPs, and those already in the country are more readily integrated. Historically, Canada has relied heavily on IEHPs to help solve shortages in rural and remote underserviced areas and in urban subspecialties.[iv] [v] [vi] Canadians have benefited from this flow in terms of greater health care access and reduced public costs of health professional training.

The integration of IEHPs into the Canadian health system has been more difficult during periods of perceived HRH surpluses, which could be more accurately described as periods of economic restraint that result in health care spending cutbacks. Accounts of IEHPs, and IMGs in particular, not being able to practice their profession has become such a common feature of media reports that it is no longer considered news. In Canada, the problem is partly due to the "complex and interdependent actors in multiple jurisdictions with unaligned accountabilities. Governments do one thing, educational institutions do another, and regulatory authorities do a third."[i] Indeed, as far as immigration policy is concerned, there is a disconnect between the migration and integration and recruitment of IEHPs.

We begin by addressing the issue of international recruitment of IEHPs, followed by an examination of their integration process. It is important at the outset to define a few key terms used in this paper. First, the terms IMGs and IENs includes foreign-born and foreign-educated health professionals, as well as Canadian-born health professionals who have obtained their training abroad. The latter group has most recently been termed Canadians Studying Abroad or CSAs, a term used most often in regards to IMGs. In some cases, the nationality of the IEHP does not matter. In other cases, particularly with respect to integration, it does make a difference.

Internationally educated health care professionals can include the following:

- Canadians who pursue training elsewhere

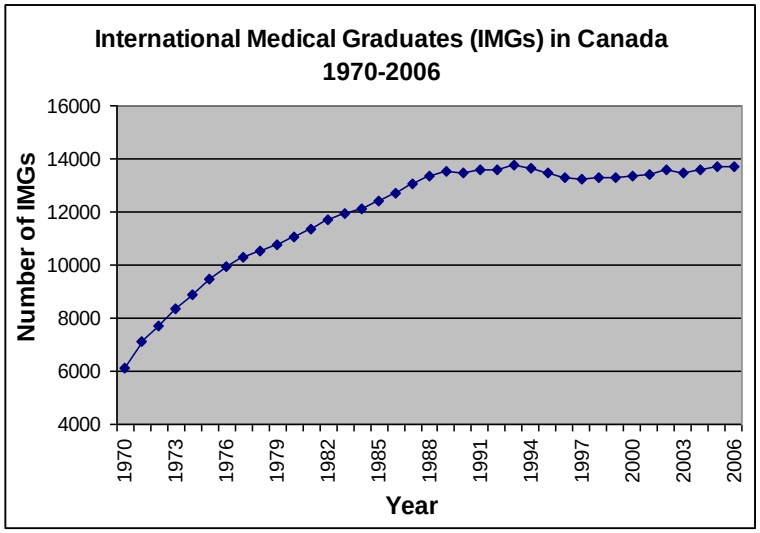
- Graduates who enter Canada as refugees or who otherwise meet immigration requirements
- Trainees who pursue post graduate positions in Canada
- Providers who are recruited (often through temporary visas) to meet the needs of particular geographic and specialty areas where shortages are most severe[iv]

Regardless of how IEHPs enter the Canadian health care system, their ability to practice depends on a range of factors, including the province in which they intend to live and work.

INTERNATIONAL RECRUITMENT OF IEHPs

Before discussing the recruitment of IEHPs into Canada, it is important to describe the extent of their involvement in the Canadian health care system. From 1970 to 2006, the number of IMGs increased steadily (see Figure 1). The overall percentage was high as 34% in 1976, although it declined to just over 22% in 2006.

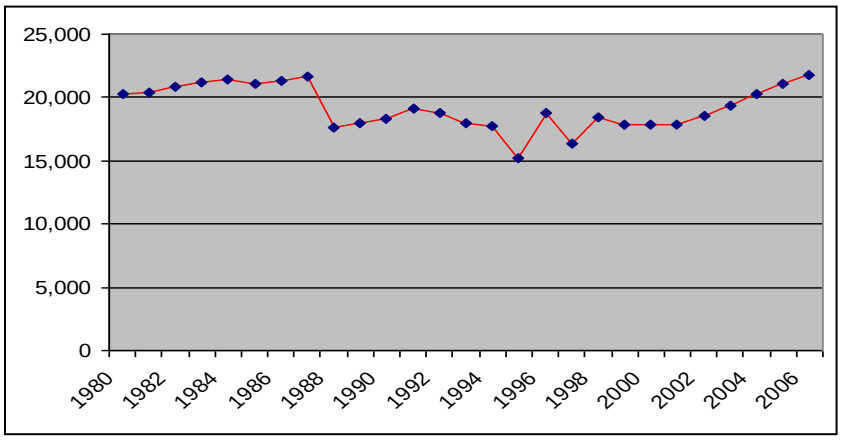
Figure 1. Number of Licensed International Medical Graduates in Canada, 1970–2006



Source: Canadian Institute for Health Information. Personal Communication with J. D. Stanway. *Number of Canadian-Trained and Foreign-Trained Doctors (active) from 1970 to 2006.* Ottawa, ON: HHR.

Recent demographic data on Canada's nursing workforce confirms that reliance upon IENs has remained steady over the past 20 years and has increased slightly in recent years following the cutbacks of the mid 1990s (see Figure 2). Internationally educated nurses have made up between 6% (in the mid 1990s) and 10% (in the 1980s) of the nursing workforce in Canada, with a more recent rate of 8%.[vii]

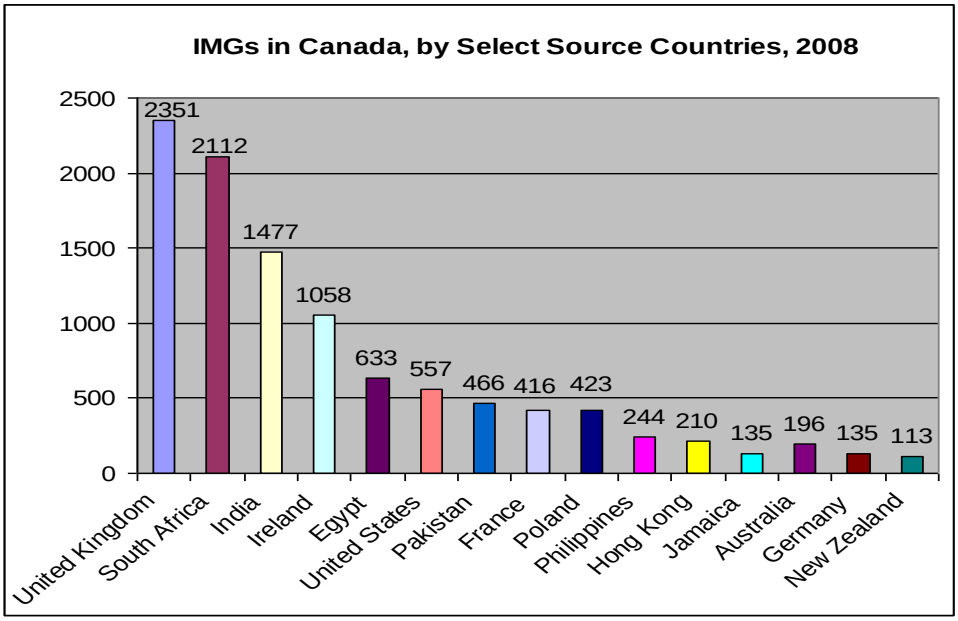
Figure 2. Number of Internationally Educated RNs in Canada, 1980–2006



Source: Canadian Institute for Health Information. (2008). *Numbers of Internationally Trained Registered Nurses in Canada, 1980-2006.* Ottawa, ON: NDB/CIHI.

It is also important to highlight where licensed IMGs and IENs are coming from. As shown in Figure 3, IMGs in Canada come predominantly from the United Kingdom (UK) and South Africa.

Figure 3. Licensed IMGs in Canada by Country of Origin, 2008 (excludes residents)

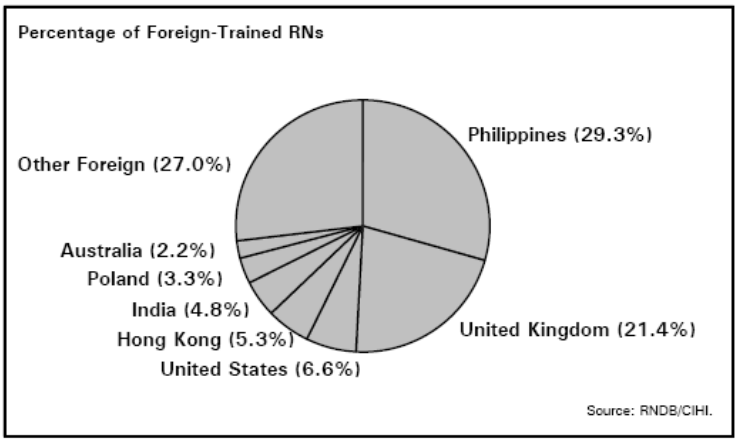


Source: Canadian Medical Association. (2008). *Percent by Country of MD graduation, Canada, 2011.* Retrieved from, http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/09GradCountry.pdf

The number of IMGs from the UK decreased from over 7% in 1994 to 4% in 2006, while the number of IMGs from South Africa increased from 2% to nearly 4% in the same period. This

reflects a larger more recent influx of South African IMGs.[viii] Figure 4 shows that the majority of IENs in Canada in 2004 graduated from the Philippines (29.3%) or the UK (21.4%).

Figure 4. Source Countries of IENs in Canada, 2004



Source: Canadian Institute for Health Information. (2005). *Workforce Trends of Registered Nurses in Canada, 2004.* Available from, http://secure.cihi.ca/cihiweb/products/Workforce_Trends_of_RNs_2004_e.pdf

There is a notable difference between the proportion of IEHPs *licensed* in the country and those *entering* the country. Not all IEHPs who enter the country enter the health care system, and many studies highlight this as a key policy problem (see detailed discussion below). The Canadian Institute for Health Information (CIHI) tracks IEHPs who enter the health care system, which makes it relatively easy to obtain demographic data on them. It is more difficult to obtain information on IEHPs who do not enter the health care system.

Recruitment Practices

It is important to preface this discussion with an explanation of the difference that is often made between *active* and *passive* recruitment. Active recruitment is generally recognized as the recruitment of IEHPs for a specific position within the health care system. Active recruiters in Canada include recruitment agencies, although only a small number specialize in IEHPs. Hospitals, Regional Health Authorities and private practice clinics also hire IEHPs for vacant positions. Individual health professionals in Canada are enlisted to encourage friends and colleagues to migrate and help them with the migration process.[ix] These activities are addressed by various ethical codes.

Many Canadian stakeholders stress that Canada does not engage in active recruitment. As noted in a study on the migration of physicians from South Africa to Canada, there are a few exceptions:

> *The few incidents of active recruitment that had occurred (e.g. when the government of the province of Alberta went on a recruitment mission to South Africa to hire physicians because of a severe provincial shortage) were cited as*

> *real exceptions. These were largely frowned upon as unethical while being excused as desperate actions to resolve desperate situations, although without consideration given to the health impact on source countries.* [ix (p. 23)]

Passive recruitment is more difficult to define and thus more difficult to control. It could include potential employers responding to enquiries from individual IEHPs interested in a position or IEHPs responding to advertisements for vacancies not necessarily targeting IEHPs.[x] The latter category includes various provincial recruitment agencies like Health Match BC and HealthForceOntario. Table 1 identifies other activities that encourage passive recruitment.[ix] Some authors argue that these grey zones between active and passive recruitment are often considered an inevitable outcome of living in a global and electronic environment. They admit, however, that even if active and passive recruitment were completely removed, IEHPs would still choose to migrate to Canada.

Table 1. Activities Fostering Passive Recruitment

- The points system for immigrants has an inherent bias towards skilled and experienced professionals
- Provincial Nominee Programs have a special stream specifically for health professionals
- Recently announced government pledges that it would set aside money to be spent on initiatives to facilitate the migration and employment of IEHPs
- The availability of Evaluating Exams in Foreign Countries

When health human resources are not adequately planned and vacant positions result, the seeking of migration becomes a form of recruitment. One provincial stakeholder observed,

> *The reality of it is ... wherever they come from we need them. So ... if they have decided that they want to live in Canada for whatever reason and have immigrated here, they should have the full opportunity that any Canadian would have.*

The authors of a recent study commented specifically on the situation in nursing:

> *"Ontario does not educate sufficient nurses to avoid a serious shortage in the future. Therefore, it is essential that planners understand the importance of internationally educated nurses (IENs) as a supply source."* [xi]

A study of employers in the older adult care sector demonstrated that many had little or no experience with recruitment or employment agencies that target migrant care workers.[xii] Employers relied on word of mouth among immigrant care workers who applied for jobs within their facilities. Many of the care workers they hired had some type of health care background such as nursing, or they had worked in the older adult care sector in their country of origin. One of the primary reasons for employing immigrant care workers was the lack of Canadian-born workers interested in these positions.

Ethical Codes

The 2010 WHO Global Code is intended to manage health workforce migration and aims to "establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel."[xiii(p. 3)] Similar codes existed previously. In 2002, the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) developed the *Code of Practice for the International Recruitment of Health Care Professionals*.[xiv] The WONCA Code (also referred to as The Melbourne Manifesto) argues, "International recruitment is related to an inability on the part of individual countries to satisfy their own workforce needs." It calls for countries that benefit from the recruitment of IEHPs to "consider the effect that their existing recruitment policies and practices are having on lesser developed countries [and] ... develop and implement their own ethical recruitment policies." In a study of Canadian policy stakeholders, the authors found that only one of the participants was knowledgeable about the Manifesto.[ix]

In 2003, the Commonwealth Ministers of Health approved the *Commonwealth Code of Practice for the International Recruitment of Health Workers*. One of the first multilateral agreements of its kind, the Commonwealth Code provided governments with a framework for the international recruitment of health workers. Yet, there was difficulty creating a coordinated national response in Canada. The Federal Ministry of Health may have been involved in the negotiations of the code, but the regulation and licensure of IEHPs lies at the provincial level. In addition, there are a variety of stakeholders involved in the migration, recruitment and integration of IEHPs. Thus, there are different levels of decision making and accountability. For example, much of the recruitment of IEHPs occurs at the regional health authority level and may extend to local communities and health care facilities. Owing to implementation problems, few stakeholder organizations have adopted the explicit policies of the Melbourne Manifesto or the Commonwealth Code.

Similar circumstances exist for the 2010 WHO Global Code. There has, however, been more direct and coordinated preparation due to the new overall HRH advisory infrastructure in the form of the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR). Anticipating the need for a response to the WHO Global Code, the ACHDHR commissioned a discussion paper entitled, *Toward a Policy on Ethical Recruitment of Health Personnel*. It identifies some of the key issues in developing a pan-Canadian approach to the ethical recruitment of IEHPs. The ACHDHR then drafted a set of principles paralleling those in the WHO Global Code but tailored to the Canadian context. In 2009, prior to the official adoption of the WHO Global Code, the ACHDHR sponsored an in-person and web-based multi-stakeholder consultation to provide input into the key principles of the Canadian companion document (see Table 2).

Table 2. Key Principles in the Canadian Companion Document to the WHO Global Code

- Jurisdictions should strive to create a ***self-sufficient*** health workforce
- Transparency, fairness and ***mutuality of benefits***
  - *Efforts must be made to maximize the benefits and mitigate the potential negative effects on health systems*
  - *Jurisdictions should promote an equitable balance of interests between health personnel, source countries and destination countries*
- Jurisdictions should enhance data, research and sharing of information
- All aspects of the employment of international health personnel should be ***without discrimination*** of any kind

It is perhaps too early to assess the impact of the Canadian companion document, as it not yet clear whether or how the principles will be translated into provincial recruitment policy. The sufficiency of HRH continues to dominate provincial policy discussions, but the conversations are not explicitly about self-sufficiency. Although the bilateral agreements with the Philippines, developed by several of the Western provinces, are consistent with the *mutuality of benefits* principle in the WHO Global Code and the Canadian companion document, this principle is not explicitly written into these agreements.[xv]

INTEGRATION OF INTERNATIONALLY EDUCATED HEALTH PROFESSIONALS

When addressing IEHP integration, it is important to recognize that it involves two distinct facets. The first is the integration into *licensed practice*, which includes national policies and processes around the recognition of international qualifications (e.g., Foreign Qualification Recognition processes in Canada) and licensure at the provincial/territorial level. The second is integration into the *culture of practice*, which is a much less salient issue of cultural competency. It is particularly relevant for foreign-born and foreign-trained health professionals versus Canadian nationals who study abroad and return to Canada to practice.

Assessment Processes and Outcomes

The regulatory context for the integration of IEHPs is largely determined at the provincial level.[iii] Prior to this step, however, the assessment of IEHP credentials occurs at the national level. For example, to become fully licensed to practice medicine in Canada, IMGs have to fulfill several requirements:

- Provide proof of completion of an undergraduate medical degree (M.D.) program in an approved university (listed in either the International Medical Education Directory or the World Health Organization World Directory of Medical Schools) and demonstrate English or French proficiency.
- Pass a set of three standardized exams: the Medical Council of Canada Evaluating Exam (MCCEE) to demonstrate equivalent general medical knowledge and two MCC qualifying exams (MCCQEI and MCCQEII).

- Take one to five additional years of postgraduate medical training (depending on background and intended specialty), of which the number of residency places is limited, particularly for IMGs.
- Pass a certification exam in either Family Medicine (through the College of Family Physicians of Canada (CFPC) or a Specialty (through the Royal College of Physicians and Surgeons of Canada (RCPSC). In general, the process for becoming licensed is the same across Canada with slight provincial variations.

Table 3 provides a general overview of the process.

Table 3. Registration to Practice Medicine in Canada - Full Licensure

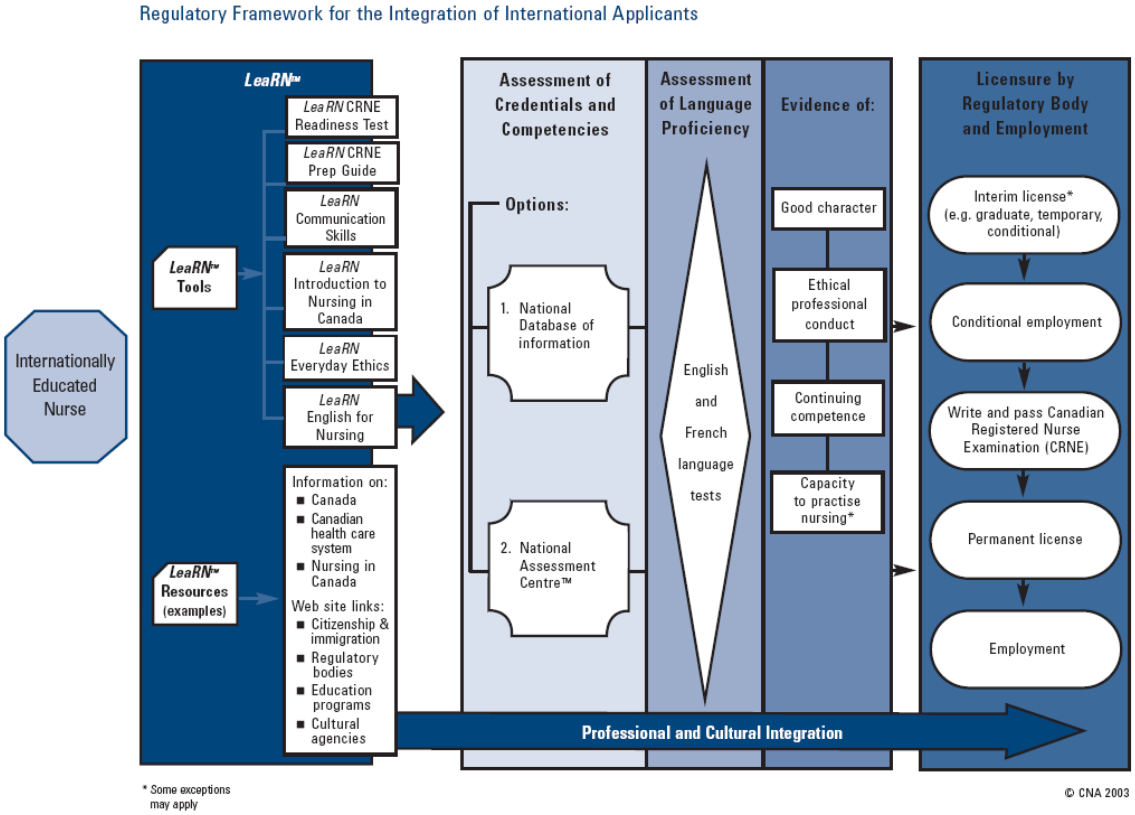
1	Undergraduate Medical School	
2	Equivalency Exams	
		Provide Proof of Language Proficiency
3	Postgraduate Training*	
	Canadian Resident Matching Service	IMG – Specific Programs
4	Certification	
	Family Physician must pass the College of Family Physicians of Canada certification Exam	Specialists must pass the Royal College of Physicians and Surgeons of Canada Certification Exam
5	Licentiate of the Medical Council of Canada (LMCC)	
6	Provincial/Territorial Registration	

Source: Dumont et al. (2008).

*Some specialists may be permitted to take the certification exams without additional postgraduate training through special assessments by RCPSC.

The process of qualifying as a registered nurse (RN) in Canada as an IEN involves fewer steps than becoming fully licensed to practice medicine (see Figure 5). Candidates must apply for registration with their provincial or territorial regulatory bodies, have their credentials assessed (some contact a credential evaluation service for advice) and pass the Canadian Registered Nurse Examination (CRNE) in provinces outside of Québec. If candidates wish to practice in Québec, they must pass *l'examen professionnel de l'Ordre des infirmières et infirmiers du Québec*. Many nurses make applications to more than one province, making accurate statistics of the total number of IEN applicants in Canada difficult to assess. In addition, some IENs apply for registration as licensed practical nurses (LPNs) or registered practical nurses (RPNs) as a stepping-stone to RN certification.

Figure 5. The Process for the Recognition and Integration of Internationally Educated Nurses in Canada



Source: Canadian Nurses Association. (2006). p. 17.

It is important to distinguish between IEHPs who are actively recruited and those who come to Canada passively via immigration routes. Another distinction exists between IEHPs who apply for assessment from outside of Canada and those who go through the process within Canada. It is for the latter group that targeted integration and bridging programs have been developed. Recruitment issues not only address recruitment into practice but also recruitment into educational programmes. For example, full fee-paying VISA trainees do not necessarily stay in country to practice; nevertheless, they occupy space within a training system that has limited capacity. This is most relevant for residency training positions in medicine.

In a qualitative study we conducted of 67 IMGs and 70 IENs in 2008, we found a number of barriers that IEHPs face while trying to integrate into the Canadian workforce. [xvi] These include English or French language skills, particularly those that are profession-specific; financial difficulties related to the requirements for licensure, which are compounded by the time-consuming and seemingly bureaucratic nature of the process; and the challenge posed by the lack of opportunity to gain Canadian cultural competency.

International medical graduates described two key barriers to their professional integration: the three standardized MCC examinations and the relative lack of access to residency training programs (see Table 4). The latter is particularly challenging. Many respondents noted the lack of positions that would allow them to utilize their health care skills while working in a related field and attempting to transition into medicine. They believed their chances of getting into medicine were very low and felt the energy invested in exam preparation would not have been wasted had they found jobs in the health care setting. These feelings are reflected in the data that are now becoming available. For example, in Ontario over 5000 IMGs are not working in their professional capacity.[xvii]

Table 4. Pass Rates of IMGS at Different Stages of the Licensure Process, 2006

MCCEE	MCCQE1	MCCQE2	CaRMS
• 65%	• 70	• 75%	• 16%

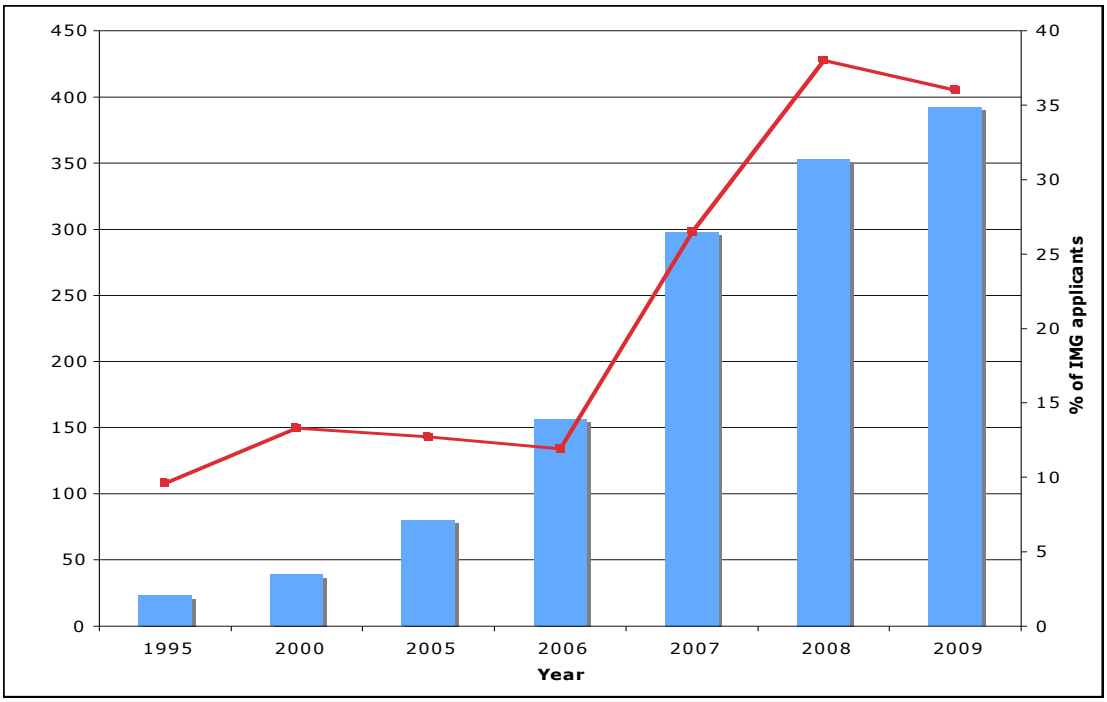
Note: MCCEE = Medical Council of Canada Evaluating Exam; MCCQEI = Medical Council of Canada Qualifying Examination Part 1; MCCQEII = Medical Council of Canada Qualifying Examination Part 2; CaRMS = The Canadian Resident Matching Service.
Source: Dumont et al. (2008).

Figure 6 shows the number of IMGs in residency positions has increased. This is largely due to efforts in Ontario to accept more IMGs into specifically created residency programs and open up the first iteration of CaRMS to IMGs.[xviii]Although the figures indicate improvement, there is the outstanding issue of residency spots left vacant while a number of IMGs are left without a placement. In 2007, 2008 and 2009, there were 154, 121 and 126 spots left vacant respectively, and the numbers of IMGs not awarded residency positions were 1056, 881 and 1001. The greatest proportion of vacant residency positions is in Québec, which accounts for 56% of the vacancies in 2007, followed by Ontario. Although vacancies in Ontario have been decreasing, the number of spots in Québec has remained relatively constant. In 2009, they accounted for 75% of vacancies.[xvii]

As noted, IENs face language and cultural competency barriers as well as problems with the CRNE, which is perceived as culturally laden. An additional barrier unique to IENs is level of education (i.e., degree or diploma). Internationally educated nurses often have to decide which process of accreditation (RN or RPN/LPN) to take without actually knowing the difference between the different levels of nursing in Canada. Another barrier to satisfactory integration cited by IENs is a lack of full recognition of their education and work experience.

The IEHPs we interviewed cited a number of consequences stemming from integration barriers, including downward professional mobility. Accepting positions at a lower skill level may be a strategic choice on the part of IEHPs so as to gain experience while accessing and upgrading their qualifications, but in most cases this 'deskilling' is imposed. The added dimension of being considered over-qualified for many other positions in health care makes the situation for IMGs particularly difficult.

Figure 6. Number of Successful IMGs in the CaRMS Process and Total Percentage of Successful IMG Applicants



Source: CaRMS. (2010).

The most salient key facilitators to integration for IEHPs included making as many arrangements for integration as possible prior to immigration. Several of the IEHPs we interviewed felt that appropriately targeted information sessions available at the outset and throughout the immigration and integration process enabled their success. The primary facilitator identified was the various bridging programs that have been established, which help to upgrade skills and assist with the amorphous cultural competency problems.

Bridging Programs

Bridging programs are intended to facilitate the integration of IEHPs into the health workforce by helping them overcome any discrepancies between their knowledge and experience and Canadian standards of professional practice and knowledge.[xix] Bridging programs vary and can serve multiple purposes:

- Assessment of existing education and skills to identify any additional training needs and, where possible, profession-specific language training
- Preparation for licensure exams
- Provision of clinical or workplace experience
- Improving familiarity with the social and cultural context of the Canadian health care system[xviii]

Completion of bridging education programs is usually one of the components necessary to secure licensure for IEHPs. In most provinces, there are bridging programs to assist the professional integration of IEHPs. For example, Kwantlen Polytechnic University in British Columbia and Red River College in Manitoba offer programs to help IENs upgrade their language, nursing skills and knowledge and prepare for licensure exams.[xx] *L'Ordre des infirmières et infirmiers du Québec* requires all IENs to complete a professional integration program, which provides background on organizational, legal, ethical and socio-cultural aspects of nursing in Québec and guidance regarding adaptation to the Québec health care context and clinical skills. In Ontario, the Creating Access to Regulated Employment (CARE) for Nurses program helps IENs meet nursing baccalaureate degree requirements. First announced by the provincial government in May 2001, CARE provides profession-specific skills, including relevant English language skills, and education in nursing culture.

Residency training acts as a form of bridging program for IMGs. This is particularly the case for residencies like those in Ontario and British Columbia, which target IMGs. However, IMGs who pursue licensure in Québec must rely on information sessions for assistance. These sessions are made available before each stage of the licensing process. Recently, the Ministre de l'Immigration et des Communautés culturelles (MICC) in Québec joined forces with Association des Médecins gradués de l'Étranger au Québec (AMEQ) to organize sessions to help IMGs prepare for examination. International medical graduates applying for licensure through the restrictive permit route must complete three months of orientation and evaluation. Teaching hospitals in Québec offer IMGs a clinical introduction to health care in the province. This acts as a type of bridging program, but it is not available to IMGs applying through the regular equivalency route.[xxi] Manitoba has the Medical Licensure Program for International Medical Graduates (MLPIMG), which helps IMGs prepare for future practice.

The Access Centre for Internationally Educated Health Professionals, funded by Ontario Ministry of Health, is another way to facilitate integration and improve the interim labour market positions of IEHPs.[xxii] The centre provides information pertaining to the regulated health professions in Ontario, including standards of professional qualifications and the licensing and registration processes. It also provides on-site reference materials and resources, including a library, links to education and assessment programs, self-assessment tools and information sessions. Value-added components include ongoing counselling and support, alternative career options, referrals to relevant organizations and community resources, as well as referrals for retraining and bridging programs.

SUMMARY AND CONCLUSION

This paper focuses on the ethical recruitment and integration of IEHPs, particularly IMGs and IENs, in Canada. Examination of IEHP recruitment and integration has highlighted the following key points:

- **HRH planning** in Canada both explicitly and implicitly draws upon IEHPs. Although **immigration policy** in Canada rarely focuses explicitly on IEHPs, the immigration points system creates the conditions for their passive recruitment.
- **Recruitment practices** in Canada may exemplify more passive than active efforts, but this distinction seems moot given that the consequences are equivalent. Even when HRH planning does not explicitly address IEHPs, vacancies resulting from inadequate resources in particular geographic regions and hard to fill sectors pull IEHPs to Canada.
- **Ethical codes** have had seemingly little impact on Canadian HRH policy. Indeed, there has been very little recognition of their existence among stakeholders; however, the potential impact of the WHO Global Code is not yet clear. It is difficult to develop a coordinated response to the codes because of the complex and politically charged jurisdictional divisions between immigration, HRH policy and assessment and licensure responsibilities at the national and provincial/territorial levels. The harmonization of provincial regulations resulting from the *Agreement on Internal Trade* may help streamline integration.
- Though much more needs to be done, Canada has excelled in the creation and availability of **bridging programs** that help IEHPs obtain professional licensure and integrate into the culture of Canadian practice. Of particular assistance is the Access Centre for Internationally Educated Health Professionals in Ontario, which assists IEHPs who have already migrated to Canada.
- Making the integration process easier may have the unintended and inevitable consequence of drawing more IEHPs to Canada. This emphasizes the challenge of reducing discrimination against IEHPs and diminishing the negative effects of their migration on their home countries, both of which are highlighted in the WHO Global Code and the Canadian companion document.

Acknowledgements

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