

Immigration and HRH Policy Contexts in Canada, the U.S., the U.K. & Australia: Setting the Stage for an Examination of the Ethical Integration of Internationally Educated Health Professionals:

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Introduction

Increased attention is being paid to the mobility of human resources for health (HRH) across international borders. Indeed, concerns about the international migration of health care providers have become a more prominent and controversial feature of health sector analysis in recent years in light of severe staff and skill shortages in health systems of many countries. Canada, the U.S., the U.K., and Australia share many features of HRH but also some important policy differences from which we can develop important insights. Comparative research recognising the distinct geographic, political and policy contexts of these countries would allow us to better understand the ethical integration of internationally educated health professionals in Canada, the U.S., the U.K., and Australia. This background descriptive policy brief was prepared with this in mind. More specifically, the organization and recent shifts in immigration HRH regulation and HRH supply policy are outlined across the four countries in general and with respect to the professions of medicine and nursing.

THE CONTEXT OF HEALTH WORKFORCE MIGRATION IN CANADA

1. Immigration policy

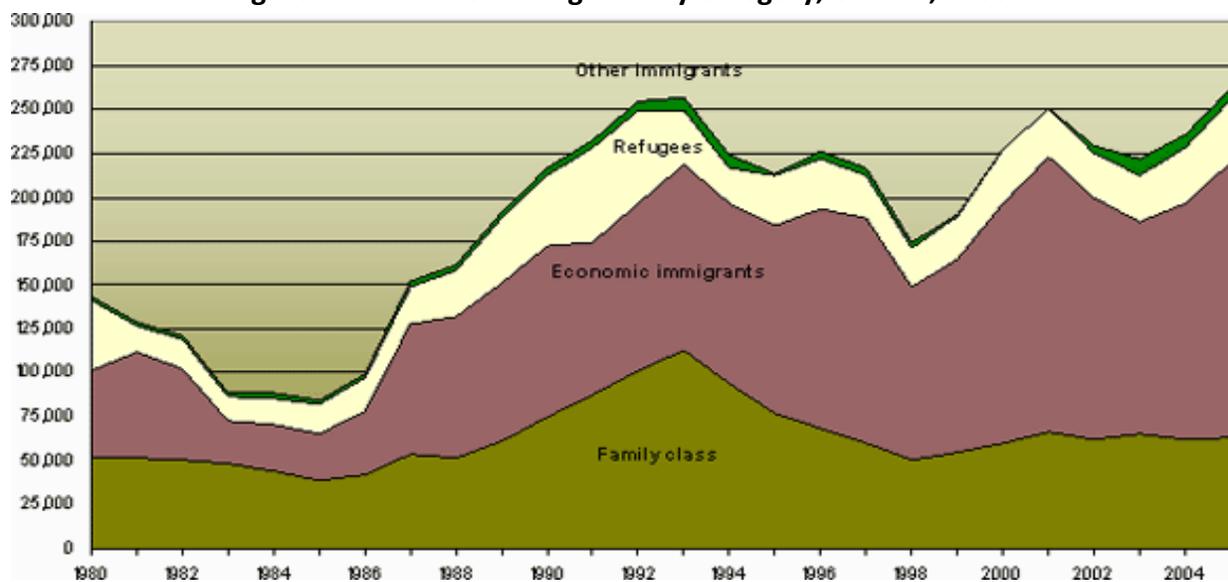
Canada is a country of immigrants with 19.8% of the population being born in another country according to the latest (2006) Canadian Census (Dumont, et al., 2008). The ultimate objective of Canadian immigration policy is to “move immigration levels to approximately one percent of Canada’s population, while bearing in mind Canada’s absorptive capacity” (CIC, 2002, p.3). Historically, the most central role of immigration in Canada has been for economic purposes. Two recent shifts can be identified in Canadian Immigration policy: (1) a shift from rural to urban immigration and (2) a shift from low-skill to high-skilled immigration.

In Canada immigration is regulated by Citizenship and Immigration Canada (CIC) which is under federal jurisdiction. Immigration to Quebec is regulated through Canada-Quebec Accord on Immigration. The province of Quebec operates its own *Selected Skilled Workers* program which is regulated through Quebec’s provincial government. More recently, almost all Canadian provincial governments take part in selecting international workers through their Provincial Nominee Programs (PNP) which “nominate” immigrants based on specific skills which are in need for their local economy (CIC, 2005). This provincial nominee program is one of clearest examples of the increased role of provinces in forming migration priorities: while in 1997 there were only 47 immigrants in the Provincial/territorial nominees sub-category, by 2006 the number increased to 13,336 (CIC, 2007). Currently, all provinces define physicians as a “strategic” occupation in their PNP programs.

In 2002, *Immigration and Refugee Protection Act* (IRPA) replaced the old *Immigration Act* of 1976. The new Act represents a fundamental shift in the policy from a focus on occupational shortages towards human capital indicators of long-term earnings potential as the basis of acceptance under the points system (McHale, 2003). The points system that is currently used to select independent immigrants was designed to ensure maximum employability in an economy where skilled labour was an emerging priority. Thus, the new Act gives government the flexibility to balance immigration with Canada's labour market needs.

According to the new Act, there are three routes through which immigrants come into Canada: (1) economic immigrants (including skilled workers) whose applications are being assessed using points system calculating relative "worth" of an applicant based on six selection factors including their skills, education, knowledge of official Canada's two official languages, experience, age, whether the applicant has arranged employment in Canada and applicant's adaptability (CIC, 2007); (2) family class (i.e. sponsored by a family member), or (3) refugees. In addition to permanent residents, coming to Canada, there are about 90,000 foreign workers (*need to check #*) that come each year to work temporarily to fill gaps in areas where there are labour shortages. Indeed, according to Dumont et al., (2008), "the Temporary Foreign Worker Program has also gained importance over the recent years. Since 2006, HRSDC had produced the *Regional Occupations Under Pressure* list to identify occupations that are facing labour market pressures. For occupations found in this list, employers are not required to undertake lengthy or comprehensive advertising efforts before being eligible to apply to hire foreign workers. (p. 43-44). Usually, these workers are required to have work permits obtained with the help of their employers. The major goals of the Immigration Program, as outlined by IRPA, are to contribute to economic development, reunite families and protect refugees (CIC, 2002).

Figure 1: Number of Immigrants by Category, Canada, 2006



Source: Compiled from Citizenship and Immigration Canada (CIC) website.
<http://www.cic.gc.ca/english/resources/statistics/facts2006/permanent/01.asp>

2. HRH regulation

a. Medical Licensure and Regulation

The process of obtaining medical license involves a number of stakeholders and regulatory bodies at the national and provincial levels. At the federal level, the Medical Council of Canada (MCC) is an organization that assesses medical candidates, evaluates physicians through exams, and grants a qualification called the Licentiate of the Medical Council of Canada, which is a requirement to gain an independent practice license in Canada. The MCC also maintains the Physician Credentials Registry of Canada, which is a repository and verification service for physicians' documents. The Royal College of Physicians and Surgeons of Canada is a private, nonprofit organization that oversees the medical education of specialists in Canada, accredits specialty residency programs, and conducts specialist certification examinations. The College of Family Physicians of Canada is a professional association that oversees the medical education of family physicians in Canada, accredits family medicine residency programs, and conducts certification examinations. Although the latter two bodies are called Colleges, they do not have regulatory powers. It is the Colleges at the provincial level that grant licenses to practice medicine in the respective province.

b. Nursing Licensure and Regulation

Similar to medicine, nurses in Canada are regulated through provincial colleges. Each college has its own standards for assessing qualification of nurses. At the national level, the Canadian Nurses Association (CNA) is a federation of the provincial and territorial registered nurses associations in Canada. CNA provides the competency exam for registered nurses and nurse practitioners (except in Quebec) and also provides a voluntary national nursing certification program. However, nurses are licensed and registered to practice by the provincial and territorial professional colleges or associations such as the Registered Nurses Association of Ontario. These regulatory bodies handle the assessment of qualifications for IENs through the Canadian Registered Nurse Examination or, for Quebec, l'examen professionnel de l'Ordre des infirmières et infirmiers du Québec.

c. The Agreement on Internal Trade (AIT) and its Impact on Licensure/Regulation

The AIT is an intergovernmental trade agreement signed by Canadian First Ministers that came into effect in 1995. The agreement was consolidated in 2010. In theory, physicians or nurses fully licensed in one province or territory should be able to practice in another province or territory without restrictions. This is also true for IMGs and IENs, once they are licensed in one province, they can freely move. For instance, as of Nov. 25, 2010, physicians with an independent practice certificate in any other province or territory can apply for a permit in Quebec. The AIT does not have a direct impact on the licensure process for IMGs before they are fully licensed in one province. However, within the MCC, the National Assessment Collaboration (NAC) is developing a streamlined, integrated IMG assessment, the Observed Structured Clinical Examination (NAC OSCE). And the College of Physicians and Surgeons of Ontario has issued more licenses to IMGs

3. HRH Supply Policy

Human resources for health in Canada has waxed and waned from shortages to surpluses for both the medical and nursing profession. With the advent of public health insurance schemes (*otherwise known as Medicare*) across the provinces in the late 1960s and early 1970s, there was a shortage of physicians and nurses to meet the needs of the now universally covered population of Canadian citizens. New medical and nursing schools were established, but in the short term international recruitment helped to meet the needs; this was largely from the U.K. and Ireland.

By the 1980s and 1990s, concerns over rising health care costs caused both federal and provincial governments to implement substantial cuts to health care spending. Often viewed as a significant driver of health care costs, this resulted in a decline in HRH in Canada, as measured by provider to population ratios (Dumont, et al., 2008). In the section below, we outline some of the key policy reports and shifts specific to physician and nursing human resources in the last 20 years.

a. Key Shifts in Physician HR Policy in Canada 1990-2010

Barer-Stoddart (1991) Report. In the early 1990s, a report prepared for the Conference of Deputy Ministers (CDM) of Health addressed issues regarding physician supply and demand in Canada – known as the Barer-Stoddart (1991) report, named after its authors, health economists Morris Barer and Greg Stoddart. The context for this report was a perceived surplus of physicians (Baranek, et al., 2002), but as noted above, the broader context was of health care cost constraints. The scope of the report was far-reaching addressing issues of the selection, training, supply, distribution and support of future physicians. Some key problematic areas included how funding for academic health science centres was found to be “unstable, chaotic, and inconsistent with their roles.” (p.12). There was inadequate co-ordination between residency programs and medical schools and because post-MD training positions were concentrated in urban areas, exposure to community clinical practices was limited. There was (and continues to be) geographic mal-distribution of specialists and generalists with respect to the need for their services. Finally, with respect to licensure and regulation, “there was no uniform national standard of clinical competence for licensure.” (p.13). Although the report made a range of recommendations; each of which were predicated on the others, few other than reduced opportunities for IMGs and a 10% decrease in the number of undergraduate medical school positions were implemented.

Task Force One (1998-1999). The shift in HHR policy concerning physician human resources began to gain salience in the late 90’s when medical professional associations, working groups and other politically active organizations started to discuss shortages of physicians. A group known as the Canadian Medical Forum, created a self-funded working group (Task Force One) to examine the issue of the shortage of physicians. They focused in particular on certain disciplines - i.e., the shrinking number of family physicians - and regions of the country. In their report to the ministers and deputy ministers of health in November 1999 they included two key recommendations. First, they called for a 27 per cent increase in medical school enrolment, raising the number of positions available to 2,000 by the year 2000. Second, they called for a

parallel increase in the number of residency positions so that there would be approximately 20% more residency positions than Canadian medical graduates. This latter recommendation was not only to provide flexibility in the system, but also to accommodate re-entry training opportunities and qualified IMGs. Most argue there was more action on the first than the second recommendation.

The **Canadian Medical Forum's** mandate is to coordinate the approaches and activities of the major national medical organizations through consultation, consensus building, strategy development and joint action. The Forum represents approximately 60,000 licensed physicians and is a coalition of, and lobby group for, nine medical organizations:

- Association of Canadian Medical Colleges
- Association of Canadian Academic Healthcare Organizations
- Canadian Association of Interns and Residents
- Canadian Federation of Medical Students
- Canadian Medical Association
- College of Family Physicians of Canada
- Federation of Medical Licensing Authorities of Canada
- Medical Council of Canada
- Royal College of Physicians and Surgeons of Canada

Source: http://www.hrsdc.gc.ca/eng/cs/comm/news/2001/010920_e.shtml#100

Task Force Two (2001-2006). Task Force Two was launched in September 2001 to continue the momentum created by Task Force One. Designed as a three-year, multi-stakeholder, multi-phase initiative with a total \$4.8 million budget funded by Human Resources Development Canada, Health Canada and the medical community, its goal was to gather information, assess relative merit and make recommendations on how to best ensure access to physicians with the necessary skills and knowledge across Canada. Task Force Two was particularly focused on five strategic areas including education and training; interprofessionalism; recruitment and retention; licensure, regulatory issues and liability; and, infrastructure and technology. Three themes which cut across these strategic areas were noted:

Chief among these is the importance of improving the capacity of our health care system to adapt to change. ... The health human resource planning approaches we use must be responsive and the system must be flexible enough to respond quickly. ... A second consistent theme is the need for a truly pan-Canadian approach to health human resource planning that is truly responsible to Canadians' changing health care needs. The gaps that currently exist between different health professions, between different principals within the health care system (i.e. education, regulation, funding, planning, etc.) and between jurisdictions must all be overcome if a truly integrated and effective approach to meeting the needs of Canadians is to be found and implemented. Finally, a third theme that runs through all five strategic directions is the need for a lasting and ongoing effort to study, plan, implement and monitor Canada's physician and other health human resources in Canada to meet the needs of the population. In a sector as dynamic as health care, we simply cannot afford to react to shortages or surpluses when and where they arise. (p. ii)

Thus, Task Force also lobbied for the development of options for a long-term federal-provincial and territorial health human resources strategy that went beyond the medical workforce.

ACHDHR (2002-). In 2002 the Advisory Committee on Health Delivery and Human Resources (ACHDHR) was developed through the efforts of the CDM. The ACHDHR is made up of representatives from the federal and all 13 provincial and territorial governments, the Health Action Lobby; representatives from First Nations communities; the Council of Ministers of Education; the Canadian Institutes of Health Research (CIHR); the Canadian Institute for Health Information (CIHI); and Human Resources and Skills Development Canada (HRSDC). The CDM outlined its role would be to provide a national forum for discussion and information-sharing of F/P/T issues to ensure Canada has the HHR to support the health system into the future. The ACHDHR was also to identify emerging issues and respond to requests for advice from the CDM and ultimately to provide strategic policy advice on the planning, organization and delivery of health services. The core working groups established by the ACHDHR include entry-to-practice credentials, internationally educated health professionals; interprofessional education and practice initiatives; and HHR modelling. One of the key products of the ACHDHR was the development of a pan-Canadian strategy for HHR.

HRH Highlights from the 2002 Romanow Commission, Building on Values: The Future of Health Care in Canada. The Romanow report makes recommendations supporting the need for a coordinated approach to HHR planning. The report points to the need to:

- substantially improve the base of information about Canada's health workforce through concerted efforts...to collect, analyze and provide regular reports on critical issues including the recruitment, distribution and remuneration of health care providers.
- establish strategies for addressing the supply, distribution, education, training, and changing skills and patterns of practice for Canada's health workforce.

Source: <http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/romanow-eng.php>

A Framework for Collaborative Pan-Canadian Health Human Resources Planning (2005, 2007).

In 2004, the CDM directed the ACHDHR to develop a pan Canadian HHR framework to facilitate the enhancement of partnerships between government and stakeholders and build a case for a pan-Canadian collaborative approach to planning. This was presented to the CDM and approved in the fall of 2005. At that meeting, there was a commitment made to: accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments; develop targeted efforts to increase the supply of health care professionals to work in Aboriginal communities; take steps to address the health needs of official language minority communities and to participate in HHR planning with interested jurisdictions. The ACHDHR subsequently consulted widely with government and non-government stakeholders to solicit feedback on the draft *Framework*. A final *Framework* was released in 2007 with an action plan to achieve the following goals:

- To improve all jurisdictions' capacity to plan for the optimal number, mix, and distribution of health care providers based on system design, service delivery models, and population health needs.
- To enhance all jurisdictions' capacity to work closely with employers and the education system to develop a health workforce that has the skills and competencies to provide safe high quality care, work in innovative environments, and respond to changing health care system and population health needs.

- To enhance all jurisdictions' capacity to achieve the appropriate mix of health providers and deploy them in service delivery models that make full use of their skills.
- To enhance all jurisdictions' capacity to build and maintain a sustainable workforce in healthy safe work environments.

The Framework did not include hard targets for increasing the supply of health care providers.

b. Key Shifts in Nursing HR Policy in Canada 1990-2010

Over the last 20 years, it has been claimed that the supply of nurses in Canada has fluctuated significantly. Between 1980 and 1991, it was claimed that there was an increase in the number of nurses from 629.1 nurses per 100,000 of the population to 819.9 nurses to 100,000 of the population (Romanow 2002). From 1991 onwards, the ratio of nurses decreased as a direct result of cutbacks to the health care system. Similar to medicine, there were cuts to nursing school enrolment, nursing positions were also cut, and there was a reduction in full time employment opportunities and an overall casualization of nursing labour (CNA 2002). By 1997, nursing organizations were sounding a similar alarm as their medical colleagues that Canada was headed for a major crisis with respect to nursing shortages (CNA 2002). There are a number of factors that contributed to the claimed nurse shortage which include a reduction in the number of nurses graduating, many nurses leaving the profession due to poor working conditions, aging of the Canadian nurse, changes in healthcare delivery and inter-provincial competition for scarce resources (Romanow 2002). The Canadian Nurses Association (CNA), for example found for the first time that many Canadian nurses were migrating to the United States and other countries as a result of layoffs and limited nursing positions in Canada.

ACHDHR *The Nursing Strategy for Canada (2000)*. In 2000, the CDM directed the ACHDHR to develop a strategy for nurses for Canada with a particular focus on supply. The Working Group on Nursing Resources and Unregulated Health Care Workers consulted widely with key stakeholders throughout the country, and produced a guiding document that formed the basis of *The Nursing Strategy for Canada*. According to the report, “[t]he goal of the Nursing Strategy was to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed throughout Canada, and deployed in order to meet the needs of the Canadian population.” (p. ii) The project to produce this integrated strategy was to comprise of two phases. The first included research about the nursing labour market in Canada. The second phase included a range of stakeholder consultations on the results of phase 1. Overseeing this project was the Nursing Sector Study Corporation (NSSC).

ACHDHR *Creating Quality Workplaces for Canadian Nurses (2002)*. Following the release of the *Nursing Strategy*, the Canadian Nursing Advisory Committee was created to formulate recommendations for policy directions that would improve the quality of nursing work life at the federal, provincial and territorial levels. Integrating Phase 1 and 2 of the Strategy, the committee conducted meetings, consultations and research activities, and presented its report in August 2002, containing recommendations “to put in place conditions that would resolve workforce management issues and maximize the use of available resources; create professional practice environments that will attract people into the profession and encourage nurses to

practice well into the 21st century; and to monitor activities and disseminate information to support the nursing workforce and attract and retain the nursing workforce.” (p. ii)

Members of the Management Committee and the Steering Committee of *The Nursing Sector Study* included the following organizations:

- Aboriginal Nurses Association of Canada
- Association of Canadian Community Colleges
- Canadian Alliance of Community Health Centre Associations
- Canadian Association for Community Care
- Canadian Association of Schools of Nursing
- Canadian Federation of Nurses Unions
- Canadian Healthcare Association
- Canadian Home Care Association
- Canadian Institute for Health Information
- Canadian Nurses Association
- Canadian Practical Nurses Association
- Canadian Union of Public Employees
- Health Canada
- Human Resources and Skills Development Canada
- National Union of Public and General Employees
- Ordre des infirmières et infirmiers auxiliaires du Québec
- Ordre des infirmières et infirmiers du Québec
- Professional Institute of the Public Service of Canada
- Registered Psychiatric Nurses of Canada
- Service Employees International Union
- Task Force Two: A human resource strategy for physicians in Canada
- Victorian Order of Nurses Canada

Source: http://www.cna-nurses.ca/CNA/documents/pdf/publications/nurse_human_resource_requirements_e.pdf

CNA's *Planning for the Future* (2002). In the same year, the CNA released its report on nursing supply revisiting a study it undertook in 1997. As noted in this report, “*Since then, there have been changes to the funding of the health care system and changes to nursing education. Governments have increased funding to educational institutions, and a variety of innovative programs have been introduced. Students are applying for a snapping up available places.*” (p. 78). The report recommended that although the output from Canada’s nursing schools was expected to double from approximately 4500 in 2000 to 9000 in 2007 and that there was an expected 1200 per year recruitment of IENs, it recommended continued increased in the enrolment opportunities for nursing education programmes to reach 12,000 per year.

ACHDHR commissioned, *Nursing Human Resource Requirements in Canada: Implications of Changes in Service Delivery* (2004). Leaning more towards a phase 1 research-focused approach, this report addressed how the need for nurses cannot be determined in isolation of broader consideration of the production of health in populations and the production and delivery of health services. Based largely on data from Ontario, it was found that although nursing input per inpatient episode increased from the mid 1990s to early 2000s, this was

largely associated with major reductions in inpatient episodes and an increasing severity of those patients. This finding was consistent with rising concerns with nursing 'burnout' and an overall concerns with nursing work-life addressed by an earlier ACHDHR committee. Perhaps the most critical argument in this report, however, was that much of the debate over HHR is incorrectly based on the implicit assumption of fixed age-specific needs for health care and fixed methods of production and delivery of services. The use of crude nurse to patient ratios is one such example.

Subsequent reports did not fully take heed of this argument. In 2006, there were continued supply-based concerns of increasing numbers of eligible retirements, concerns about losses to the U.S. or U.K. recruitment campaigns, and in the province of Quebec in particular, an increasing trend of nurses leaving the public sector for more lucrative private sector positions (Keatings, 2006; Shamian, 2006). The CNA reported that a 2004 OECD study reported that "Canada had the highest relative nursing shortage of the six countries examined, at 6.9 per cent of the present workforce." (CNA 2005i:4). Shamian (2006) also noted that while the number of RNs employed was decreasing, the population was growing at a steady rate. CIHI (2006) estimated an impending nursing shortage reaching 78,000 by 2011 extending to 113,000 by 2016 unless policy directives to address the current and predicted nursing shortage in Canada were undertaken (CNA, 2005, Lome, 2011).

To counteract the shortage of nurses, Canada has tried to increase its domestic supply of nurses, bring back nurses who have emigrated, and recruited internationally educated nurses (IENs). Regarding increasing its domestic supply, the following statistics from a recent report by the Canadian Nurses Association (CNA) and the Canadian Association of Schools of Nursing (CASN) entitled, "Nursing Education in Canada Statistics 2008-2009" point to some ameliorations in that situation (CNA and CASN, 2010):

- *There is an increase of 4.6% from 2007-8 to 2008-9 in students admitted to entry-to-practice (ETP) programs*
- *The number of ETP graduates has been over 9,000 from 2007-2009 (3 years in a row) and from 2008 to 2009, the number of graduates rose 6.0%*
- *Post-RN programs are offered at 42 schools in all provinces, except PEI (and none in the territories)*
- *The number of fast-track ETP programs is growing. 52 schools offered them (an increase of 67.7% from the previous year) and many offered multiple fast-track programs.*
- *The number of distributed learning (distance education) programs was 88 (an increase of 3% from 2008 to 2009).*

Despite the optimistic numbers in terms of graduates and programs, the replacement pool for retiring faculty is still inadequate and schools face recruitment issues (CNA and CASN, 2010).

More recent projections of nursing human resources takes various HHR assumptions more explicitly into consideration. The CNA (2009) report on the nursing human resources landscape, *Tested Solutions for Eliminating Canada's Registered Nurse Shortage*, provides new projections for how projected shortages need to take into consideration the changing health needs of the Canadian population. The report started first with the projected if no policy interventions are

implemented that Canada will be short almost 60,000 full-time equivalent RNs by 2022. However, six different policy scenarios were tested to see where the greatest strides toward reducing Canada's RN shortage could be made. These included:

- **Increasing RN productivity** by 1 percent per year (non-cumulative) would reduce the shortage by close to half by 2022. This policy yields the best results in the shortest time.
- **Reducing RN annual absenteeism** from 14 days to seven days for just three years is equal to adding 7,000 FTE RNs to Canada's nursing pool
- **Increasing enrolment** in RN entry-to-practice education programs by 1,000 per year from 2009 to 2011 would reduce the shortage to 45,000 from 60,000 FTE RNs by 2022. However, the effects of this policy would start to be felt only in 2015.
- **Improving the retention of practising RNs** by reducing exit rates to 2% for all RNs except those 60 and over (the rates for this group are instead reduced to 10%) would reduce the shortage by close to half.
- **Reducing attrition rates in RN entry-to-practice programs** from 28 per cent to 15 per cent over the next three years (2009-2012) would reduce the shortage to 45,000 FTE RNs by 2022.
- **Reducing international in-migration** by 50% would result in a larger shortage of RNs; however, the effect of this change is not at all substantial (less than 10%) even in the long term. (p. 3)

In sum, there have been similar policy shifts affecting nursing and medical HHR in Canada with greater attention addressed and reports produced or commissioned by the ACHDHR. As it was noted in a recent review of HRH in Canada by the Parliamentary Standing Committee on Health (2010), there is still a long way to go:

Despite the various initiatives undertaken by the ACHDHR, some witnesses appearing before the Committee articulated that it was not providing an effective mechanism for national collaboration in HHR planning. First, they found that the membership of the ACHDHR was not inclusive, as it did not have representatives from the many different health professions involved in collaborative health care. Second, they indicated that implementation of the Pan-Canadian Collaborative Planning Framework was slow and that the ACHDHR had not been successful in ensuring that the Framework was receiving the attention and support it needed from governments to be implemented. Most tellingly, some witnesses appearing before the Committee spoke of the need for a national plan or strategy to address HHR challenges, but seemed unaware of the existence the ACHDHR's Framework.(p. 13)

THE CONTEXT OF HEALTH WORKFORCE MIGRATION IN THE U.S.

1. Immigration policy

The Immigration and Nationality Act (INA), originally created in 1952, and its amendments form the foundation for the vast majority of immigration law in the United States (Jeffereys & Monger 2008:1). The Hart-Cellar Act which was passed in 1965 eliminated nationality quota system and broadened the diversity of U.S immigration to include skilled and family based immigration. This act is cited as the foundation of current U.S. immigration policy (The Congress of United States 2006). This was followed by the introduction of The Refugee Act which defined refugees in line with UN definitions (The Congress of the United States 2006). In 1990, the *Immigration Act* (IMMACT) modified and expanded upon the 1965 Act by significantly increasing the total immigration limit, visas & employment-related immigration. More specific

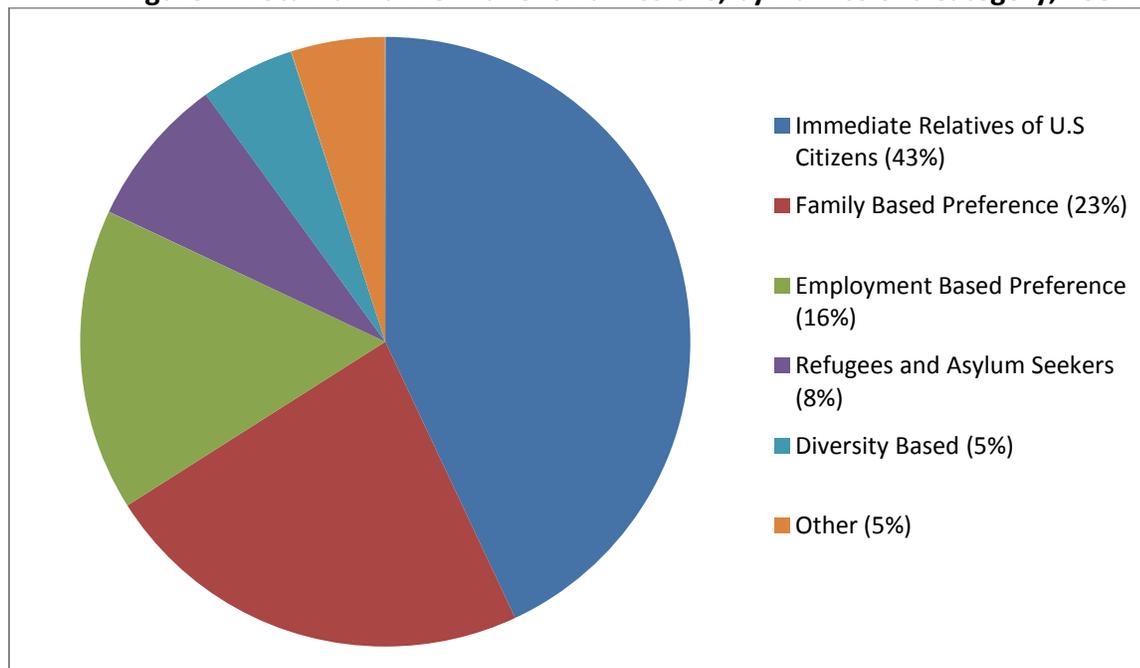
changes include the division of H Visa into a number of different visas (i.e. H-1A, B & C) which are specifically for temporary workers. In addition, the L visa was introduced for employees of international companies who have offices in the U.S. Overall, the IMMACT made the H-1 and L visa easier to access, creating a “preferred pathway” at a time when administrative backlogs hindered permanent admissions. This act also created a notable increase in numerically restricted employment-based migration. Additionally, the 1990 Act expanded the admission of temporary workers with about 300,000 skilled entries annually.

In addition to these changes there, has been a trend in US immigration (even prior to 9/11) towards security, with legislation in 1996 and 2001 both having a considerable focus on illegal immigration and terrorism. There has, however, been little change to actual policy in recent years despite the perceived increase in restrictions (YALE-Loehr, Papademetriou and Cooper, 2005). In 1996, changes were introduced to U.S. immigration laws with the *Illegal Immigration Reform & Immigration Responsibility Act* which raised constitutional and deportation issues surrounding the issue of unauthorized immigration (The Congress of the United States 2006). In 2002, the *Homeland Security Act* was enacted to establish the Department of Homeland Security which represented a major reorganization of the U.S. government (P.L. 107-296). It has been noted that “Since the September 11, 2001 terrorist attacks, policy makers have linked the issue of immigration, particularly unauthorized immigration, to homeland security. This linkage was cemented with the passage of the Homeland Security Act of 2002 (P.L. 107-296), which shifted primary responsibility for immigration from the former Immigration & Naturalization Service (INS) to a new Department of Homeland Security (DHS).”(CRS Report for Congress: Immigration Legislation and Issues in the 109th Congress. 2005). Three new agencies were created in DHS in order to absorb INS functions: 1) Bureau of Citizenship & Immigration Services (BCIS) was created to administer immigration services (including responsibility for processing visa applications). BCIS was later renamed U.S. Citizenship & Immigration Services (UCSIS) which is the name currently in use; 2) U.S. Immigration & Customs Enforcement (ICE) was created to administer Investigative & enforcement functions of the former INS; and 3) U.S. Customs & Border Protection (CBP) was created to administer border patrol, (former INS) inspections & U.S. Custom inspections (<http://www.customs.gov/xp/cgov/home.xml>) These represent the key immigration policy stakeholders that are common to all health professionals migrating to the U.S.

Current U.S immigration law allows non-citizens to enter the country through two paths: permanent (immigrant admission) or temporary (non-immigrant admission) immigration. The goals of permanent migration range from reuniting families to bringing in immigrants who have skills that are highly demanded and to provide refuge for those seeking political asylum (The Congress of the United States 2006). Historically, U.S law has favoured the immigration of foreign nationals with family members who are U.S citizens or permanent residents (Jefferys and Monger 2008). Debates on reform which challenge the historic role of family reunification as the main objective of U.S. immigration system are not new. As highlighted by Martin, Lowell & Bump (2007:7), “During the past twenty years, there have been persistent calls for shifting admission numbers from family categories, under which many immigrants with less than a high school education enter, to skills-based ones that attract more highly educated immigrants.”. It

has been noted that permanent family based immigration in the U.S is approximately five to six times higher than employment based immigration (Jefferys and Monger 2008). The employment based category is identified by preferences groups such as persons of extraordinary ability, professionals with advanced degrees, skilled workers, religious workers and entrepreneurs (The Congress of the United States 2006).

Figure 2: Total Lawful Permanent Admissions, by Admissions Category, 2004



Source: Congressional Budget Office based on Department of Homeland Security, Office of Immigration Statistics, 2004 Yearbook of Immigration Statistics (January 2006).

Temporary immigration allows non-citizens to enter the U.S for purposes of tourism, study, business, temporary employments, professional exchange or diplomatic work (The Congress of the United States 2006). Recently, concerns regarding shortages of workers (primarily in the areas of science & engineering) form a central part of the context behind recent congressional advances (which were denied) towards substantive increases in admission numbers for skilled workers. Although in 2006 a five-fold increase in skilled immigration visas and in 2007 consideration of a Canadian style point system did not move forward it is unlikely these issues will disappear from the U.S. immigration arena (Martin, Lowell & Bump 2008:3&4).

In the U.S, the major route for skilled healthcare workers is through the permanent admission category (Martin, Lowell, Gozdzik, Bump & Breeding 2009). Both permanent and temporary admission categories focus on professional healthcare providers as opposed to lesser skilled healthcare workers. Data on permanent visas shows that nurses are admitted approximately 1.5 times more than physicians. With respect to temporary visas, the speciality H-1B visa is the most popular for healthcare workers. In 2005, approximately, 7022 practitioners and 4102 medical workers were provided with this visa (Martin et al. 2009).

2. HRH regulation

a. Medical Licensure and Regulation

The United States Medical License Examination (USMLE) is a three-step examination to obtaining medical licensure in the United States. The USMLE is sponsored by two bodies: the Federation of State Medical Boards (FSMB), a national non-profit organization representing and supporting the 70 medical boards of the United States and its territories, and the National Board of Medical Examiners (NBME) (FSMB 2010). The USMLE is governed by representatives from the FSMB, the NBME and the Education Commission for Foreign Medical Graduates (ECFMG). Individual state boards represented by the FSMB grant medical licences and the NBME is responsible for managing the USMLE. The ECFMG's role is to engage in assessment of international medical graduates on whether they are ready to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) (ECFMG 2010). The Federation credentials Verification Service's (FCVS) is a centralized body operated under the FSMB to provide a standardized process for state medical boards as well as private and governmental agencies to verify a physician's medical credentials. This service was established to decrease the workload of credentialing staff and avoid duplication by verifying and permanently storing credentials in a centralized location for physicians (FSMB 2010).

b. Nursing Licensure and Regulation

The leader in nursing regulation in the U.S is the Council of State Boards of Nursing (NCSBN). The NCSBN's role is to provide a centralized body through which state boards of nursing work in cooperation on issues that affect the public's health, safety and welfare (NCSBN 2011). The NCSBN is also involved in the management of the nurse licensing examinations, NCLEX-RN and NCLEX-PN. Members of the NCSBN include the 50 states boards, the District of Columbia and the 5 territories (NCSBN 2011). With respect to licensing for internationally educated nurses, The Commission on Graduates of Foreign Nursing Schools (CGFNS) is a non-profit organization that is responsible for credentials evaluation relating to the education, registration, and licensure of internationally educated nurses in the U.S. The CGFNS is responsible for protecting the public by making sure that internationally educated nurses meet the criteria for licensure and immigration requirements in the United States (CGFNS 2011).

3. HRH Supply Policy

The U.S. has had a history of predictions (as well as experiences) of surpluses and shortages of HRH. The predictions of physician oversupply, for example, began as early as the 1980s which led to numerous policy discussions regarding the production of physicians in the U.S. and the number of IMGs that should be admitted into the U.S. Similar to the case of physicians, the nursing labour force shifted from being considered in a surplus but more recently the situation is of a shortage which came to the forefront in 1999. Population increase and aging are the key demographic factors affecting HRH demand and supply. In the section below, we outline some of the key policy changes specific to physician and nursing human resources in the last 20 years.

a. Key Shifts in Physician HR Policy in the U.S. 1980-2010

The predictions of physician oversupply as early as the 1980s but well into the 1990s, resulted in many recommendations regarding the production of physicians in the U.S. as well as the number of IMGs that should be accepted into the U.S. medical system. The COGME, IOM, AMA, and AAMC, for example, all expressed strong concerns regarding a potential surplus of physicians over the number required to meet the nation's health care needs (Ramamurthy 2005). The Graduate Medical Education National Advisory Committee, tasked with examining the adequacy of physician supply, projected to Congress a net excess of 70 000 physicians by 1990 and 140 000 by the year 2000 (Ginsburg et al. 1994). GMENAC's study measured the prevalence of disease and used expert panels to build a consensus regarding the proportion of individuals with each disease who should be treated, the time required for that treatment and the number of physicians necessary to provide that time. The dependence of its model on disaggregating and reconstituting the universe of health care, coupled with its need to assign the *metric of time* to both the elements of care and the effort of physicians in providing them, seriously handicapped its ability to determine what actually was occurring. But GMENAC went one step further, it proceeded to extrapolate its calculations twenty years into the future, predicting that there would be a 30% surplus of physicians in the year 2000, a prediction that has had a pervasive and continuing influence on health policy discussions." (Cooper 2008:27).

In some cases the projections were more nuanced. In the 4th COGME Report produced in 1994, a shortage of 35,000 generalist physicians was projected by 2000 but a surplus of 115,000 specialist physicians (Salsberg 2006:15). "... in a study that was carried out on behalf of COGME in 1994, Weiner predicted that 65% of all specialists (165 000 physicians) would be in excess supply by the year 2000, a prediction that led to a call for the closure of 20 US medical schools, a sharp decrease in specialty training and the curtailment of funding for international medical graduates. Nonetheless, it was characterized as "the most complete forecast to date" and had a profound impact on policy in the late 1990s, leading ultimately to the "Consensus Statement on the Physician Workforce" in 1997 and to GME provisions in the Balanced Budget Act (BBA) of 1997." (Cooper 2008:28).

In 1995 the Pew Health Professions Commission similarly recommended a 25% reduction in the nation's production of physicians, and it was suggested that such cuts in enrolment could be afforded through the closure of existing medical schools (Salsberg 2006:15). Similarly, the 11th COGME Report (1998) called for a cap on IMGs due to concerns about physician surplus. There was a moderate reaction to these predictions – namely a cap on the number of residency positions in 1998. Specifically, in 1997, the Balanced Budget Act cut GME funding by billion through to 2003 and attempted to cap the number of residents at 1996 levels (COGME 2000; Salsberg 2006:20). As a result, "the number of places within US allopathic schools was voluntarily frozen at their 1980 levels for more than two decades." (Cooper 2008:34). In 2002, Cooper et al. (2008) published a report which, by using a trend model, predicted a physician shortage for the period 2020-2025. Approximately two years later, COGME published a new report (followed by AMA and other stakeholders) reversing its predictions from physician surplus to shortage.

In 2005, the COGME predicts a significant shortage of physicians by 2020 (COGME 2005) and in the same year, the AAMC recommended the number of U.S. med grads increase by 15% by 2015 through increased enrolment and the establishment of new schools but just a year later they had increased that estimate to 30% over 2002 numbers (AAMC Statement on Physician Workforce 2006:2). Some estimates put the shortage at 50,000 physicians by 2010, with the gap growing to 200,000 by 2020 (Paral 2004:5).

According to experts in the U.S. medical education sector, the key drivers for these shortages include on the demand side, the growing U.S. population, in particular those over the age of 65 and Americans' increasing use of services; and on the supply side, the aging of the physician workforce and a new generation of physicians who do not work the same kind of long hours as previous generations of physicians (Salsberg 2006:5). Salsberg (2006:16) also argued that these recommendations missed the mark because of the incorrect assumption that the US health care system was going to be dominated by managed care plans that would tightly control the use of services.

More recently, the discussion surrounding the shortage of primary care physicians has escalated. There is growing concern that medical students are discouraged from entering primary care and opting for higher paying specialties as a result of the debt from their student loans (Robeznieks 2009). According to a recent report by the Association for American Medical Colleges (2010) and the American Medical Association (2010), the shortage is expected to be even worse because of the passage of health care reform that will now insure an additional 32 million Americans and a continuous aging population. The report states that in approximately 10 years, there will be a shortage of 90,000 physicians. Due to this concern, there has been an increase in the number of medical schools (4 new medical schools) and the number of medical graduates (an additional 7000 medical graduates), however, the major obstacle remains that there has been no increase in the number of residency slots by the federal government. Residency positions in the U.S are funded through Medicare, however, Medicare's support for residency positions has been capped since The Balance Budget of 1997. The proposal put forth by primary care physicians is to increase Medicare payments to general practitioners so as to make primary care an attractive career path has become a controversial issue as specialists are lobbying against any change that would affect/change their reimbursements. According to the specialists, Congress should not redistribute their resources so that general practitioners are paid more but rather increase funding which in an economic downturn is almost impossible (Pear 2009).

In order to address this physician shortage, officials from the Obama administration are considering three options. The first is to increase medical school enrolment and residency slots. The second option is to increase the use of nurse practitioners and physician assistants and the third option is to expand the National Health Services Corps which appoints physicians and nurses to rural areas (Pear 2009). According to the AAMC (2010) report cited above, Medicare needs to lift their cap on residency training positions and increase residency slots by at least 15% in order to accommodate 4000 medical graduates to meet the 2020 needs.

These critical issues have led to a few proposed legislations to address the primary care shortage. The first is the Access for All America Act which proposes that community health centers and The National Health Service Corps be expanded (Reiselbach et al. 2009). The next is The American Recovery and Reinvestment Act of 2009 which has delivered \$1.5 billion for reconstruction, equipment and technology at community health centers in addition to \$500 million for services provided at the community centers. The National Health Service Corps was also provided with \$300 million (Reiselbach et al. 2009). The next legislation that addresses primary physician shortage is The Preserving Patient Access to Primary Care Act of 2009. This particular bill would generate new residency slots for primary care trainees especially in community health centers as well as additional opportunities to train as primary care physicians in ambulatory settings. (Reiselbach et al. 2009). And lastly, The Resident Physician Shortage Reduction Act of 2009 proposes to expand the number of residency positions supported by Medicare by 15%. In addition, it proposes that training preferences for primary care in community health centers and community based training (Reiselbach et al. 2009).

b. Key Shifts in Nursing HR Policy in the U.S 1990-2010

In the 1990s, the U.S. health care system underwent considerable restructuring including a shift to managed care, that among other things led to an overall decline in the number (through task shifting or skill mix initiatives) and in the quality of nursing positions through short-staffing and increased workloads (The Centre for Nursing Advocacy 2007). This occurred despite fierce opposition by the nursing lobby (Blakeney 2006). The availability of nursing jobs in many areas were attractive to prospective students, however, between 1996 and 2004, there was a drop in the number of graduations from nursing schools which is thought to be the result of lack of confidence in nursing as a career due to the layoffs. Graduations from nursing programs plummeted from 97,000 in 1995 to a drastic 71,000 in 2001. Nursing advocates pointed out that by 2005 nearly half a million American nurses had made the choice to no longer work in nursing (Centre for Nursing Advocacy 2007).

Perhaps even more quickly than the situation changed for physicians, discussions of the nursing shortage came to the fore in 1999. The U.S. Dept of HHS (2002) estimated in 2000 that the National supply of RNs was 1.89 million FTE which was below the demand for 2 million - a shortage of 6 percent. Further, it anticipated the shortage would grow to 12 percent by 2010 and to 20 percent by 2015 and if left unaddressed it would grow to 29 percent by 2020 (USDHHS 2002:1). Similar to the case for physicians, population increase and an aging population are factored into the HHS estimates. If current trends continue, it is argued that by 2020 only 64 percent of projected demand would be met (USDHHS 2004a). Beyond these projections, the shortage was already being felt on the front lines. According to a November 2004 report in Health Affairs, national surveys of RNs conducted in 2004 found that a clear majority of RNs (82%) perceived a shortage where they worked (Buerhaus, Staiger & Auerbach 2004).

It was only in 2005 that graduations from nursing schools began to increase (Aiken & Cheung 2008). Graduations from nursing schools have skyrocketed to its highest in history with 136,621 graduates from U.S. nursing schools who wrote the NCLEX-RN exam in 2006. A major factor

that had led to this increase are the numerous reports of nursing faculty shortages coupled with the excess number of nursing school positions as a result of the decline in enrolments between 1996 and 2004. Nursing faculty shortages create two situations. One being the increase in clinical care roles such as nurse practitioners (which is linked to the physician human resource issues discussed above) and the second, a decreased supply of number of nurses with baccalaureate degrees to meet the demand for more educated nurses working in education and at the bed-side (Aiken & Cheung 2008).

With respect to nurse stock outflows, it has been found that retirement, as a result of the aging population, is the major factor affecting the nurse supply (Buerhaus, Staiger & Auerbach 2000 cited in Aiken & Cheung 2008). According to the HHS (2004 cited in Aiken & Cheung 2008), in 2004 the average age of a RN was 46.8 years. This figure is said to have increased since then. Nurse retirements have affected hospitals the most. This is because in 2006, approximately 45% of all the RNs in hospitals were at least 50 years old and about 12% were 34 years of age or less (Buerhaus, Donelan, Ulrich, DesRoches & Dittus 2007 cited in Aiken & Cheung 2008). According to the Bureau of Labour Statistics, nurses begin to leave the profession permanently after the age of 50 and the retirement rates for those between 50-54 years of age is 17%, for those between 55-59 years of age is 29% and those between 60-64 years of age is 60%. It is estimated that between 2002 and 2012, 478,000 nurses will retire (U.S. Department of Labour 2005 cited in Aiken & Cheung 2008).

The current perceived shortage of nurses is thought to be in the hospital sector, as mentioned above, which started in 1998. Surveys conducted by the American Hospital Association have revealed that approximately 8%, which translates to 150,000 RN positions, in the hospital sector are unfilled. It is expected that the demand for RNs in the hospital sector will increase due to a number of factors which include an increase in demand for specialty care (Cooper 2004 cited in Aiken & Cheung 2008), new medical technology that requires nurse labour and limitations on the number of hours physicians can work for (Aiken & Cheung 2008). Since it is also predicted that a future physician shortage is underway, the demand for nurses will increase further to compensate for the physician shortage (Cooper & Aiken 2006 cited in Aiken & Cheung 2008). Furthermore, if the U.S. government decides to provide health insurance to uninsured citizen, it would mean that an additional 40,000 nurses will be needed in order to serve more patients (Aiken & Cheung 2008).

Perhaps not surprisingly, the first response considered by the industry was to open up the door to IENs (Blakeney 2006). The ironic situation is that there are thousands of qualified applicants rejected from nursing schools in the U.S. every year just as they are from medical schools (Academy Health 2006). It has been speculated that relying solely on nurse migration to overcome the shortage is insufficient as the projected shortage of nurses is too large. IENs will continue to be a part of the strategy to combat the shortage, however, it is not a feasible long term strategy to beat the projected shortage (Aiken & Cheung 2008) The American Hospital Association also convened a Workforce Commission for Hospitals and Health Systems in 2002 which recommended improving work conditions for nurses and other retention strategies, such as increasing educational capacity and curtailing demand (Aiken & Cheung 2008), as a way to

deal with the shortage situation (Brush et al. 2004). Nursing advocates had also argued that wages had declined during a booming economic period (Blakeney 2006).

In light of the current recession facing the U.S., many have returned back to the nursing profession, however, there are approximately 100,000 nursing positions that remain unfilled. The nursing shortage is more likely to also affect those that are going to be newly insured under the “public option” of President Obama’s health care reform. Some law makers are suggesting increasing the number of foreign nurses but the president opposes this strategy since the unemployment rate is high in the U.S (Business Week 2009a). Critics are arguing that hiring foreign nurses is not a long term solution to the shortage. Hospitals prefer to hire foreign nurses at lower wages. Low pay discourages Americans from entering the nursing field which further creates a dependence on foreign nurses (Business Week 2009b).

More recently, the Obama administration has begun to discuss policy options towards attaining self-sufficiency of nurses in the U.S. These discussions have resulted in additional funding provided by the U.S Department of Health and Human Services to encourage and promote nursing education. In 2009, the Department of Health and Human Services announced that \$13.4 million was now available in financial assistance for nurses. This financial assistance was in the form of loan repayments for nurses who were willing to work in critical shortage areas as well as for those nurses who were willing to become part of a nursing faculty. These particular funds were made available through President Obama’s signing of the American Recovery and Reinvestment Act which was signed in February 2009 (U.S Department of Health and Human Service 2009). On June 16, 2010, the U.S Department of Health and Human Services Secretary, Kathleen Sebelius, announced that additional funding of \$320 million was now available through the Affordable Act Care to begin the process of strengthening the health workforce. The Advanced Nursing Education Expansion program will provide \$31 million to 26 nursing schools to increase the enrolment of primary care nurse practitioners and nurse midwives. It has been projected that by 2015, this program will produce 600 nurse practitioners and nurse midwives (U.S Department of Health and Human Services 2010).

CONTEXT OF HEALTH WORKFORCE MIGRATION IN THE U.K.

1. Immigration policy

The immigration in the UK is regulated through the Home Office UK Border Agency which mandate is to secure the UK borders and assess application for immigration and work visas, citizenship and asylum (Home Office, 2011a). The UKBA (UK Border Agency) also funds and manages Regional Strategic Migration Partnerships which mandate is to work with local communities and the Border Agency to facilitate the integration of migrants, refugees, and asylum seekers (Communities and Local Government, 2009). Traditionally, the UK has predominantly been a country of emigration but over the past twenty years that trend has shifted to one of economically driven immigration (Gish 1970; Hatton 2005; Rollanson 2002; House of Lords 2008). Until the government’s ten year “competitive future” plan was outlined in 1997 there was little public debate over the control of migration as set forth in the Immigration Act of 1971 (Rollanson 2002:327). Since that time major changes in immigration

policy have ensued. The “re-evaluation of skills needs” within the UK workforce along, free movement of health professional within the EEA, and disputes over the increase in asylum seekers and refugees within the UK are part of the current controversy (ibid). Immigration rule changes encompassing routes of entry, visas, work permits, level of English competence, enculturation, and eligibility to remain in the UK all impact on immigration.

Entrance to the UK is different for EU and non-EU categories and includes five different routes: economic migrants, visitors or temporary workers, refugee and asylum seekers, students, and family members. There was a decline since 2005 in both family and work migration from the non-EU members while the number of student migrants has increased by 53% between 2005-2009 (Blinder, 2011). Since the 1990’s there has been a marked increase in the number of individuals seeking refuge in the U.K. (Winkelmann-Gleed 2006). To deal with this influx The National Asylum Support Service (NASS) was first introduced in the 1999 Immigration and Asylum Act and formed in 2000. This was part of an overall integration strategy to ensure equal rights and opportunities for refugees in their adjustment to the cultural and economic life of the UK. A clearly defined plan to facilitate the integration of refugees both nationally and regionally was outlined (Home Office: 2000). The strategy encouraged local communities to support refugees, sought to raise awareness among employers and professions regarding the difficulties facing refugees, planned to provide access to funding for training programs such as English language courses, ensure adequate health care assistance, and suitable housing (Home Office 2000: 3). The Home Office also committed funds to refugee organisations such as the Refugee Council, Refugee Action, the Scottish Refugee Council and the Welsh Refugee Council to assist refugees in regional integration (Home Office 2000: 12). In addition, The Home office encouraged profession-specific strategies modeled after a study done by the NHS Executive to address challenges faced by medical refugees. Issues such as “mentoring, induction programmes, access to libraries and the provision of information” were addressed (Home Office 2000: 12). Since 2002, the proportion of asylum has declined to 4.4% of total immigration in 2009.

Within the EU nationals, there is further difference in regulation of entrance, migration and work in the UK. The nationals of the members of European Economic Area, Switzerland, as well as Iceland, Lichtenstein and Norway have right to enter and work in the UK without obtaining work permit. In regard to policy development an important point is made. “As a member of the European Union, the UK cannot regulate the number or selection of nationals of the European Economic Area (EEA) entering the country. Most EEA nationals [despite some restrictions] also have the automatic right to work in the UK. Asylum seekers have rights to humanitarian protection in the UK by virtue of international human rights treaties. *This leaves as the major area of discretionary policy the entry of non-EEA nationals other than asylum seekers.*” (my emphasis; House of Lords 2008: 9). The employment of Romanians and Bulgarians (who joined the EU in January 2007) continues to be restricted through the work permit system. This restriction must be lifted by 2014 at the latest (House of Lords 2008:53). It is estimated that more than half of immigrants to the UK (53%) were coming from non-EU countries. The immigration from non-EU countries had been increasing between 1997 and 2004 (from 166,000 to 370,000) and then gradually decreased in 2009 to 309,000 (Blinder, 2011). A similar trend

was observed in migration from EU countries, with a significant increase in 2004, when the restrictions placed on A8 countries had been lifted, and then decrease to 167,000 in 2009 (Blinder, 2011).

As outlined above, the economic migration to the UK underwent a number of significant changes in the past decade. The High Skilled Migrant Program (HSMP) was outlined in The Home Office White Paper "Secure Borders, Safe Haven: Integration with Diversity in Modern Britain" and launched on January 28, 2002. The HSMP employed a points-based system of assessment similar to Canada and Australia and was designed to ease the entry of internationally trained individuals with specialized skills into the UK workforce. A revised points-based system was released in 2006 - *A Points-Based System: Making Migration Work for Britain* - to help streamline the migration process for those outside the EEA. The intent was to reduce the more than eighty routes of migrant entry to the UK into five tiers based on skills. Under the new system the migrant initiates the application process and does a self assessment through a points' calculation formula. Tier 1 category was designed to allow entrance to highly skilled immigrants, entrepreneurs, artists, and people of exceptional talent. This category also included Fresh Talent program, which was designed for post-study applicants who wish to stay in Scotland. Tier 2 category required skilled workers to obtain a job offer from the employer in the UK. The limited number of workers needed to fulfill specific gaps in labour market could apply for immigration through Tier 3. Tier 4 was restricted to students and finally, Tier 5 category was designated for temporary workers and other migrants who do not come to satisfy UK economic needs (e.g. sportsmen, voluntary workers, etc.) (Home Office, 2006).

On April 06, 2011, the government introduced new changes and added restriction on immigration into the UK. The aim is to reduce migration numbers to pre migration boom of the 90s with hopes to reduce unemployment rates among both, UK nationals and immigrants. Despite the suggestion of Migration Advisory Committee, which was set up by the government to study migration and integration of immigrants in the UK to reduce immigration to approximately 44,000 immigrants, the skilled migration cap was set at 21,700 migrants. The Tier 2 route for immigration was reduced to 20,700 individuals who can be supported by the UK employer in seeking visa (Home Office, 2011b). Tier 1 entrance was changed to allow entrance only to 1000 individuals, including investors and entrepreneurs as well as people of "exceptional talent", such as artists or scientists (Home Office, 2011b). The category Tier 1 (General) has been closed for the skilled workers entrance. This change to immigration policy is said to bring more employment opportunities to the individuals who are residing in the UK (Home Office, 2011b). Most likely, it will significantly affect the immigration process for IMGs and IENs who are willing to practice in the UK.

2. HRH regulation

a. Medical Licensure and Regulation

In general, the certification and regulation of health professionals are managed at the level of the UK government, although they involve different organizations. The registration to practice medicine in the UK is controlled and regulated by General Medical Council (GMC) (GMC, 2001). The mandate of GMC is to ensure protection and safety of the public by ensuring proper

standards in medical practice. The GMC regulates the entrance to medical register, sets up the guidelines for good medical practice and regulates practicing physicians. Since April 2010, the GMC has merged with Postgraduate Medical Education and Training Board (PMTEB) and now it also regulating all medical education in the UK.

The current requirements for practising medicine in the UK include registration with the General Medical Council and determined by education, nationality, and previous experience. There are currently five registration routes. *Provisional registration* allows a newly qualified doctor (who completed medical training in the U.K. or EEA, to carry out the clinical training necessary requirement for full registration (similar to an internship period in Canada). *Full registration* is necessary in order to practise medicine in an unsupervised setting in the NHS or private practise in the UK. *Specialist registration* and *GP registration* is necessary to practice as a consultant or as a GP (respectively) in the NHS. Temporary full registration is granted to doctors coming to the UK to provide specialist medical services for a short period (GMC Website 2007).

For IMGs, the process for obtaining provisional or full registration includes providing proof of medical qualification as per GMC criteria, 12 months' postgraduate clinical experience from an approved hospital in the home country and a satisfactory score on the PLAB test (for IMGs outside the European Economic Area (EEA)) (GMC Website 2011). Prior to October 2007 *Limited registration* was obtained by graduates from medical schools in countries outside the UK and EEA in order to carry out clinical training or by those seeking higher specialist training in the UK but this registration category was eliminated to simplify the process of registration (GMC Website 2007,, <http://www.gmc-uk.org/>)

b. Nursing Licensure and Regulation

Similarly to medicine, the nursing is regulated at the UK level by the Nursing and Midwifery Council (NMC). The NMC's responsibilities include registration of nurses to work in the UK, setting up standards for education, training, and professional conduct, and protection general public from professional misconduct (NMC, 2011). The NMC register includes nurses, midwives, and specialist community public health nurses. The nursing fields include adult, mental health, learning disabilities, and children nursing. The registration should be renewed every three years and is conditioned by successful completion of mandatory professional development in the area of practice (NMC, 2007). International nurses interested in working in the UK are required to provide evidence of nursing education meeting the standards outlined by the NMC and at least 12 months of practice. The other requirements differ for EU and non-EU nurses. The non-EU nurses are required to demonstrate English proficiency and to complete For nurses trained in the European Union (EU)ⁱ and European Economic Area (EEA)ⁱⁱ, the steps to secure employment only require obtaining NMC registration which requires the assessment of the adequacy of nursing training.

3. HRH Supply Policy

Overall, the general HHR policy context in the UK evolved around workforce planning issues. The conundrum of brain drain, skills shortage, and lack of employment has long challenged

health care stakeholders in the U.K. Working conditions “characterized by low wages, long hours, and no guarantee of ever reaching the top” (Gish and Wilson 1970: 507) led to massive emigration of doctors from the UK in the late 1960s into the 1970s causing much concern (Gish and Wilson 1970: 507).

The 1980’s and 1990’s marked a period of rapid changes in the NHS which were oriented to increase efficiency and control costs. The Griffiths Report (1983) identified a number of problems with the management of the NHS, including a lack of managerial responsibility, a neglect of the consumer and performance and the lack of strategic central direction (Dopson, 2009). The report set in motion a set of reforms that were oriented to deliver a number of management changes to the NHS. The National Health Services and Community Care Act (1990) transferred the responsibility to assess the health needs of the community to the local health care authorities who would become responsible for the purchase of health services from NHS trusts. The GPs had become fund holders who were responsible for purchasing the services for their clients. Following this change, the NHS trusts were established and the district health authorities had been transformed into health authorities. The transformation of the patients into consumers was marked by the Patient Charter released in 1991, which emphasized the rights of patients with respect to receiving care. This period was also marked by long waiting times and lack of health care providers (Kennedy, 2001).

When the government changed hands in 1997 health service expansion efforts began. The UK began to implement measures to increase health worker capacity in 1997 and along with other strategies aggressively recruited international health professionals. The NHS introduced a workforce reform plan with specific national targets set to increase the workforce size through the recruitment of the 10,000 more Doctors and 20,000 more Nurses (Department of Health 2001a: 11) In 2000, Barbara Roche, the Minister for Immigration further announced the need to make the work permit system less stringent and to increase the numbers allowed to enter the UK to work (Raghuram and Kofman 2002). This culminated in a 23% growth in the NHS nursing workforce in England by the year 2005. Similar increases were reported for doctors and allied health professionals (Buchan and Seccombe 2006). According to Curson (2003) “ It was also clear that the main thing that could be done quickly was to recruit from overseas as the expansion of the medical schools would take 12 to 20 years to affect the number of specialists available” (16).

a. Key Shifts in Physician HR Supply Policy in the U.K.

Although there has always been a cycle of gluts and shortages of doctors (Maynard 2000:246), by 2000 a perceived ‘shortage’ of doctors (particularly in England) prompted the government to increase medical school intake by 20 per cent (to 6000 per annum), and (Maynard 2000:246) and to embark on an intensive recruitment plan (Department of Health 2001a). Reforms continued into 2001 and 2002 with increases in the number of staff, updating of contracts and providing pay incentives, and modernizing medical education and training (Department of Health 2001b). In addition, expanded roles and competencies for current employees and increased participation of auxiliary/non-medical personnel were recommended (Department of Health 2002a).

The situation differs in Scotland. Although emigration of physicians from Scotland has always been prevalent (Parkhouse and Parkhouse 1990) a 2002 report showed that compared to England, Scotland is relatively well provided for doctors (Temple 2002: 34). Similar to other areas in the UK, shortages exist in specialty areas such as radiology, pathology, and psychiatry. Although these demands are recognized, there appears to be more of a concern for future shortages. It is also noted that “traditional models for the medical staffing of small general hospitals will be difficult to sustain in the face of increasing specialisation and constraints on working hours”(Temple 2002: 25).

European Working Time Directive: In August of 2004 junior doctors in the National Health Service Europe were included in the 1993 European Working Time Directive. The policy document “The New Deal on Junior Doctors’ Hours and working conditions” outlined the “contractual limits on hours” and the scheduled implementation of Working Time Directive (WTD). At that time hours of work were reduced to 58 per week with cuts to 48 hours per week scheduled for implementation in 2009. According to Moss et al. “problems remain in fully complying with working hours regulations within the timeframe required. In addition, the reforms to training at senior house officer level, and the need to ensure that there are enough doctors at all grades to provide 24 hour coverage probably means that problems related to working hours and their unsocial effect will continue for some time. Concern also exists about whether the reduction in working hours will reduce doctors’ opportunities to gain enough experience to become adequately trained” (Moss et al 2004: 6).

Modernising Medical Careers: In February 2003, a policy statement on Modernising Medical Careers was published by the four UK Health Departments and the principles outlining a massive reform of UK postgraduate medical education and training were set out. It was recognized that reform was long overdue “and was driven by the need for care based in more effective teamwork, a multi-disciplinary approach and more flexible training pathways tailored to meet service and personal development needs” (Scottish Executive 2004: 7). In 2005, the DH introduced and began to implement changes to modernize medical training in Modernising Medical Careers (MMC).

Between 2006 and 2007 reforms in the medical training system coupled with Home Office immigration rule changes, DH workforce planning under-assessments, and glitches in the online application process led to a ‘crisis’ situation for junior doctors seeking training placements. In short “there were 9,402 more applicants than posts” (Tooke 2008: 68). An inquiry into the situation was led by Sir John Tooke and an interim report, *Aspiring to Excellence*, was published in October 2007. After a period of consultation with stakeholders a final report, with 47 recommendations was released in January 2008.

Policy disconnect: The BMA expressed their outrage at the “incoherence of the current NHS reform programme” at their 2006 annual meeting. They claimed that “any failure in the NHS is primarily the result of a constant wave of initiatives with little connecting them, a resultant incoherence in the ‘system reform’ programme, and an ongoing failure to engage clinicians in

reform.” (BMA 2007: 5). It is further argued that “it is not the system that is at fault. It is the lack of a coherent strategic plan for the health service in England and a poor record of managing change that has led some to cast doubt on the future of the NHS.” (BMA 2007b: 5).

b. Key Shifts in Nursing HR Supply Policy in the U.K.

Nursing work force planning is of primary concern to policy makers and stakeholders. In the late 1990’s the UK nursing shortage was acknowledged to be part of a global crisis requiring long term solutions. In the UK, the number of newly graduated UK nurses declined by a third between 1990 and 1999. In 2000, vacancies for registered nurses and midwives were estimated to be between 10,000 -20 000. Fewer nurses were entering the profession and there were problems with retaining nurses. Factors contributing to UK shortage include an aging nursing population and decreased enrolment in nursing schools (Maynard 2000:246). It was estimated that National Health Service would need to recruit 110 000 nurses by 2004 (Marchal & Keggels 2003: S94).

In Scotland, for example, Buchan (2002) claimed that it was experiencing a tightening’ in the nursing labour market; an “ageing workforce’, “attrition of nursing students during nurse education”, “a diminishing pool of potential returners’, and the “probability of increased demand” (p.215). He outlined five policy areas worthy of attention: “integrated planning of the healthcare workforce, improved recruitment, incentives to improve retention, improved staff deployment, and improved utilization/skill mix” (p.215). It becomes obvious that health policy developers in Scotland take the issue of capacity building and self-sufficiency seriously. National Strategies encompassing, workforce planning, education and training and selective recruitment have been put forward in a number of policy documents (see Kerr 2005; NHS Scotland 2002, 2006; Scottish Executive 2004; Home Office 2007b).

Modernizing Nursing Career: Setting the Direction Report (2006): The report emphasized the importance of patient choice and collaboration in treatment, the need to develop skills that would allow nursing to work in diverse professional and geographical settings, enhance knowledge of caring for people suffering from long-term conditions and aging population, leadership and collaboration in the teams of diverse health care workers. The report identified four areas for action: 1) Develop a competent and flexible nursing workforce; 2) Update career pathways and career choices; 3) Prepare nurses to lead in a changed health care systems; and 4) Modernize the image of nursing and nursing career (Department of Health, CNO’s Directorate, 2006).

NMC 2008: In September 2008, the Nursing and Midwifery Council announced that it is moving to the degree-level qualification in nursing education. This decision was made in spite of recognition of the diverse workplace tasks that are currently undertaken by nurses, the high level of authority and interaction with other members of health care team and the attempt to attract students with higher qualifications into nursing (NHS Employer 2009). In some areas, the changes to nursing programs have already been implemented and it is expected that the degree level nursing will replace other programs within the next few years in all the UK.

Freezing of nurses' recruitment: Buchan and Seccombe (2009) suggest that recruitment of IENs to the UK has significantly decreased in the past few years. Among the factors contributing to this change they identify (1) Introduction of more difficult and expensive retraining program for overseas nurses by the NMC in 2005; (2) removal of many nursing positions from shortage occupations list of Home Office in 2006; (3) increase in the average received on language test requirements introduced by NMC in 2007; and (4) shift to the point based system of immigration introduced by the government in 2008 (Buchan & Seccombe, 2009). Since immigration numbers have been capped to just 20,700 in April 2011, the recruitment of IENs will probably decrease even further.

Prime Minister's Commission on the Future of Nursing and Midwifery in England Report (2010): In 2009, the Prime Minister's Commission undertook overarching inquiry into nursing and midwifery practice in the UK. The report included 20 recommendations which were organized under following areas: (1) high quality, compassionate care, (2) the political the political economy of nursing and midwifery; (3) health and wellbeing; (4) caring for people with long-term conditions; (5) promoting innovation in nursing and midwifery; (6) nurses and midwives leading services; (7) and careers in nursing and midwifery. Among other recommendations, the report supported the transition of UK nursing into first-degree level, seeing it as an opportunity to improve the quality of care and the skill mix of nurses (COI for the Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010).

Some of the key responses to the report include:

- employers to take a greater role in workforce planning and the need to directly link employer-led estimates of workforce directly to decisions over funding for staffing and training. New systems will be introduced during 2011/12
- consideration is being given to introducing a pilot programme to allow a junior nurse or midwife representative to sit with the trust board to give staff at a junior level the opportunity to express new ideas to decision makers and gain a wider understanding of the operation of the organisation
- subject to Parliamentary approval, the Government intends to appoint the Council for Healthcare Regulatory Excellence (CHRE) as the national accrediting body for assured voluntary registers covering groups which are currently not subject to statutory professional regulation
- the development of a model of school nursing that makes clear the key contribution of those nurses to the health of children and young people in the school and the wider community
- no reduction in midwifery training places during 2011/12. The Centre of Workforce Intelligence to monitor levels to ensure the right balance of numbers is achieved
- employers must implement policies supporting zero tolerance of direct threats to the physical safety of staff.
- development of a system where the money for training follows the individual member of staff
- development of leadership fellowships for nurses and midwives
- to support research careers provision of national funding to support for clinical and academic training schemes

Source: NHS Employers. (2010). Prime Minister's Commission on Nursing.

<http://www.nhsemployers.org/PlanningYourWorkforce/Nursing/toolsandresources/Pages/PrimeMinistersCommissiononNursing.aspx>

Thus, the shortage of doctors and nurses coupled with the need to modernize medical and nursing educational training, improve infrastructure, and improve lifestyle and working conditions resulted in a massive series of reforms commencing in 2000. It has been argued that

in the UK “the shortages are caused in part by excess demand for particular kinds of skills (including managerial) but also by failure to retain staff in the public sector because of non competitive pay and conditions” (Spencer 2002: 1). While these policy matters flourished in 2004, by 2005 they waned in the wake of concerns with retention, integration, and self-sufficiency. The notion of ‘growing our own’ became a central focus.

Recent funding deficits further complicate workforce planning issues. The expansion of the NHS in the early years of the millennium came to an abrupt halt in 2006 with the Reform Funding Crisis. As Palmer (2006: xv) described, “In recent years, the NHS has seen the most sustained period of rapid funding growth ever. By 2007/8, annual spending will be 40 per cent higher in real terms than it was five years earlier. But despite the increased funding, the NHS is in deficit. In 2005/6 NHS trusts in aggregate overspent by more than £1.2 billion, and the NHS as a whole overspent by more than £500 million. More than 60 trusts incurred significant deficits, and stories of staff reductions, service cutbacks and ward closures are widespread.”

CONTEXT OF HEALTH WORKFORCE MIGRATION IN AUSTRALIA

1. Immigration policy

Australian immigration policy has undergone major shifts across the twentieth century, with state policy affected by both ideological and economic considerations promoted by increasingly diverse interest groups. In the postwar decades, state policy largely reflected employers’ emphasis on increased immigration as central to growth. By the 1980s, the influence of ethnic groups also increased, encouraging a strong focus on family reunion and welfare support, goals to which Labour governments were sympathetic. Immigration policy became increasingly politicized both in the community and in terms of policy, but with little coherent direction—typified by several changes of Federal ministers in the late 1980s to early 1990s. Tensions have continued between the desire of the Minister for Immigration and associated departments to maintain discretionary control, and a more active judiciary asserting immigrants’ rights (Betts 2003).

Whilst Australian policy has adjusted to the greater diversity of immigrants, especially from Asia, from the early 1980s, public concerns about the impact of immigration grew during the early 1990s’ recession. Under the incoming Liberal-National Coalition government in 1996, an immigration policy review further intensified existing stress on economic rather than humanitarian factors, and in 1999, produced significant revisions of entry criteria. Temporary migration, especially of skilled migrants to meet specific labour force needs, was encouraged through expansion of particular visa categories (the ‘400 series’) and more stringent screening of qualifications and mandatory English testing introduced for those seeking entry (Hawthorne 2005, 2008). The proportion of family class migrants thus declined from 69% between 1995-96 to 34% by 2002-03 (Richardson and Lester 2004:16). This overall policy thrust was accompanied by a strong emphasis on border protection and mandatory detention of unauthorised asylum-seekers, renewed emphasis on Australian nationalism rather than multicultural ideals and, in keeping with the philosophy of recruiting self-sufficient migrants, a decline in welfare support. New migrants were no longer able to apply for and receive social welfare benefits for their first

two years in Australia unless they had arrived on a humanitarian visa (Richardson and Lester 2004: 15). When it published its revised selection protocol in 2001, the Immigration Department's six fundamental attributes defining "a good (skilled) applicant"; included securing skill-related employment quickly after arrival and not needing welfare benefits (Hawthorne 2002:82).

Concurrent with these policy changes, the number of skilled migrants to Australia increased from "25 percent in 1995-96 to 55 percent in 2002-03" (Richardson and Lester 2004: 16). The increase in the number of individuals entering on temporary visas for particular occupations and skills defined as being in high demand increasingly included medicine and nursing (Parliament of Australia 2007:1). More recently, immigration policy in Australia has shifted from one of focusing on labour outcomes of migrants to placing emphasis on ensuring that new migrants are able to secure employment in order to become economically independent (Spinks 2010). New protocols such as the introduction of the nominated skills test, strict regulation around the English language test and the increased restrictions around foreign qualifications illustrate the shift in immigration policy (Spinks 2010). As a result, the focus of the Migration Program has now switched away from family stream migration to skilled stream migration. It has been reported that between 1996 and 1997, skilled migration constituted of 47% of the Migration Program, however, between 2008 and 2009, this figure had leaped to 67% (Spinks 2010).

Permanent Migration. The permanent immigration program continues to comprise two components, the Humanitarian program for those entering Australia as refugees and the 'Migration program for Skilled, Family and Special Eligibility Stream' migrants (Richardson and Lester 2004). Skilled workers can immigrate to Australia through the General Skilled Migration (GSM) Program which includes a range of permanent and temporary visas designed to attract workers such as medical professionals (Australian Visa Bureau 2007b). Under the GSM are four programs: General Skilled Migration, Employer Nomination, Business Skills Migration and Distinguished Talent (Spinks 2010). More recently, as a result of the intention to reduce 'brain waste', there has been a shift within the skilled migration program as well. The shift reflects a change away from independent skilled migrants, that is, those who do not have to seek employment prior to their arrival in Australia, to those who are sponsored skilled migrants, that is those that have secured a job offer before their arrival in Australia (Spinks 2010). In July 2010, a new Skilled Occupation List was introduced which included 181 occupations that were considered to be in demand in Australia. The focus of list was to ensure that skilled migration should be demand-driven versus supply-driven (Spinks 2010).

Temporary Migration. The most significant change in immigration patterns over the last 10 years to Australia is the increase in long-term temporary migration (Spinks 2010). Important to note here is that temporary migration is not part of the GSM but temporary migration is now becoming the stepping stone towards permanent migration. It has been reported that in 2008-2009, one third of all the migrants in GSM who were given permanent residence had initially come to Australia through temporary migration (Spinks 2010). Overseas students and temporary skilled migrants have been the biggest groups of temporary migrants that are

entering Australia on the Subclass 457 (Temporary long stay business visa). It has been noted that employers in the health sector particular hospitals and large business industries sponsor the largest number of temporary migrants through Subclass 457 (DIMIA 2005). Unlike permanent migration, temporary migration visas are not capped but the numbers constantly change according to the demand from potential temporary migrants and employers who want to recruit temporary migrants (Spinks 2010, DIMIA 2005).

2. HRH regulation

a. Medical Licensure and Regulation

Prior to 2010, medical licensure was controlled by individual state and territory medical boards. The state and territory boards made decisions regarding registrations (AHPRA 2010). The Australian Medical Council (AMC) was responsible for educational standards and accreditation of medical schools and specialist medical training in Australia. Its mission is to ensure, monitor and maintain the standards of the medical profession in Australia so as to protect the public (AMC 2011a). With respect to IMGs, the AMC assesses the medical education of those IMGs who are seeking to practice in Australia. In July 2008, the AMC introduced a nationally consistent process for IMGs by offering 4 different pathways of assessment: competent authority, standard pathway, workplace based assessment and specialist assessment pathways (AMC 2011b, McLean 2008). The AMC also provides credential verification services to the Medical Board of Australia (AMC 2011b).

b. Nursing Licensure and Regulation

Similar to the licensure and regulation of the medical profession in Australia, The Australian Nursing and Midwifery Council (ANMC) was the national body that worked with state and territory Nursing and Midwifery Regulatory Authorities (NMRA) in setting standards for nursing regulation. Each State had had its own regulatory authority which was responsible for regulating the registration of nurses including Overseas Qualified Nurses (OQN). The ANMC's role with respect to OQNs involved assessing whether OQNs were ready to migrate or whether they needed additional training to be eligible for migration. The Australian Nursing and Midwifery Accreditation Council's (ANMAC) role is to accredit nursing and midwifery schools and programs in order to ensure that nursing education is at its highest level (ANMAC 2011).

c. Relevant Policy Changes to Health Professional Regulation

Effective July 2010, a new centralized organization, known as the Australian Health Practitioner Regulation Agency (AHPRA) regulates ten health professions including doctors and nurses through nationally consistent legislation. This builds upon the Mutual Recognition Agreement in place since 1992 which served to increasingly standardize the regulation process. Ten health professional boards operate under AHPRA including the new Medical Board of Australia (MBA) and the Nursing and Midwifery Board of Australia (NMBA) (AHPRA 2010). The medical and nursing boards "set standards and policies that all registered health practitioners must meet." (AHPRA 2010). AHPRA is now responsible for managing registration across the country for all 10 professionals. The role of the AMC new role is to ensure the national standards of education, training, assessment of the medical profession through accreditation (AHPRA 2010). In July 2010, the ANMC changed its name, primarily due to the change in its role, to the Australian

Nursing and Midwifery Accreditation Council's (ANMAC). The ANMAC is solely responsible for the accreditation of nursing and midwifery schools and programs while the NMBA has taken the responsibility of registration regulatory functions.

3. HRH Supply Policy

Australia has moved from a perceived oversupply of doctors to significant shortages that are especially acute in rural and remote areas. By the mid-1990s, Federal government policy attempts at central planning of the health care workforce through the Australian Medical Workforce Advisory Committee (AMWAC), contributed to physician shortages through a coordinated reduction in the numbers of medical school positions by the 2000s. Government policy has shifted and is now focused on growing the medical workforce. As with doctors, a perceived oversupply of nurses in the late 1990's/early 2000's is now acknowledged to be a chronic shortage. Policy strategies now aim to increase the numbers of physicians and nurses by the establishment of new medical schools, increasing the number of undergraduate nursing positions and through the temporary and permanent migration of a significant number of overseas trained health workers. In the section below, we outline some of the key policy shifts specific to physician and nursing human resources in the last 20 years.

a. Key Shifts in Physician HR Supply Policy in Australia 1980-2005

Public funding of the healthcare system in Australia accounts for approximately 70 percent of the total expenditure. Between 1980 and 1995, per capita spending on health care increased quickly in Australia and continues to increase, but at a slower rate (Bloor and Maynard 2003). According to the Productivity Commission Report (2005), Australia has gone from a place of surplus to chronic shortages in areas of health care including nurses and doctors, with shortages most acute in rural and remote areas. The report stressed that governments and stakeholders will continue to face the issue of mal-distribution of the health workforce for many years to come (Productivity Commission 2005:209).

During the mid-1980's the number of medical school enrolments in Australia was reduced (Hawthorne & Birrell 2002:55) and as in Canada, government policy in the 1990s limited the number of places available in medical schools (Weyden & Chew 2004:633). In February of 1992 the Medical Workforce Supply Working Party announced concern about Australia's "persistent over-supply of doctors" (Hawthorne & Birrell 2002:55). Controlling the intake of medical students represented an attempt at central planning of the health care workforce (Bloor and Maynard 2003).

By the mid-1990s, in addition to increased Medicare costs, this decline led to the AMWAC stating that any shortages in doctors were a result of a mal-distribution of the medical workforce rather than any real or concrete doctor shortage in Australia (Birrell & Hawthorne 2004:635). Accordingly the AMWAC advised the Australian government to contain the growth of the medical workforce by limiting entry to medical schools, limiting the immigration of doctors and restricting the number of medical practitioners eligible to bill Medicare (Healy et al., 2006:81). Other policy changes included the 1996 Amendments to the Health Insurance Act which meant that physicians who passed the RACGP training program no longer had

guaranteed access to Medicare provider numbers (Hawthorne & Birrell 2002:55). Overall HHR Policy initiatives during the mid-nineties were aimed at reducing the growth rate of Australian's medical workforce (Hawthorne & Birrell 2002:55).

In the late 1990's the Commonwealth Government responded to the shortage of GPs in rural areas by allocating funding to support state-based rural recruitment agencies (Birrell & Hawthorne 2004:88-89). Physician shortages worsened during the late 1990's and early 21st century. In 2002, Access Economics, commissioned by the AMA, found that Australia had a shortage of 1200-2000 GPs (Healy et al., 2006:84). Shortages were also increasingly found in areas of medical work deemed "least prestigious" and where living and working conditions were considered more difficult (Birrell & Hawthorne 2004:85-86). Other factors noted as further exacerbating the shortages included changing demographics of the work force and changing lifestyles and especially the ageing population (AMWAC 2005)

The AMWAC produced a report in 2000 emphasizing the distributional issues related to GP services in Australia. For example, the number of GPs working in remote communities versus those in capital cities was 66.1 versus 122.7 per 100,000 population. (Healy et al. 2006:84). In 2000 Australia launched the Regional Health Strategy "More Doctors, Better Services". This program, along with other initiatives, sought short and long term solutions for rural health care shortages, including opening up additional rural practice places, increasing financial incentives for GPs working in designated "Rural Pathways", funding clinical schools which encouraged rural medicine, and general scholarships directed at students studying rural medicine (Healy et al. 2006:84).

In 2004, the National Health Workforce Strategic Framework (NHWSF) was widely endorsed by health ministers as well as health sector stakeholders. This strategy is used to guide health workforce planning over 10 years and was formulated by the cooperation of various stakeholders such as professional associations, governments, educators, Indigenous groups, etc (Australian Government Productivity Commission 2005). The Australian Council for Safety and Quality in Healthcare was also involved in establishing this framework. The main principle of the framework is to "focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market." (Australian Government Productivity Commission 2005:37). Although the framework is widely accepted as the step forward in Australia's health workforce planning, the education stakeholders have expressed their concern over the lack of consultation from them regarding this framework (Australian Government Productivity Commission 2005).

In 2005, the Australian Government's Productivity Commission's report on health workforce issues highlights policy changes that reflect the need to curb the shortage through increasing the number of medical school slots by 30% between 2001 and 2009. On the contrary, others have argued that simply increasing the number of doctors, nurses, beds, etc. is not a means to achieve long-term sustainability in the health care system (Queensland Health Systems Review 2005).

b. Key Shifts in Nursing HR Supply Policy in Australia 1980-2006

Australia was not immune to the shortage of nurses experienced in Canada, the U.S. and the U.K. Australian shortages were exacerbated in the mid 1980s as nurse training moved to tertiary education settings. (Hawthorne 2001:216). Strategies designed to improve the cost effectiveness of the health care system, such as casualization of nursing labour, also led to a declining nurse to population ratio in Australia (Baumann et al. n.d). The 1999 Nursing Labour Force Report, for example, found that the nursing shortage was influenced by many full time nurses moving towards part time employment (Wickett & McCutcheon 2002:45). Cuts in the number of full-time positions particularly for nursing students in the 1990s in turn negatively affected the numbers completing nursing degrees (Wickett & McCutcheon 2002:45). It also increased the exodus of nurses emigrating from Australia which, between 1983 and 1994, numbered almost 24,000 locally trained nurses (Jeans et al., 2005:19). Each of the national nursing workforce reports consistently agreed on the following key drivers of supply and demand:

- the general inadequacy of numbers of nursing graduates produced over recent years to meet demand (in terms of both replacement and growth in demand for health services);
- the ageing of the nursing workforce (and projected retirements), decreasing hours worked and turnover will have an effect on the ability of the nursing workforce supply to replace itself;
- growth in demand for health services which is expected to increase especially in the aged care sector but also across acute care sectors. (AHWAC 2004:8)

In July 2004, the Australian Government announced that it would provide additional nursing places in the 2005 year (AHWAC 2004:31). Later on April 8, 2006 The Commonwealth announced it would provide 1,000 new higher education nursing places (COAG 2006:ⁱⁱⁱ). A number of other government initiatives have recently been put in place to encourage non-practicing nurses to re-enter practice (Healy et al. 2006). These initiatives include scholarships to cover transportation costs to and from work, financial aid for tuition and child care, and additional training when they return to work (84-85). For the 2006-7 year, states and territories have taken steps to strengthen the nursing workforce in Australia (COAG 2006):

- New South Wales committed to funding recruitment and retention strategies for the nursing workforce as well as addressing the health workforce through recruitment, education and training strategies (COAG 2006). Other initiatives include a scholarship program targeting areas of need, “professional and clinical skill development programs” and higher remuneration. The government of New South Wales claims these initiatives have been positively received. Between January 2002 and July 2005, more than 5000 nurses have been either recruited or returned to the public health workforce (Productivity Commission 2005:44).
- Western Australia’s commitment included expenditures on nursing programmes, specialist trainees and a focus on strengthening mental health programming (COAG 2006).

- Victoria committed to 1500 extra Technical and Further Education (TAFE) places for nurses (COAG 2006). TAFE provides education to become an Enrolled Nurse (Dept of Education, Science and Training 2001).

As of 2006, Australia-wide shortages persist in many areas of nursing and are worse in specialty areas including theatre, critical and intensive care and mental health. These shortages are also evident in midwifery and neonatal care (Healy et al.2006:84-85). The most crucial nursing shortages exist in rural and remote Australia where nurses comprise the largest proportion of health professionals providing care. Additional concerns for the rural and remote nursing workforce include exceptionally high staff turnover rates (National Rural Health Alliance Inc. 2006). The Report on the Inquiry into Nursing, (2002) suggests that nursing suffers from a failure in long-term planning, particularly evident at the national level (Commonwealth of Australia 2002).

c. Recent HRH Policy Shifts 2007-

In 2007, the COAG established a taskforce, The National Health Workforce Taskforce (NHWT), to conduct projects and provide advice on health human resource issues (AHMAC 2008). The role of the taskforce is to align its work with the National Health Workforce Strategic Framework's (NHWSF) principles whose main aim is to achieving self-sufficiency. The NHWT's projects would focus on supply, distribution and retention (AHMAC 2008). Most recently, in 2010, a national health workforce agency, Health Workforce Australia (HWA), was established by the COAG. The COAG's goal in developing this agency is to "provide more effective and integrated clinical training for health professionals, support workforce reform and more efficient workforce use, and provide effective, accurate planning of health workforce needs." (HWA 2010a:670). The HWA acts as a cross-jurisdictional body between the government, non-governmental agencies and the education sector to tackle issues relating to health workforce planning in Australia with the aim to align HHR polices with education policies The HWA also assumed responsibility of the NHWT (HWA 2010b).

SUMMARY

In sum, there are clear similarities across the four case studies in terms of HRH policy, but differences as well particularly in regards to health professional regulation and immigration policy. Table 1 presents a summary of the immigration, HRH regulation and policy contexts across the four countries. Briefly, each country manages immigration at the national or federal level and includes economic as well as family and refugee/asylum seeking categories, but each of the countries has a different emphasis on the use of visas to target certain worker categories. In terms of HRH regulation, two models are apparent: the federated model of the U.S. and Canada, the centralised model of the UK and the newly centralised/hybrid model in Australia. What is most striking, however, is despite different policy contexts, all four countries experienced periods of projected surpluses and shortages of both medical and nursing human resources. All of these contextual features play out in the way each country approaches the ethical recruitment and integration of internationally educated health professionals.

Table 1: Summary of Immigration and HRH Policy Contexts in Canada, the U.S., the U.K., and Australia

Country	Immigration Policy	HRH Regulation	HRH Policy Shifts
Canada	<ul style="list-style-type: none"> • Federal jurisdiction; three categories: refugee, family class and economic class based on a points allocated to social capital • Some provincial input through PNP for shortage occupations 	<ul style="list-style-type: none"> • Specialty certification is nationally based • Licensure and professional regulation is provincial/territorial based • A harmonization process is underway in response to the Agreement on Internal Trade 	<ul style="list-style-type: none"> • HRH Policy is largely a provincial jurisdiction with recent coordinative involvement by the ACHDHR • HRH has waxed and waned from perceived surpluses in the 1990s to current or projected shortages for both medical and nursing HR.
United States	<ul style="list-style-type: none"> • Federal jurisdiction; two paths to immigration: permanent (immigrant admission) and temporary (non-immigrant admission). • Major route for foreign skilled healthcare workers is admission through the permanent category. 	<ul style="list-style-type: none"> • Licensure and professional regulation is state/territorial based. 	<ul style="list-style-type: none"> • HRH policy is largely a federal jurisdiction. • There has been a history of perceived oversupply of both physicians and nurses as early as the 1980s. • Currently, there are projected shortages for both medical and nursing HR.
United Kingdom	<ul style="list-style-type: none"> • Federal jurisdiction; five routes to entrance: (1) economic migrants; (2) temporary workers and visitors; (3) family category; (4) students; and (5) refugee and asylum seekers • Major route for health care workers is through economic path (Tier 2) 	<ul style="list-style-type: none"> • Licensure and professional regulation are based at the UK-level 	<ul style="list-style-type: none"> • HRH policy has largely been at the UK-level, but more recently, this has been devolved to the different nations • The 1980's and 1990's were marked with shortages in funding and supply of HRH • Starting 1997 and until early 2000s active expansion of HRH including domestic production and international recruitment • Recent change include a move to self-sufficiency and a focus on domestic production of HRH
Australia	<ul style="list-style-type: none"> • Federal jurisdiction; two categories: permanent and temporary migration. • Recently, major route for non-citizens is through long-term temporary migration programs. 	<ul style="list-style-type: none"> • Prior to 2010, licensure and professional regulation was state/territorial based. • Effective 2010, a centralized body, AHPRA regulates the medical and nursing profession through nationally consistent legislation. 	<ul style="list-style-type: none"> • HRH policy is largely a federal jurisdiction with some input from the states/territories. • There has been a shift from a perceived oversupply to significant shortages for both medical and nursing HR.

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Endnotes

ⁱ EU countries include: Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Estonia, Denmark, Finland, France, Germany, Greece, Hungary, Republic of Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Portugal, Poland, Romania, Slovakia, Slovenia, Spain, Sweden, and the UK. Switzerland has mutual recognition of nursing qualifications.

ⁱⁱ EEA countries include: Iceland, Liechtenstein and Norway.

ⁱⁱⁱ <http://www.coag.gov.au/meetings/140706/index.htm#health>