Mobility and Migration of the Health Workforce
Abstract Submissions

A National Nursing Assessment Service: From Conception to Implementation

Presenter: Louise Taylor Green, National Nursing Assessment Service and Julia To Dutka, CGFNS
Co-Authors: Mary-Anne Robinson, College and Association of Registered Nurses of Alberta Franklin Shaffer, CGFNS International

Background:
The development of a centralized national nursing assessment service (NNAS) for international nurse applicants to Canada is innovative, collaborative self-regulation in action. The regulation of health professions is a provincial responsibility in Canada leading to different rules governing the practice of registered nurses (RNs), licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs) across the country. Federal and provincial governments are intervening with domestic labour mobility agreements to meet workforce demands, resulting in restriction on the autonomy of regulatory bodies. A 2005 Report entitled Navigating to Become a Nurse in Canada, published by the Canadian Nurses Association recommended the creation of a centralized body for internationally educated nurse (IEN) assessments. Canadian nurse regulators recognized an opportunity for self-directed collaboration. The NNAS project began by harmonizing application requirements of 23 separate regulators across three nursing disciplines, an unprecedented achievement in Canada. This work was followed by an agreement to establish a single-window application process for IEN applications to Canada. Following incorporation in 2012, the NNAS formed a partnership with CGFNS (Commission on Graduates of Foreign Nursing Schools), an international authority on credentialing. CGFNS will create the single point of access for IEN applicants to Canada as well as complete a comprehensive credential assessment report of each applicant. The NNAS is a nurse regulator-led initiative, based on an exceptional level of consensus and the progressive use of technology. It will provide a simplified, innovative, consistent approach to assessment of IEN applicants in Canada – combining public protection with improved access for IENs.

Objectives:
1. Provide a single point of access for IEN applicants to Canada.
2. Plan and manage a pilot of the new system
3. Launch and evaluate assessment service
4. Develop policies and guidelines to guide project implementation and NNAS operations
5. Evaluate initial implementation

**Methods:**

Development of the NNAS occurred through a project-managed process of collaboration and consensus. Executive sponsorship was provided by the NNAS Board of Directors, who represented the governing interests of the corporation on behalf of its member nursing regulatory boards. The Board also serves as the Policy Committee of the NNAS during project development. A Project Implementation Sub Committee (ISC) was appointed by the NNAS Board and led by the Board Chair and provided unified direction to the Project Manager Office (PMO).

The PMO reports directly to the ISC and held responsibility for overall NNAS project governance until NNAS staff leadership was recruited and engaged. The PMO provided a centralized layer of control and coordination among all key stakeholder groups: NNAS Board, CGNFS International, NNAS member regulatory bodies and NNAS staff leadership. To facilitate timely decision making, the ISC Chair was authorized to make decision on behalf of the NNAS between scheduled meetings, except where issues arose that required escalation to the ISC as a whole.

Nursing regulatory bodies (RBs) representing the member boards of the NNAS were actively engaged throughout all phases of the project through a Change Management (CM) Team where numerous best practices in change management were leveraged to accelerate the change experience.

CGFNS International had a direct reporting relationship to the PMO, given its governance role, as relates to development and delivery of the functional requirements of the NNAS system outlined in a Master Services Agreement (MSA) between the NNAS and CGFNS. Planning for pilot and implementation commenced in January 2013 and has an estimated completion date of October 2016.

Regular monthly Project Status Reports will be submitted to the ISC Chair and quarterly project status meetings aligned with key project milestones are scheduled with the ISC over the course of the project. An escalation and resolution process was agreed to at the outset of the project and used to manage issues that arose during the project.

Key activities and timelines for the project are organized into four stages:

1. Project Initiation, January – April, 2013
3. Pilot, July – October 2014
Retention of Recent Medical Graduates: Are Canada’s New Physicians Looking Abroad for Employment Opportunities?

**Presenter:** Mr. Steve Slade, Canadian Post-M.D. Education Registry (CAPER)

**Co-Authors:** Dr. Geneviève Moineau, Association of Faculties of Medicine of Canada

**Background:**
Waxing and waning medical class sizes tell the story of Canada’s pendulum-like perception of physician supply. Following periods of expansion and reduction, the number of first year medical students has increased 85% since 1997. However, the growth rate has slowed and, for the first time since 1997, the number of entry level medical students decreased in 2013-14. Furthermore, graduating physicians report being unemployed or underemployed and residents are extending their training as a result. As well, there are anecdotal reports of new physicians looking abroad for employment opportunities. In the context of a possibly changing physician supply paradigm, this study examines physician migration from Canada to the United States and other countries to determine if there are early signs of decreased physician retention in Canada.

**Objectives:**
The purpose of this study is to examine physician migration within Canada and as well as out-migration to the United States and other countries to determine if there are early signs of decreased physician retention in Canada.

**Methods:**
The Canadian Post-M.D. Education Registry (CAPER) collects training and ongoing practice location data for all residents and fellows at Canada’s 17 faculties of medicine. Two-year and five-year practice location was examined for all those who completed medical training in Canada from 1995 onward. Graduating cohorts from 1995-1997, 2002-2004, and 2009-2011 were compared to evaluate retention patterns during time periods of generally perceived physician shortage and surplus. Further analysis measured retention among medical specialties that report difficulty finding employment.

**Findings:**
Retention of graduating physicians was lowest between 1995 and 1999, when 12.6% were located outside Canada two years after completion of training; on average, 7.9% of these new physicians were located in the United States and 4.7% were located elsewhere outside Canada. Retention of newly graduated physicians increased throughout the study period; 91.8% of those who completed training from 2009-2011 were located in Canada two years into practice. Despite increased emphasis on primary care in the United States, the number of Canadian family medicine graduates moving to the US decreased significantly, from 144 (6.7%) of those who completed family medicine training from 1995-1997 to only 5 (0.2%) of the 2,794 family physicians who completed training from 2009-2011. Surgical trainees are more likely to leave Canada compared to other medical specialists. Among all...
physicians who completed training from 2009-2011, 14.0% of surgical trainees left Canada, compared to 10.2% of medical specialists and 4.0% of family medicine trainees.

**Conclusion:**
MD program enrolment exhibits a cyclical pattern of growth in Canada, despite linear upward population growth. While there is variation among medical specialties, recent graduates are more likely to stay in Canada, compared to earlier exit cohorts. However, interprovincial migration has increased among medical specialties that report employment difficulties.

**Take Home Messages:**
1) The cyclical pattern of physician supply is discordant with the steady, linear upward trend in population growth.

2) While survey data speaks of physician employment challenges in Canada, there is little evidence to suggest that new medical graduates are looking for work outside of Canada.

3) Retention is lowest among recently-graduated surgical specialists, as compared to medical and family medicine specialists. Furthermore, interprovincial migration has increased among surgical specialists, including those specialty groups that report employment challenges.

**Two Wings and a Prayer: Should Canada Make it Easier for Canadian Doctors Trained Abroad to Enter Practice Here**

**Presenter:** Ms. Lindsay Hedden, University of British Columbia
**Co-Authors:** Dr. Morris L. Barer and Dr. Robert G. Evans

**Background:**
About 3,600 Canadians are currently studying medicine abroad (CSMAs) in around 130 medical schools in 30 countries. More than 90% hope to return to practice in Canada. But the road back is not easy. These graduates must complete postgraduate residency training in Canada and, alas, there are many fewer openings than there are aspirants. One might have thought, amid the endless rhetoric of "physician shortages," that an obvious solution would be to increase the number of residency positions. Do existing supply statistics support the notion of a widespread shortage? And would expanding access for the CSMAs be a pain-free solution?

**Objectives:**
We sought to address the question of whether policy makers should expand access to residency training for the increasing number of Canadians who are studying medicine abroad.
Methods:
We undertook a critical examination of data from existing repositories, including medical school admission rates, residency statistics, and physician supply trends, as well as a brief review of related literature. We then reflected on the current state of international training for Canadians hoping to return to Canada, and whether, based on current supply trends, it would be a wise policy decision to expand residency access.

Findings:
Anecdotes of individuals unable to find a physician or access timely care indicate a physician shortage, one that could be addressed by making it easier for CSMAs to enter practice here. However, there is evidence that Canada’s physician supply is increasing. As a result of swelling domestic medical school class sizes, growth in physician supply has outpaced population growth for the last five years. On top of that, physician expenditures continue to grow faster than supply. Neither of these trends show signs of abating, and reports of under- and unemployed physicians are beginning to emerge. Isolated access issues cannot be mitigated by increasing supply in a system where physicians can have near-complete autonomy over practice location and service delivery. Therefore, it is hard to imagine provincial ministers of health opening up more residency slots for physicians trained abroad, whether or not they are CSMAs.

Conclusion:
The current swell of physician supply in Canada makes opening up additional residency slots for CMSAs unlikely. Rather, policymakers in both government and medicine should be clear about the prospects for foreign-trained Canadian physicians expecting to return to Canada to practice.

Take Home Messages:
1) Despite anecdotes of access issues, Canada is at the beginning of a dramatic expansion in physician supply.

2) More and more Canadians are going abroad for medical training and hope to return to practice in Canada. They face very long odds of accessing post-graduate residency training, which is a requirement to practice here.

3) The recent increase in domestic medical school training capacity makes opening up additional residency slots for CMSAs unlikely; policy makers would do well to be clear about the prospects for foreign-trained Canadian physicians expecting to return to Canada to practice.
I Wish I Had Known This Before I Immigrated!

**Presenter:** Kelly McKnight, Nova Scotia Community College

**Background:**
Canada remains an attractive destination for internationally educated health professionals and they represent a viable solution to addressing our health human resource shortages. However, many IEHPs arrive in Canada only to learn that their training and experience don't meet the regulators requirements for licensure. Why not learn all one needs to know about the requirements to practice their profession in Canada... **PRIOR** to immigration?

Nova Scotia Community College, in partnership with Health Professional Regulators/Associations, Atlantic Connection, and funded by Health Canada, has developed 17 Self Assessment Readiness Tools (SARTs©) for Internationally Educated Health Professionals.

**Objectives:**
SARTs provide a transparent/effective way for an IEHP to determine if they want to immigrate to and practice in Canada. SARTs offer a glimpse into the life and practice of many health professions by outlining the competencies, knowledge and skills that an IEHP must have to be eligible to apply for registration and be ready to practice in Canada. Users can determine their own gaps in education/experience. This is NOT a formal assessment for licensure but paves the way for the next steps.

**Methods:**
The tools are rigorously assessed for accuracy in French and English including plain language review, are offered at no charge via the internet and are meant to support pre-arrival activities.

**Findings:**
This project includes a research component in partnership with Canadian regulators and the Association of Canadian Community Colleges (ACCC) Canadian Immigrant Integration Program (CIIP) to assess the “Accessibility, Uptake and Utility of the Self-Assessment Readiness Tools©”. The SARTs roster also includes assistive-level and some non-regulated health care occupations. This provides added benefit as this information outlines alternative career pathways and possible career ladders to a IEHPs chosen profession, prior to immigration.
A recent and unexpected outcome has been the interest from educators who are finding SARTs are a useful career advisement resource too!

To view the tools please visit [http://www.atlanticcanadahealthcare.ca](http://www.atlanticcanadahealthcare.ca).
Conclusion:
In 2016, this project will conclude with the development and deployment of 20 SARTs for IEHPs. Our aim has been to help potential health professional émigrés to Canada make an informed decision about professional practice before immigration.

Take Home Messages:
Additional time and money is now being expended on determining alternative careers for many health professionals who have come to Canada in the hopes of working in their chosen disciplines. The stories of health professionals driving cabs or working in Tim Horton’s are commonplace and unfortunately... true. We need to do better. We know that prevention is much less costly than treatment – the SARTs represent another form of “prevention”. The information provided is not meant to dissuade one from considering Canada as their new home but rather ensure that all the facts are presented clearly and accurately.

Please [click here](#) to see the attached brochure re SARTs.

Health Worker Migration from South Africa, India, Jamaica and the Philippines: Causes, Consequences and Responses

**Presenter:** Dr. Ivy Lynn Bourgeault, University of Ottawa on behalf of Dr. Ronald Labonté, University of Ottawa.

**Co-Authors:** Gail Tomblin Murphy, Ivy Bourgeault, Erlinda Palaganas, David Sanders, Benjamin Wayson, I Rajan

**Background:**
An adequate health workforce is essential to an effective health care system, but many countries are subject to high levels of health worker migration. The aim of this study is to better understand the drivers of health worker migration, its consequences, and the various strategies being employed to mitigate its negative impacts. The session will present the study’s methods and preliminary findings, as well as some common themes emerging across countries.

**Objectives:**
The following questions will be explored:

- What is the present picture of and recent historic trends in the migration of highly skilled health personnel in each of the countries?

- What, according to those ‘on the ground’ are the most critical consequences of the migration of health workers that should be examined and how could these consequences be ‘measured’ for comparative policy analyses?
What is the range of program and policy responses that have been considered, proposed and implemented to address these causes and consequences of health worker migration from low- to high-income countries, and what have been some of the outcomes to these responses?

**Methods:**
The study was conducted in four countries – Jamaica, India, the Philippines, and South Africa – which have historically been ‘sources’ of health workers migrating to other countries. Data were collected through surveys of diverse categories of health workers including physicians, nurses, midwives, pharmacists, physiotherapists, dentists and dental auxiliaries, as well as key informant interviews, in each country. Quantitative data were analyzed descriptively and with regression models. Qualitative data were analyzed thematically. A workshop which brought together co-investigators from each of the participating countries was held to share preliminary results so as to begin to identify common themes emerging across countries.

**Findings:**
Migration of health workers from each of these countries continues to be prevalent. The causes of this migration are numerous, long-standing, and systemic, and are largely based around differences in living and working conditions between these ‘source’ and ‘destination’ countries. There is minimal systematic tracking of health worker migration in these countries, making scientific analysis of its consequences difficult. Although there have been national and international efforts to manage and mitigate the negative impacts of migration on ‘source’ countries, there is little evidence of the implementation or effectiveness of such efforts.

**Conclusion:**
More effective management of health worker migration requires investment in information systems to monitor and study it. Better management of health worker migration will require stronger collaboration between source and destination countries.

**Take Home Messages:**
A better understanding of the drivers of migration, the consequences to local systems and health workers, and the various strategies that have been employed in a number of countries will help policy and decision-makers to mitigate negative impacts on their countries.