Nurse Migration: A Canadian Case Study

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Objective. To synthesize information about nurse migration in and out of Canada and analyze its role as a policy lever to address the Canadian nursing shortage.

Principal Findings. Canada is both a source and a destination country for international nurse migration with an estimated net loss of nurses. The United States is the major beneficiary of Canadian nurse emigration resulting from the reduction of full-time jobs for nurses in Canada due to health system reforms. Canada faces a significant projected shortage of nurses that is too large to be ameliorated by ethical international nurse recruitment and immigration.

Conclusions. The current and projected shortage of nurses in Canada is a product of health care cost containment policies that failed to take into account long-term consequences for nurse workforce adequacy. An aging nurse workforce, exacerbated by layoffs of younger nurses with less seniority, and increasing demand for nurses contribute to a projection of nurse shortage that is too great to be solved ethically through international nurse recruitment. National policies to increase domestic nurse production and retention are recommended in addition to international collaboration among developed countries to move toward greater national nurse workforce self sufficiency.

Key Words. Nurse migration, nurse shortage, nursing workforce

Canada is projecting a significant registered nurse (RN) shortage in the near future with a shortfall of over 100,000 by 2016 (Canadian Nurses Association [CNA] 2002). Immigration has been suggested by some as an important policy lever to address that shortage. Others have denounced it as unethical given the global nursing shortage. The purpose of this paper is to examine the impact of migration on the Canadian RN workforce and to determine the feasibility of immigration as an appropriate policy lever to address the shortage. It begins with an examination of the trends in nurse migration, both in and out of Canada, and its net effect on the Canadian RN workforce. This is followed by a policy analysis regarding the role of immigration in dealing with the shortage from the perspective of several relevant stakeholders. The paper then

concludes with recommendations regarding the various policies, including immigration, to address the shortfall.

TRENDS IN NURSE MIGRATION

Emigration

In the 1990s, problems related to funding and restructuring prompted many Canadian RNs to consider migration to the United States or elsewhere (Malugani in Nadeau, Whewell, and Williamson 2000; Baumann et al. 2004). Fiscal restraint created a loss of full-time positions and subsequent casualization of the nursing workforce. How many of these RNs left Canada and where they went is not clear as a result of incomplete data; estimates are crude at best. Registration rates in 2001 of graduates in the 1990s indicated that "of the 81,044 graduates of Canadian nursing schools [RNs] who graduated in the 11 years from 1990 to 2000, only 64,394, 79 percent, were registered in the year 2001" (CNA 2002, p. 55). Therefore, 16,650 recent RN graduates were not registered and not available to work in nursing in Canada (CNA 2002). It is suspected that many of them migrated to the United States given the lack of full-time employment opportunities as a result of fiscal restraint and restructuring in the Canadian health system. During the 1990s Canada witnessed a gross outflow of approximately 27,100 RNs through permanent emigration to the United States (Industry Canada 1999).

A recent national report provided an overview of the literature pertaining to the emigration and immigration of Canadian nurses (Baumann et al. 2004). In their report, the authors note that according to Zhao, Drew, and Murray (2000), the number of RNs leaving for the United States increased from 330 per year in the late 1980s to 825 in 1996 and 1997. The total outflow of RNs to the United States was equivalent to more than a quarter of the 3,000 new RN Canadian graduates in 1995 (Zhao, Drew, and Murray 2000). Another report indicated that from 1993 to 1994, 40 percent of the graduates of Canadian nursing schools from registered nursing educational programs left for the United States (DeVoretz 1999). A further study indicates that 22 percent of RNs applying for licensure from 1997 to 2000 in the United States were educated in Canada (Buchan, Parkin, and Sochalski 2003). However, in the

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last half of the 1990s the annual number of RN applicants from Canada to the United States fell by nearly one-half (Buchan, Parkin, and Sochalski 2003).

Tracking of these RNs is only possible if they maintain a Canadian license (Canadian Institute for Health Information [CIHI] 2003); therefore, these data are likely to underestimate the number of RNs emigrating. In 2003, 5,366 RNs maintained their Canadian license while working outside of Canada (CIHI 2004). Of these, 81.5 percent (4,371) were employed in the United States.

Requests to regulatory bodies for verification of credentials are a proxy of RNs' intent to migrate. It is not known if they actually leave or just consider the option. It is also known that these numbers contain duplicates as the same RN may request several verifications to different destinations. However, the overall trend provides some indication of the interest in migration. The number of Canadian RNs requesting verification rose from 1,032 in 1988 to a peak of 5,433 in 1996 with 5,040 of these requesting verification for the United States (as cited in Baumann et al. 2004).

Some have attempted to use the number of Canadian nurses writing the Commission on Graduates of Foreign Nursing Schools (CGFNS) and NCLEX-RN examinations as a proxy measure for migration to the United States. However, this has limitations because many Canadian nurses, except those from Quebec, have been exempted in the past from the CGFNS examination, and sometimes the NCLEX-RN examination, depending on the state to which they are applying for licensure. In the past, several states accepted Canadian licensure by endorsement (Davis and Nichols 2002). There is now a reversal of this policy decision since the events of September 11, 2001 in the United States. In addition, there are stricter credentialing requirements as of 2004.

Canada is listed as one of the top two countries for candidates writing the U.S. licensure examination for RNs (Brush, Sochalski, and Berger 2004). In 2000, fewer Canadian educated RNs (1,093) wrote the NCLEX-RN examination than in 1997 (1,891) (CIHI 2003). It is not known if this reflects reduced migration or the movement of Canadian RNs to the individual U.S. states that did not require this examination at the time, or a combination of the two (CIHI 2003).

CGFNS conducted a survey of characteristics of foreign nurse graduates in the U.S. workforce in 2000–2001. They found that 23 percent of the licensed foreign nurse graduates were born in Canada. Thirteen percent of the respondents entered the United States under Trade NAFTA status; all were Canadian. The majority of Canadian-educated nurses reported working in the hospital sector (CGFNS 2002).

The report by Baumann et al. (2004) documented other sources of data indicating the migration of Canadian nurses to the United States. It notes that “In 1994 and 1995, 6,821 and 5,234 Canadian RNs, respectively, obtained temporary permits to work in the United States [Assess and Intervene 2000] . . . between 1993 and 1997, the proportion of baccalaureate graduates from the McMaster University School of Nursing that left Canada increased from 8.9 percent to 10.6 percent, showing the same effect in a single university cohort” (Rideout, Mallette, and Coates [1998] in Baumann et al. 2004, (p. 22). A Canadian study showed that between 1995 and 1997, nearly one in 10 RN nursing graduates (9.3 percent) moved to the United States (CNA 2000).

The reason for the outflow of nurses from Canada, especially in the late 1990s, is linked to domestic labor market conditions. In 2000–2001, the Registered Nurses Association of Ontario (RNAO) surveyed nurses registered in Ontario but residing outside of Ontario to understand why they had left and what factors would affect their decision to return. Many left in the late 1990s, noting downsizing and lack of job opportunities as their primary reason for leaving (RNAO 2001).

It is believed that the global nursing shortage, particularly that of the United States, will continue to play a role in the emigration of Canadian nurses. Estimates from the United States suggest a nursing shortage of 800,000 nurses by 2020. This has the potential to significantly increase the pull factor to the United States, especially if financial incentives are incorporated. The number of nurses who emigrated to the United States in the 1990s will pale in comparison with this potential drain.

Immigration

The flow of internationally educated nurses (IENs) into Canada has three dimensions: application, eligibility to write the national licensing exam, and success on the licensing examination which secures registration. These dimensions were recently captured in a report titled *Navigating to Become a Nurse in Canada: Assessment of International Nurse Applicants* (Jeans et al. 2005). In Canada, the profession of nursing is regulated in order to assure the public that nurses in Canada meet an acceptable standard of care and performance. The requirements generally include graduation from an approved school of nursing and demonstrated competencies in delivering nursing care. Candidates must also meet language requirements and be in good standing with a regulatory body if already licensed elsewhere. Finally, all candidates must successfully complete a licensing examination. There are no differences between

temporary or permanent migrants in terms of their right to practice as a RN in Canada; the licensure/registration process is distinct and separate from the immigration process.

Table 1 reflects the results of this study for the first dimension of application. "This number may be inaccurate as some IENs apply to more than one province and/or more than one nursing group. On the other hand, there were missing data for some of the years requested. Nevertheless, there appears to be a clear trend indicating that the number of IEN applicants overall is increasing at a rapid rate. From the year 1999 to 2002 the number of applicants almost tripled" (Jeans et al. 2005, p. 15).

Approximately 40 percent of the IENs registered were older than 40 years. This is supported by a previous study by CNA (2002) examining ages of international applicants writing the licensure exam. The data show that nurses from abroad who come to practice in Canada are typically in the 35–44-year-old age bracket when they start practicing in Canada.

In the current study, RN regulatory bodies reported the following countries in descending order as the most frequent source of IEN applicants: the Philippines, United States, United Kingdom, and Australia (Jeans et al. 2005). The Philippines as the major source country is supported by the Canadian Registered Nurse Examination (CRNE) administrative data (Assessment Strategies Inc. [ASI] 2004). Interestingly, the number of U.S. writers of the CRNE is dropping from previous years and India is emerging as one of the top three sources of international nurse applicants writing the CRNE.

It is estimated that only approximately 50 percent of those who applied for licensure met the educational and language requirements deeming them eligible to write the national licensure exam (Jeans et al. 2005). The reasons for this include: incomplete documentation, inadequate education, poor English/French language proficiency. Passing the licensure exam is the final step in the licensure/registration process. First time writers of the CRNE (English and French versions) educated outside Canada increased from 548 in 1998 to 2,194 in 2003. These numbers are provided by Assessment Strategies Inc.

Table 1: Total Number of IEN Applicants for the Years 1999–2003

	1999	2000	2001	2002	2003	Total
RN	1,376	2,592	4,047	4,971	4,044	17,030

Source: *Navigating to Become a Nurse in Canada: Assessment of International Nurse Applicants, 2005.*

RN, registered nurse; IEN, internationally educated nurse.

(2005), through the regulatory department at CNA. The overall pass rate for IEN first timers has increased over the years from 42 percent in 1998 to a high of 68 percent in 2002 with a reduction in 2003 to 62 percent. This is in comparison with those educated within Canada whose pass rate for first timers is 93 percent (ASI, 2004). The pass rate is, however, variable depending on the country. Countries such as the Philippines and India have traditionally had much lower first time writing pass rates than countries such as the United States. It is speculated that similarity of language, health care system, and role of nursing between source and host countries is linked to higher success rates.

Canadian Nursing Workforce

The number and characteristics of RNs in the Canadian workforce is well documented. Data are collected on annual licensure renewal forms by provincial/territorial nursing regulatory bodies and then forwarded to the CIHI to form the content of a national registered nurse database (RNDB). Data cleaning and quality assurance processes clean these data and remove duplicates that may be licensed in more than one province/territory.

The national RNDB at CIHI provides a wealth of information about the workforce in terms of demographics, education, and employment. For example, in 2003, there were 241,342 RNs employed in nursing in Canada, 95 percent of which were female (CIHI 2004). "For every RN aged 35 or less in Canada, there are 1.8 RNs aged 50 or greater" (CIHI 2004, p. 19). This aging cohort of nurses has been in the making over the course of several decades with the average age in 2003 at 44.5 years (CIHI 2004). The number of RNs employed full-time has remained fairly constant over the past 5 years at 50 percent. Another important feature of the database is that it can identify the location of graduation of RNs licensed in Canada. The numbers of RNs indicating their location of graduation outside of Canada has fluctuated between 15,000 and 20,000 (6–9 percent) between the years of 1996 and 2003 (CIHI 2004). See Table 2 for the most identified countries of RN graduation as of 2003. A comparative profile of those RNs educated outside of Canada versus those educated in Canada can thus be generated.

For example, the age of RNs educated outside Canada tends to be older than that of Canadian educated. CIHI data from 2003 show that 37.4 percent are in the age group 55+ compared with 17.0 percent for Canadian educated. This pattern is consistent for the past 5 years. Multiple employment is a phenomenon that emerged after the 1990s with the shift to casual and part-time employment. Many RNs were forced to hold down two or more jobs.

Table 2: Percentage of Foreign RN Graduates by Country of Graduation, Canada, 2003 (CIHI 2004)

<i>Country</i>	<i>Percentage of Foreign Graduates</i>
Philippines	27.9
United Kingdom	23.3
United States	6.9
Hong Kong	5.6
India	4.7
Poland	3.2
Australia	2.2
Other	26.2

Interestingly, in 2003, the percentage of internationally educated RNs reporting multiple employment is 17.2 percent compared with 12.3 percent for those educated in Canada (CIHI 2004). Employment patterns regarding position in nursing indicate that internationally educated RNs are more likely to hold a staff nurse position, as opposed to advancing to positions such as manager or director. Seventy-four percent of internationally educated RNs in 2003 were employed in a staff nurse position compared to 68.3 percent for Canadian educated. While the number of internationally educated RNs employed in Canada is increasing, their overall proportion of the workforce has remained constant at 6–9 percent since 1990 (CIHI 2004).

STAKEHOLDER ANALYSIS

Stakeholders involved in the migration and integration of internationally educated nurses into the Canadian workforce are varied and numerous in number. They include academic institutions, professional associations, regulatory bodies, unions, and governments. Government involvement reflects the activities and policies of various departments including immigration, labor, health, and finance.

Government Policy Analysis

The factors that shape immigration policy are complex and intertwined as governments struggle to balance economic, labor market, social, demographic, human rights, humanitarian, international, and political goals. Moreover, in Canada, legislative jurisdiction for immigration is shared by the federal

government and the provincial/territorial governments. There are dozens of players involved at different levels of government and in different government departments.

Federal immigration policy in Canada, as in most nations, has long been used as a tool to serve policy and political objectives. Since Confederation, Canadian immigration policy has evolved and mutated regularly as the federal governments of the day struggled to meet these objectives. "Canada, more than other countries, has relied on immigration as a development strategy. This is partly due to its small size—particularly relevant to its geographic neighbor, the United States—and its low fertility rate. Demographic projections show that for the most part, labor force growth in Canada for the foreseeable future will stem from immigration" (Reitz 2005, p. 3).

In early 1985, the federal government undertook a major review of immigration policy that led to a number of significant changes that "reflected a view that immigration could be used as a source of capital and as a means of establishing trade links" (Green and Green 1996, p. 25). The review concluded that immigration levels had to increase in order to compensate for a sharp decline in birth rate, and that the economic component of immigrant intake should be increased.

In 1986, the requirement for prearranged employment for independent (assessed) immigrants was removed. This began a steady increase in the number of immigrants between 1986 (99,812) and 1993 (nearly 250,000). This policy shift represented a deliberate decision to increase immigration levels in a period of economic recession and high unemployment, a significant departure from historic immigration policy, practice, and experience. In 1992, the government's Immigration Planning document stated "our supply of highly skilled workers is not keeping up with demand. Even though unemployment is relatively high today, hundreds of thousands of jobs go unfilled because there are no qualified applicants to fill them . . . Immigration can benefit the labor market by helping employers fill skilled jobs for which Canadians are not available. This alleviates structural 'bottlenecks' in the supply of skilled workers."

It should also be noted that in the early 1990s (starting in 1993) a number of provinces cut enrollment opportunities in nursing schools as a result of fiscal restraint, fueled in part by the federal government's preoccupation with deficit reduction. The impact of these decisions began to be felt in the late 1990s, when fewer health professionals were graduating to fill the gap caused by increasing demand for nursing services and increasing numbers of nurses coming into retirement. A change in federal policy occurred in the late 1990s

with a focus on job creation and growth, including investments in higher education and skills development, as well as on improving immigration processes.

In the early 1990s, the issue of skills shortages began to draw increased attention from key economic stakeholders, including business and industry, labor, education, and all orders of government. There were predictions of “looming” critical shortages of skilled workers in many sectors of the economy as a result of a combination of factors, including the aging population and massive retirement of older workers; low birth rates; international competition for skilled workers; weaknesses and inequalities in the education and training regimes across the country; *inter alia*. Among other tools, immigration was put forward as a way to address needs for skilled workers in key sectors of the economy. This was not the case for nurses. It was not officially identified by governments as one of those professions for which there was a labor market shortage. It was only in 1997 when CNA published a report projecting a significant RN shortage by 2011 that a nursing crisis was acknowledged. Even then, it took several years to achieve general acceptance of this projected shortage by policy makers. Meanwhile, cuts to nursing positions continued and an already aging workforce continued to age.

The publicly funded health care system in Canada was experiencing major strains by the late 1990s. Challenges included increased demand for services, shortages of health care providers, technological advances, regional disparities, and increasing “privatization” of health care services. Health care is primarily a provincial/territorial jurisdiction funded in part by annual federal funding transfers. Federal–provincial/territorial relations were increasingly strained by the provincial/territorial demands for “more money” for health. It became evident that the health care system was in need of a major review and renewal.

In September 2000, the federal and provincial First Ministers agreed on a vision, principles, and action plan for health system renewal (Health Canada 2000). In the area of Health Human Resources, the federal and provincial/territorial governments agreed to develop collaborative strategies aimed at supporting national planning, promoting interdisciplinary education, improving recruitment and retention, and ensuring the supply of health care providers. Ministers agreed to a comprehensive annual reporting process to measure progress in the different areas of the Accord. Performance indicators under Health Human Resources included a 10-year rolling forecast of providers expected to enter the system (trained in Canada, incoming from other countries).

Health human resources, particularly nursing, is seen as one of the major factors underlying the health care crisis in Canada. The federal government has been developing two main streams of policy directions for tackling the nursing shortage. The department of health, and in particular the department devoted to nursing policy, seems to be fostering a self-sufficiency model, while the departments of immigration and labor are propelling the notion of immigration as the solution to the skilled-worker shortages, including nursing. Where and how these two policy directions intersect to create the "right" balance is the question at hand. It should also be noted that these policies are being developed to correct other short sighted policies from the 1990s that in fact have contributed to the nursing shortage; namely, reductions in funded full-time RN positions and cuts to educational seats. In an attempt to balance budgets, governments drove nurses to the United States and threatened the sustainability of the health workforce. Now they struggle with how to reverse that damage.

In response to the nursing shortage, the Conference of Deputy Ministers/Ministers of Health directed the Advisory Committee on Health Human Resources (ACHHR) to develop a pan-Canadian strategy for nursing. In 2002, the Working Group on Nursing Resources and Unregulated Health Care Workers (WGNR) presented *The Nursing Strategy for Canada* to the Conference (Advisory Committee on Health Human Resources 2000). The goal of *The Nursing Strategy for Canada* was to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed, and deployed to meet the health needs of Canadian residents. The 11 strategies for change in *The Nursing Strategy for Canada* were organized according to four key issues: unified action; improved data, research, and human resource planning; appropriate education; and improved deployment and retention. The first strategy was to establish a federal/provincial/territorial multistakeholder Canadian Nursing Advisory Committee (CNAC) to address priority issues. The key focus for CNAC for 2000/2001 was improving the quality of work life for nurses and providing advice to support the implementation of other strategies of *The Nursing Strategy for Canada*.

The CNAC was created and presented its landmark report in August 2002, titled *Our Health, Our Future. Creating Quality Workplaces for Canadian Nurses*. The report contained 51 recommendations designed 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 twenty first century; and to monitor activities and disseminate infor-

mation to support the nursing workforce and attract and retain the nursing workforce. Several of the recommendations highlighted the need to increase domestic production through increased educational capacity as a means to address workload issues in the work environment. In 2003, the report on the National Nursing Strategy reported on the progress of the recommendations contained in the original report (Advisory Committee on Health Human Resources 2003). In terms of domestic production of nurses, it noted that by 2001, the number of nursing education seats in Canada rose by approximately 43 percent over 1998/1999 levels (O'Brien-Pallas et al. 2002). Interestingly, 1998/1999 represented the lowest number of RN graduates in a 30-year history. There was no mention of the role of immigration would play in meeting the nursing crisis that lay ahead.

Concurrently, the departments of immigration and labor were developing policies and providing associated funding to increase the role that immigration would play in addressing critical shortages, particularly in nursing, medicine, and engineering. By the late 1990s, they were paying increasing attention to the numerous calls for action in the area of foreign credential recognition (FCR). As many stakeholders—including business and industry, education and health sectors, immigrant advocacy groups, and academic experts—were pointing out, merely increasing the numbers of skilled immigrants was not enough. Many highly educated and skilled immigrants encountered major obstacles to working in their professions once they came to Canada, as their foreign credentials were not easily recognized or accepted by Canadian professional associations, employers, or regulatory bodies. The question of licensing and regulation of professions in connection with immigration to Canada is a confusing one, as there is no centralized mechanism or body for control of this, and each province/territory has its own licensing and regulatory requirements. The regulation of professionals falls under provincial/territorial jurisdiction. However, because immigration is largely a federal jurisdiction, the federal government began to play a leadership role in trying to bring together a national approach to FCR. Federal activity related to FCR and Prior Learning Assessment and Recognition service has been steady since 1998, right up until the present day supporting projects to foster greater consistency and coherency to licensing procedures for international graduates including nurses.

The effect of all of these various policies has largely yet to be seen. Nurses caring for patients at the bedside or in the community say they see no change at the bedside. Nurses in hospitals believe that the quality of patient care has in fact diminished over the years (O'Brien-Pallas et al. 2004). Concerns regarding access to care and wait times continue to grow. Continuing

issues of patient safety and the poor health of nurses suggests these policies have yet to make a difference (O'Brien-Pallas et al. 2004).

CNA Policy Analysis

The CNA is a federation of 11 provincial and territorial nursing associations representing more than 120,000 RNs. For several years, CNA has advocated for a national, integrated health human resources strategy. CNA recognizes integration of IENs as one tactic to address the impending nursing shortage projected to be 78,000 RNs by 2011 and 113,000 by 2016 (CNA 2002). It does not, however, support the unethical recruitment of nurses. In 2002, the CNA Board endorsed the International Council of Nurse position statement on Ethical Recruitment of Nurses. In doing so, CNA initiated a number of strategies to fulfill its role as a national nursing association as articulated in the position statement.

In its briefs and presentations to various federal governments commissions and committees on health, finance, and immigration, CNA repeatedly calls for an increase in the domestic production of nurses. In 1990, Canadian RN graduates were approximately 10,000. In 1999, after years of fiscal cuts, this number fell to 5,000 (CNA 2002). CNA in its most recent report on the projected nursing shortage recommends an immediate increase in education seats to produce at least 12,000 nursing graduates per year to stave off this shortage. The report goes on to suggest that since 1992 Canada has a net loss of RNs when comparing the numbers of new registrants gained through immigration and losses incurred through emigration of RNs. Furthermore it notes that because of the worldwide competition for nurses, it will be more difficult than in the past to recruit large numbers of nurses from other countries. For this reason, Canada will not be able to greatly relieve its nursing shortage by recruiting overseas. It estimates that nurse immigration will barely reach levels of 1,200 new RN registrants per year. Recent data suggest this level has been surpassed. Will the upward trend continue or will it just level off at a higher value than that projected?

In 2003, the CNA Board passed a motion that CNA, in collaboration with regulatory bodies, coordinate the development, pending financial support, of products and services such as a national assessment center to support the integration of international nurse applicants into Canada. Recognizing the right of individuals to migrate, CNA embarked on developing supports for those individual nurses who choose to come and work in Canada. This began with the development of a regulatory framework for international nurse

applicants (Barry et al. 2003). CNA also developed a line of support products under the title of *LeaRN*. The *LeaRN* tools were undertaken to support individuals in making informed decisions before they come to Canada.

CNA in collaboration with the Registered Psychiatric Nurses of Canada and the Canadian Council of Licensed Practical Nurse Regulators also undertook a project to understand the issue of the rising number of international nurse applicants and their integration into the workforce. This report was released in 2005 and recommended the following:

- Establish a national assessment service to create a standard evidence-based approach to the assessment of IENs.
- All stakeholders reach consensus on a principled, comprehensive, and collaborative approach to assessment and recruitment within an ethical framework.
- Establish nationally standardized, flexible bridging programs to ensure IENs are competent to meet Canadian nursing standards. These programs should integrate language and communication courses to meet their learning needs.

CNA continues to support a model of self-sufficiency while respecting the right of individuals to migrate. In fact, in April 2005, CNA participated in a conference organized by the British Medical Association on the global health professional: improving health, fighting poverty. Four key principles were recommended as a result of this conference. They include:

1. All countries must strive to attain self-sufficiency in their health care workforce without generating adverse consequences for other countries.
2. Developed countries must assist developing countries to expand their capacity to train and retain physicians and nurses, to enable them to become self-sufficient.
3. All countries must ensure that their health care workers are educated, funded, and supported to meet the health care needs of their populations.
4. Action to combat the skills drain in this area must balance the right to health of populations and other individual human rights.

These four principles were forwarded through Health Canada to the Minister of Health and the Commonwealth Secretariat in preparation for the Commonwealth Meeting of the Ministers of Health held in May 2005.

It was also articulated in a letter to the World Health Organization (WHO) with a recommendation that a high-profile department dedicated to health human resources be established within WHO.

CONCLUSIONS, DISCUSSIONS, AND POLICY IMPLICATIONS

The entry of health professionals, especially nurses, began to emerge as a specific policy interest and focus of the federal government only in the mid-to late 1990s. While immigration policy began to focus on “skilled workers” much earlier, the emphasis was on current and potential shortages in other economic sectors such as high tech, automotive and aerospace industries, and skilled trades. Gradually, however, the urgent human resource needs of other key sectors—including education and health—began to emerge in policy statements, initiatives, and budgets at both the federal and provincial/territorial levels.

While health human resources has emerged in government policy, there appears to be a lack of coherence in the policy approach to addressing the nursing shortage in Canada. Government departments such as labor and immigration are developing policies to address the nursing shortage through immigration while other departments (health) are articulating a solution through increased domestic production, with no substantial coordination between the two. Furthermore, policy decisions continue to encourage the immigration of RNs while the lack of full-time employment encourages Canadian educated nurses to emigrate from Canada, resulting in a minimal net gain. The coexistence of inflows and outflows results in a probable net loss. The internationally educated nurses who do enter the Canadian nursing workforce are older than their Canadian counterparts and potentially offer reduced years of nursing service. The study by Jeans et al. (2005) showed that approximately a third of IEN applicants are being integrated into the nursing workforce in Canada. It is not suggested that all IEN applicants will be successful. However, appropriate support and education and a modernized approach to assessment could enable more IENs to be contributing members of the workforce. Perhaps two-thirds of IENs who apply for licensure could become RNs in the Canadian nursing workforce resulting in an annual supply of 2,700, given average recent application numbers of 4,000 per year.

This discussion would not be complete without consideration of issues related to the recruitment of IENs. Considerable attention has been directed to the “ethics” surrounding the active recruitment of nurses internationally. The

International Council of Nurses (ICN) position statement on ethical recruitment emphasizes the adverse consequences that international migration may have on the quality of health care in countries already reporting a shortage of nurses (ICN 2001). The ICN condemns the practice of recruiting nurses to countries that have failed to implement sound human resource planning and not addressed the problems which caused nurses to leave the profession. Jeans et al. (2005) notes that in addition to the ethical concerns of recruiting from countries already depleted of nurses, there are other areas where ethics must be considered; namely, in the proliferation of unscrupulous recruiters who are exploiting IENs.

Recruitment of IENs as a solution to the shortage of nurses has been questioned by some and condemned by others suggesting it only perpetuates the cyclic nature of shortages. They further argue that unless the underlying causes of nurse shortages are addressed, shortages will continue.

Policy levers for addressing the nursing shortage in existence to this point have varied. Increased domestic production of nurses has been a dominant one. This has also led to preliminary examinations of issues such as student attrition, selection processes, and targeted male recruitment. While improvements have been made, this policy has not had the required impact needed to prevent the shortage. Graduates of RN educational programs number far less than the recommended 12,000 per year. The need to retain nurses has become increasingly important as nurses are beginning to be recognized as a scarce resource. This has resulted in several retention policies, although inconsistent, including the creation of healthy work environments, full-time employment opportunities, valuing and respecting nurses, and appropriate compensation. Another policy lever receiving much attention as of late is the need for appropriate utilization of existing health care providers in the form of appropriate skill mix within a multidisciplinary approach. Substitution of RNs by licensed practical nurses is a policy decision being taken within this context by many employers. This is a limited policy choice given that the pool of licensed practical nurses is also depleting. In addition, the literature on nurse staffing and patient outcomes does not support such practices. The development and support for new roles including nurse practitioners and increased use of technology and innovation are early policy directions that have the potential to be very effective.

More appropriate though is the question of how do we organize resources differently to meet health needs while maintaining patient safety? It begs the need for health professionals to work together in a more multidisciplinary approach, reducing duplication of efforts and promoting the right

care by the right provider at the right time. It calls for innovative care delivery models that use health professionals to their full scope of practice. Perhaps it also suggests a critical examination of the traditional role of RNs. Should we be employing them more as navigators of the system or case managers, that more appropriately reflects their competencies as knowledge workers? And finally, is it not prudent to also explore policies that reduce the demand side of the equation? There is great potential in a primary health care approach that employs strategies to promote self care, health promotion, and illness prevention.

Capacity building in developing countries to develop and maintain a sustainable nursing workforce and decrease push factors is one policy that has been fairly low key and presents an opportunity for significant expansion. Canada supports developing countries to address their own shortages by developing and retaining their nursing staff at the same time as it opens its doors and promotes increased nurse immigration to Canada. Overlaying all of this is the need to position Canada's approach within an ethical framework and sound national health human resource planning based on principles agreed to by all the various policy makers at the federal and provincial/territorial levels.

It is the right balance and mix of these various policy levers within the federal and provincial/territorial boundaries that will determine Canada's ability to adequately address the health needs of Canadians. Migration of nurses of some magnitude will continue into the far future, as it has for several decades. The level of this migration and its effect on the RN workforce, and ultimately the health system, will be dependent on the policies developed by both Canada and its source countries. The Canadian health system is in a state of great flux. Various policy levers are being employed at various levels of government and by various departments of government simultaneously to address the nursing shortage. Evaluating the effect of individual policies (including immigration) or combinations of various policies will be a challenge. Unfortunately the impact of many of these policies takes years to actualize. In the meantime, the nursing shortage will deepen.

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