

Notes from the Editor-in-Chief

EVEN AS RECENTLY as a decade ago, it was not uncommon for many Canadian decision- and policy makers in healthcare and government to ignore the matter of internationally educated healthcare professional (IEHP) integration and retention. With all the talk in the past few years, however, of employee shortages in nearly every healthcare profession and a rapidly aging population that requires more and more care, nobody can afford to neglect this potentially large and highly skilled talent pool.

The problem facing IEHPs is part of a systemic difficulty many highly educated immigrants in general face when attempting to bridge from their education and profession in their country of origin to an equivalent profession in Canada. By 2006, 42% of immigrants who had arrived in Canada since 2001 held university degrees; that figure compared with just 16% of the native-born population (Zietsma 2010). Yet, when those newcomers sought employment in regulated professions (healthcare as well as fields such as teaching, law and engineering), just 24% of internationally educated immigrants ended up working in the profession for which they had been trained, versus 62% of those born in Canada. While proportions for healthcare workers were generally higher than for other registered occupations, IEHPs still tended to fare below those born and educated in Canada. Take but two examples: 56% of foreign-trained nurses were employed in their field versus 76% of Canadian-born nurses; and 65% of foreign-trained occupational therapists were employed in their field versus 82% of those born in Canada.

In their lead essay to this issue of *Healthcare Papers*, Andrea Baumann, Jennifer

Blythe and Dana Ross take as a given that “to ensure a sustainable workforce in the future,” governments, educational institutions, licensing bodies, health services organizations and others must do much more to facilitate the entry and retention of IEHPs into regulated healthcare professions. Accomplishing those twin goals requires developing three intersecting bodies of knowledge and practice:

- An understanding of who IEHPs are
- Awareness of the common profession-related and personal problems IEHPs encounter when attempting to secure employment
- Methods of assisting IEHPs to enter the workforce

Those three bodies of knowledge and practice also inform the useful policy recommendations Baumann, Blythe and Ross make. Policy reform needs to occur, they contend, in the area of IEHP data collection; there must be workforce integration at the provincial and local levels that extends to include all IEHPs (not just physicians and nurses); and greater coordination and information sharing is needed among educators, employers and governments.

In her commentary on the lead essay, health policy expert Raisa Deber concurs with the authors in their call for better data and the need to move beyond physicians and nurses as the premier occupations addressed by IEHP integration policies and strategies. In addition, Deber proposes four ways of framing the IEHP issue:

- The shifting need for healthcare professionals (including preparing for a possible

- future of healthcare professional “oversupply”) and how they are to be compensated
- “Fairness” for the IEHPs themselves (e.g., training people and then not using their skills, or forcing them to live in certain areas of the country)
 - “Fairness” for IEHPs’ countries of origin when skilled workers emigrate
 - The complexity of negotiating intergovernmental roles and responsibilities (e.g., immigration is a national issue, whereas certification and licensure rest at the provincial/territorial level)

The call by Baumann, Blythe and Ross for greater coordination among educators, employers and governments dovetails with Deber’s fourth framework. It receives further amplification in the commentary by Sandra MacDonald-Rencz and Janet Davies. Co-chairs of the International Educated Nurses Task Force, MacDonald-Rencz and Davies go beyond the lead essay’s largely Ontario focus to discuss initiatives – many of which are under the umbrella of the Foreign Credential Recognition Program – across Canada that support policy coordination among the health, immigration, labour and other sectors. MacDonald-Rencz and Davies also outline the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, which is aimed at enhancing immigrants’ workforce participation and is based on the principle that human resources recruitment and integration are a “collective responsibility” of all stakeholders.

In their commentary, Michel Landry, Neeru Gupta and Joshua Tepper are, not unlike Deber, interested in the “distribution” of IEHPs across various parts of the healthcare system and Canada itself. In particular, they discuss a piece of the IEHP puzzle that Baumann, Blythe and Ross do not fully address: “the extent to which the integration

of IEHPs can be used to address the challenge of equitable distribution” of health services. For example, as most citizens of a country as vast as Canada are aware, access to medical services is often much scarcer in many rural areas than it is in urban centres.

But, as Landry, Gupta and Tepper point out, the recruitment of internationally educated physicians to rural areas has led, in the long term, to “mixed” results; simply put, once an IEHP’s contract is up, he or she tends to gravitate to cities where, some evidence suggests, immigrants find it easier to integrate. Similarly, policies aimed at streaming IEHPs into certain specific healthcare sectors (e.g., long-term care) have not been successful in retaining workers. Perhaps, as Landry, Gupta and Tepper argue, solving these difficulties requires lifting our gaze from an exclusive focus on IEHPs. In order to address recruitment and retention issues confronting rural locales and certain practice areas, it might be time, instead, to consider “broader initiatives for health providers of all educational backgrounds.”

The lead essay and the majority of commentaries look at IEHPs with a wide-angle professional lens. In their contribution, Jill Hefley, Jack Mandel and Rocco Gerace instead zero in on the licensure-related problems affecting international medical graduates (IMGs) in Ontario. All three co-authors are associated with the College of Physicians and Surgeons of Ontario, and their piece offers a history and appraisal of the college’s efforts over the past 10-plus years to improve access to practice for qualified IMGs. In light of the barriers to integration that Baumann, Blythe and Ross address, one of the most interesting portions of Hefley et al.’s discussion is the college’s policy shift from emphasizing credentials to evaluating individuals in terms of their unique skills and competence. However, as the authors are quick to acknowl-

edge, despite the success of this policy shift, the training IMGs receive in certain foreign medical schools and parts of the world remains virtually untranslatable to Canada's contexts and standards; as well, limited capacity means that not all IMGs are able to access or qualify for the college's integration programs.

While all the contributors to this issue of *Healthcare Papers* believe in the potential benefits of integrating and retaining well-qualified IEHPs, I leave you with a somewhat-sobering evaluation by Arif Bhimji, the president of Medicentres Canada, a business that operates 25 primary care clinics in Alberta and two in Ontario. Bhimji's commentary takes a less sanguine look at IEHP integration than that of most of the other contributors. In response to significant human resources shortages at his Alberta clinics, Bhimji expended a good deal of time creating an innovative "route" to licensing for internationally educated physicians in Alberta. This "provisional – conditional" model seemed splendid on paper, but, in practice, the path to assisting these physicians proved "long and arduous," often because of significant bureaucracy-driven hurdles.

More controversially, at least in the view of some readers, is Bhimji's assertion that his experience has shown him that a "substantial proportion of IMGs simply do not have adequate training, knowledge and communication skills to safely work within the Canadian healthcare environment." Striking a similar note, Hefley, Mandel and Gerace remark, "CPSO's specific experience supports the concern that some internationally trained physicians are not practice ready." To ensure patient safety across the country, those authors advocate working toward a national standard for IMG licensing in order to uphold the college's "duty to serve and protect the public interest."

With that overriding goal of patient safety in mind, my thoughts return to Baumann, Blythe and Ross, who argue that the entire IEHP question is intimately bound to "making patient care central to healthcare." I take from this point that, while we definitely ought to devote considerable time and resources to IEHP integration and retention, as we formulate policies and strategies we must always orient them toward fulfilling the reason healthcare exists: to do what is best for patients.

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Reference

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