

# Global Trends, Local Impact: The New Era of Skilled Worker Migration and the Implications for Nursing Mobility

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## **Abstract**

The global movement towards free trade and market integration has enabled greater mobility for skilled professionals, including nurses. As of 2015, newly graduated Canadian nurses will enter the register with an exam prepared by the US-based National Council of State Boards of Nursing, making Canadian nurses possibly the most mobile skilled workers in North America. But given the fragmentation of Canada's internal labour market, it is the United States that stands to benefit most from greater nurse mobility.

## **Background**

Since the end of the Second World War, governments have been working on a series of market integration projects to enhance the movement of goods and services across borders. The creation of the General Agreement on Tariffs and Trade (GATT, 1947–1993) and its successor in 1995, the World Trade Organization (WTO), reflects three-quarters of a century of global efforts aimed at bringing the world to agreement on common markets. Other important multilateral free trade areas include the North American Free Trade Agreement (NAFTA) and Association of South East Asian Nations (ASEAN). There are multiple more trade groupings in the pipeline for Asia and central Asia, between Europe and Brazil, Europe and the United States, Europe and Canada and so forth. Canada has also seen much publicized discussion with the federal government concerning the Pacific Free Trade Agreement (DFAIT 2012).

This global policy trend has had an impact on every area of the economy. One of the important issues opened up by these mobility agreements is that of the movement of services, that is, labour. Individuals can move and sell their labour across different markets, and companies can offer services that involve skilled labour: engineers and architects for building and construction, lawyers and accountants in the financial sector and health professionals in healthcare.

Interestingly, Canada as a sovereign state has yet to achieve a seamless internal single market, something to which critics attribute the productivity lag between the United States and Canada (Sands 2007). In fact, the Agreement on Internal Trade (AIT), the legislative basis for the creation of a Canadian single market, was introduced in Canada only in 1995 following the implementation of NAFTA which, somewhat ironically, gave Canadian provinces better access to US and Mexican markets (and vice versa) than they have to their Canadian provincial neighbours (Sands 2007).

According to the Secretary General of the OECD, Angel Gurría, the global economic crisis and the challenges of the Eurozone have failed to diminish the drive for single or integrated markets and the competition for skilled labour (Gurría 2011). In fact, competition for skilled workers has put increased pressure on governments to shift from traditional supply-driven immigration policies, under which highly qualified workers migrate without employment, and have tended to result in poor alignment of skills, qualifications and local workforce needs. Recent policy moves have supported a demand-driven approach to migration in which suitably skilled workers are recruited directly by employers (Chaloff and Lemaitre 2009).

Current Canadian immigration policy direction has followed suit. In 2012, a series of initiatives were launched directed at increasing the economic benefit of immigration and supporting employer-driven initiatives (CIC 2012).

How do these macro economic and policy trends, such as increased labour mobility and demand-driven immigration policy, affect the regulated professions, specifically, nursing? Looking at the world's biggest single market can help us answer this question.

In Europe, single-market mobility provisions were introduced in the 1970s. Currently, the 27 member states of the European Union regulate around 4,700 professions on the basis of a professional qualification. These professions can be grouped into about 800 categories. The Professional Qualifications Directive offers mutual recognition for most of them, and there is automatic recognition for members of seven professions: nursing, medicine, midwifery, dentistry, pharmacy, veterinary science and architecture (EC 2011a).

The EU's ruling that oversees this policy is Directive 36, and it is currently undergoing review. To this end, a Green Paper was released in 2011 calling for submissions to the European Commission (EC 2011a). There have also been formal consultations with the regulators, or Competent Authorities (CAs) as they are known, leading up to the release of the Green Paper. Representatives from both nursing and medicine made submissions to the Commission, including both individual country reports and a collective response for each profession, responding to the questionnaire and describing mobility and mutual recognition in each state (EC 2011a). The document that recommended changes to the Directive was released late in December 2011 (EC 2011b). The key recommendation of the final report was that a European Professional Card be introduced, and legislation is currently before European Parliament to this effect. The idea is that this card would enable data to be readily accessed between states so that the bona fides of a mobile professional can be ascertained. The European Professional Card aims to address the challenge of competing demands – to ensure high levels of mobility and, at the same time, to ensure public safety obligations are addressed so that incompetent or criminal professionals are not able to move between jurisdictions (EC 2011b).

The contemporary framework for professional regulation arose as a result of sustained lobbying on behalf of each of the professions in each jurisdiction, with the goal of controlling access to practice and to protect the public from unqualified practitioners. What is typically involved is the oversight of curricula and accreditation of schools, the maintenance of the register (ensuring members are in good standing however so defined, but typically with continued education and recency of practice, along with relevant re-certification requirements and other auditable dimensions to competency assessment) and the management of misconduct.

As a general observation, one could say that the question of the proper level of independence versus the level of direct state input is an equation that appears to be shifting. In the United Kingdom and, to some extent, in Australia, the legal profession has lost its right to self-regulate in recent years (Flood 2011); in 2010, the national government in Australia abolished all state regulatory boards in the health professions and constituted a national board under an entirely new governance structure; and the General Medical Council in the UK underwent major transformation in the wake of accountability and public confidence crises. In Ontario, Canada, more stringent safeguards and increased government powers of intervention through a government-appointed administrator are now part of the health professions regulatory framework (Leslie 2012).

Mobility agreements have put pressure on the professional regulators to ensure that everyone working in their jurisdiction is competent to do so. It has taken many years for health professions to develop a framework for establishing equivalence of education preparation around the world. And this framework provides the basis of mobility today. With increased mobility, the lack of an international framework – concerning equivalence of competence and formal processes for ensuring that everyone holding a licence to practise is engaged in lifelong learning and continuing professional development are causing concern among government, policy makers and the public (EC 2011a). Given the importance of patient safety and pressures on regulators to ensure the bona fides of all members on the register, we are moving into a new era in which educational programs and entry-level competencies will no longer be sufficient to assure the public that an individual is fit to practise across jurisdictions.

States, in requiring the professions to adapt to mobility provisions as in the best interests of their citizenry, are exercising their responsibilities to ensure economic growth and stability. They are demanding that their regulated professions adapt to the complexity of a mobile skilled market in a regulated field without risk to the public. In some respects, this is the new job of regulators: to meet these state-driven demands without creating an additional level of barriers to mobility.

For Canadian nurses, there is a further twist to these global trends and state-based pressures to create highly mobile workforces and agile economies. Come 2015, the newly graduated Canadian nurse will enter the register through an exam prepared by the US-based National Council of State Boards of Nursing. It is difficult to predict what this will mean for Canadian nurses. One thing we can say for sure is that poor market uptake of skilled labour increases losses to competitor markets. With the creation of a single exam, Canadian nurses may well become the hypermobile skilled workers of North America, even if the Canadian labour market remains a case study in over-regulation and the United States is the ultimate beneficiary.

The Canadian government has been keen to play in the major league of world trading partners, aware that there are winners and losers in the movement of global capital and in the competition for skilled workers (DFAIT 2012). Retaining home-grown and imported talent is key to the success of this strategy. Canada's regulated professions should know that the stakes are high. Regulators around the world need to understand the labour flows that drive economic growth and immigration policy if they are to have a constructive role to play locally in our globally driven economies.

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