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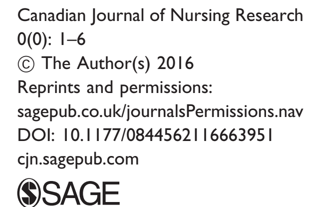

Migrant nurses and federal caregiver programs in Canada: Migration and health human resources paradox

Bukola Salami

Abstract

Despite the links between health human resources policy, immigration policy, and education policy, silos persist in the policy-making process that complicate the professional integration of internationally educated nurses in Canada. Drawing on the literature on nurse migration to Canada through the Live-in Caregiver Program, this paper sheds light on the contradictions between immigration and health human resources policy and their effect on the integration of internationally educated nurses in Canada. The analysis reveals a series of paradoxes within and across immigration and health human resources policy that affect the process of professional integration of this group of health professionals into the nursing workforce in Canada. I will further link the discussion to the recently implemented Caregiver Program, which provides a unique pathway for healthcare workers, including nurses, to migrate to Canada. Given recent introduction of the Canadian Caregiver Program, major policy implications include the need to bridge the gap between health human resources policy and immigration policy to ensure the maximum integration of migrant nurses in Canada.

Keywords

Health human resources, home caregivers, internationally educated nurses, immigration policy, migrant caregivers, nurse migration

Introduction

Health human resources policy issues have been a challenge for the global healthcare workforce for decades. In Canada, authors have argued that the current health human resources inadequacy stems from geographical and health systems distribution rather than a real shortage (Landry, Gupta, & Tepper, 2010; Wilson, 2013). Moreover, authors have argued that the siloed nature of health policy formation makes it challenging to find effective solutions to health human resources policies and to maximize health outcomes for Canadians (Baumann, Blythe, & Ross, 2010; Nelson, Verma, McGillis-Hall, Gastaldo, & Janjua, 2011). Even at the provincial level, policies that have an influence on health human resources across departments are not always congruent (Baumann et al., 2010). Baumann et al. (2010) recommended further research to illuminate and reconcile contradictory health human resources policies in Canada and to ensure evidence-based policy making.

Gaps in policy making are relevant to the case of internationally educated health professionals in Canada. Despite the links between health human resources, education, and immigration policy, there remain abiding gaps in policy on the integration of internationally educated health professionals into the workforce in Canada (Duckett, 2009). One obvious reason for this is that health professions are regulated provincially, while immigration policies are set at the federal level and formed on a generic rather than a sector-specific basis. Moreover, there are paradoxes across policies that relate to the professional integration of internationally

Faculty of Nursing, Edmonton Clinic Health Academy, University of Alberta, Edmonton, Alberta, Canada

Corresponding Author:
Bukola Salami, Faculty of Nursing, Edmonton Clinic Health Academy, University of Alberta, Level 3, 11405 87 Avenue, Edmonton, Alberta, Canada, T5T 5Y7.
Email: bukola.salami@ualberta.ca

educated nurses. I will argue that lack of policy harmonization and policy paradoxes is particularly problematic for internationally educated health professionals, who face several major barriers to workforce integration (Blythe, Baumann, Rheaume, & McIntosh, 2009).

To some extent, the challenges faced by internationally educated health professionals are consistent with those faced by the general immigrant population in Canada. Immigrant-skilled professionals face higher unemployment rates than Canadian-educated professionals (Yssaad, 2012) and are less likely to work in their own profession when they do participate in Canada's labor force (Hawthorne, 2008). This is especially the case for Indian-educated nurses and Philippine-educated nurses (Hawthorne, 2008). Philippine-educated nurses are increasingly working below their skill level in Canada. Data from the College of Nurses of Ontario (2014) illustrate the increasing number of Philippine-educated nurses who are becoming registered as practical nurses. In 2004, a total of 455 Philippine-educated nurses became registered to practice in Ontario, while 14 became practical nurses that same year. By 2013, the number of Philippine-educated nurses who were able to become registered nurses in Ontario had decreased to 36 individuals, while the number who became practical nurses had increased to 253 individuals (College of Nurses of Ontario, 2014). This occurs despite the fact that all nurses in the Philippines complete a baccalaureate nursing degree. One reason for this trend is likely related to issues of assessment of credentials as being equivalent to those of Canadian baccalaureate-prepared nurses, especially after the change to baccalaureate-level educational requirement for registered nurses in Ontario. However, there is a potential that other factors contribute to this trend which has not been explored in the literature.

The Live-In Caregiver Program (1992) and Caregiver Program (2014)

Canada has increasingly relied on temporary foreign workers to meet employer needs across diverse sectors (Lowe, 2010). In 2012, a total of 213,573 temporary foreign workers gained entry to Canada—almost as many as the number of permanent immigrants, 257,887 (Citizenship and Immigration Canada, 2013). Those who migrate to Canada via the previous Live-in Caregiver Program and the current Caregiver Program represent a subgroup of temporary foreign workers in Canada. The conversion of the Live-in Caregiver Program to the Caregiver Program in 2014, a significant change in Canadian immigration policy, has great potential to influence nursing policy.

The Live-in Caregiver Program was created in 1992 to allow individuals to migrate to Canada to provide care to children, the elderly, and the disabled. While live-in caregivers initially migrate temporarily to Canada, they can transition to permanent resident status after a minimum of two years in Canada. The majority of individuals who migrated to Canada through this route were women from the Philippines (Kelly, Astorga-Garcia, Esguerra, & Community Alliance for Social Justice, 2009). Prior to 2014, a majority of these caregivers worked as nannies while living in the home of their employers. Although well-documented research indicates that some live-in caregivers are nurses, evidence in this regard is mixed (Bourgeault et al., 2010; Kelly et al., 2009). This trend in the Live-in Caregiver Program was no secret; in fact, policy makers verbalized awareness that nurses migrate through the Live-in Caregiver Program. For example, in a December 2009 statement, then Minister of Citizenship and Immigration, the Honorable Jason Kenney, remarked, "Many of them [live-in caregivers] have training as medical practitioners, as nurse assistants, and as nurses, and they come from different backgrounds. Many, if not, in fact, the vast majority, originally are from the Philippines" (Citizenship and Immigration Canada, 2009).

In 2014, several changes were made to the program, including its conversion to the Caregiver Program. One of the motivations for changes to the program was the documented cases of abuse and exploitation of live-in caregivers by recruiters and employers (D'Addario, 2013; Pratt, 2009; Spitzer, 2009). The current Caregiver Program also allows individuals to migrate to Canada to provide care work, but now caregivers can either live in a client's home or live out (Citizenship and Immigration Canada, 2014). The new program permits individuals to work in healthcare institutions such as long-term care centers. The creation of two streams of caregivers—those who provide care to children and those who provide care to individuals with high medical needs—is another notable change. Fifty percent of individuals who migrate to Canada through the new Caregiver Program will be healthcare workers providing care to individuals with high medical needs. Individuals who migrate under this category must be a registered nurse, registered psychiatric nurse, licensed practical nurse, nurse aide, or home support worker. Thus, there is now a clear pathway for nurses to migrate to Canada through the Caregiver Program.

Experience of nurses who migrate to Canada as live-in caregivers

The experiences of nurses who migrate to Canada as live-in caregivers are well documented. The earliest research is Pratt's 1999 article, "From Registered Nurse to Registered Nanny." Pratt found widespread deskilling of nurses through the Live-in Caregiver Program, largely

due to the two-year requirement to work as a domestic worker before becoming registered to practice as a nurse in Canada. Barriers to taking courses further impede the professional integration of live-in caregivers in Canada. In addition to experiences of exploitation and abuse, issues of deskilling and barriers to professionalization in Canada are discussed in other literature on the migration of nurses through the Live-in Caregiver Program (Hawkins, 2013; Pratt, 1999).

Previous research by the author confirms that nurses who migrate to Canada through the Live-in Caregiver Program experience several challenges with workforce integration (Salami, Nelson, McGillis-Hall, Muntaner, & Hawthorne, 2014). Notably, many of these nurses have international experience; in fact, many of them worked in the Middle East before migrating as a nurse to Canada (Salami, Nelson, Hawthorne, Muntaner, & McGillis-Hall, 2014). Thus, they engage in step-wise migration pathways, mainly in an attempt to gain Canadian citizenship for their family (Hawkins, 2013; Salami, Nelson, McGillis-Hall, et al., 2014; Walton-Roberts & Hennebry, 2012). In their interviews with 15 nurses who migrated to Canada through the Live-in Caregiver Program and nine stakeholders (i.e., nurse educators, recruiters, support groups, and policy makers), Salami, Nelson, Hawthorne, et al. (2014) found that these nurses experienced challenges associated with credential assessment, costs of education and recertification, and lack of employer support. For instance, under the Live-in Caregiver Program, upon completion of the two-year requirement as a live-in caregiver, they are eligible to apply for permanent resident status and to become a nurse in Canada, but they are often required to complete bridging or upgrading programs to gain access to the profession. However, these migrants are often on an open work permit for two to four years after completion of the program and before becoming a permanent resident in Canada. Under such a designation, they must pay international student fees to access any upgrading program, a cost that most cannot afford. In addition, they do not qualify for student loans under the Live-in Caregiver Program or the new Caregiver Program to assist in their integration process. While there are explicit policies that encourage the migration of nurses through the Caregiver Program, the paradoxes within and across policy jurisdictions creates complexities and barriers to access to the profession for this group of nurses.

Another contradictory gap between immigration and nursing human resources policy is the time required to demonstrate safe nursing practice. For instance, in the province of Ontario, these nurses must demonstrate that they have practiced in the nursing profession in the last three years. However, given that most work as live-in caregivers for three to four years prior to becoming eligible for permanent resident status as well as nursing registration, they are unable to demonstrate evidence of recent safe nursing practice. Inability to demonstrate this evidence means that almost all live-in caregivers in Ontario will be required to complete upgrading and bridging programs. However, research indicates that they experience barriers in accessing such programs, including a lack of flexibility in the scheduling of bridging and upgrading programs (Hawkins, 2013; Salami, Nelson, McGillis-Hall, et al., 2014). Moreover, employers who often want to retain these migrants as low-skilled care workers may not be supportive of a live-in caregiver's goal to regain his or her occupational identity in Canada. Thus, there are paradoxes within the Caregiver Program as it overtly allows nurses to migrate to Canada with embedded rules that restrict access to professional integration of these nurses in Canada due to contradictions between this immigration policy, nursing regulatory policy, and health human resource policy.

Discussion: Contradictory gaps within and across immigration and health human resource policy

Internationally educated health professionals migrate to Canada through different streams, including the Provincial Nominee Program, the Federal Skilled Worker Program, the Temporary Foreign Worker Program, the International Mobility Program, and the Caregiver Program (or the previous Live-in Caregiver Program). However, the integration of nurses who migrate to Canada through the Caregiver Program and its predecessor, the Live-in Caregiver Program, has been largely neglected in the health human resources literature. Given recent policy direction and the 2014 launch of the Caregiver Program, a major policy question emerges: Should Canada be relying on temporary migrant workers to meet its care labor force needs or are there other options to solve labor force needs? Tomblin-Murphy et al. (2009) suggest that internationally educated nurses are not a solution to the nursing shortage in Canada. While internationally educated nurses cannot be deterred from migrating to Canada (after all, individuals should have liberty to choose where to reside), nursing policy makers must recognize that current immigration policy paradoxically often leads to the deskilling of internationally educated nurses, especially those who migrate through the Caregiver Program. The need for more attention to this issue is especially crucial at this moment, as the current Canadian Liberal government plans to increase the number of live-in caregivers in Canada by making it easier for employers to hire migrant caregivers (Liberal Party of Canada, 2015).

Even though migrant caregivers provide care to the elderly, children, the sick, and the disabled in the home, the program has not been considered within current discussions of home care policy. Thus, with the decades of reliance on migrant caregiver programs to meet the needs of the sick, elderly, and disabled who require live-in caregivers, and despite a wide array of research by social scientist on the weaknesses of the Live-in Caregiver Program (D'Addario, 2013; Spitzer, 2009), no research exists on the need for this group of workers. This is especially important considering projected increase in the elderly population and the trend towards aging in place (Keefe, Knight, Martin-Matthews, & Legare, 2011). Furthermore, with the creation of the Caregiver Program and a pathway for individuals to migrate to provide care (including homecare) for individuals with high medical needs, it is important that migrant caregivers are included in discussions on home care policy in Canada.

Attention must also be paid to the broader lives of the nurses who migrate to Canada through temporary migration routes. Given that the Caregiver Program and its precursor, the Live-in Caregiver Program, ensure a path to permanent residency, these workers have a long-term plan for their lives in Canada, with family reunion, socioeconomic mobility, and professional reintegration as major goals (Salami, 2014). However, the policies of both programs, including barriers to taking courses, oblige these workers to focus on Canada's short-term objectives—namely, to fulfill a perceived labor market shortage—rather than their own long-term economic potential to contribute at a higher level to the Canadian health workforce as fully integrated, regulated nurses.

Currently, the policies surrounding the Canada Caregiver Program are opaque. While we know that nurses migrate through this program, there is no publically available data on the total number of nurses that migrate through this route or on their experiences with nursing integration. As opposed to nurses who migrate to Canada as "high-skilled" temporary foreign workers, nurses who migrate through the Caregiver Program face significant challenges with family integration, as the program prohibits them from bringing their family with them to Canada. Researchers have documented the challenges of family separation and reunification for migrant caregivers (Pratt, 2012), and these challenges impact the socioeconomic lives of migrants' children as well. Furthermore, migrating as a permanent resident through the Federal Skilled Worker or Provincial Nominee Program enables workers to access educational programs to upgrade their knowledge and skills, whereas those that migrate through the Canada Caregiver Program must pay international student fees.

It should be acknowledged that in the final years of its mandate, the federal conservative government made several changes in an attempt to improve the Caregiver Program for sponsored workers, including necessitating employers to pay all recruitment costs and granting open work permits immediately after program completion (Citizenship and Immigration Canada, 2009, 2014). However, several of these policies have resulted in trade-offs, including between the needs of live-in caregivers and employers. This speaks to the issues of paradox in policy making (Stone, 1988). As political scientist, Deborah Stone (1988) argues, policy making involves struggle over values and ideas of multiple stakeholders. For instance, one recruitment agency in a previous study observed that the implementation of policies that ensure the employer pays for all live-in caregiver fees did indeed decrease the risk of financial exploitation of live-in caregivers (Salami, 2014). However, it has also meant a higher financial burden for employers in Canada without guarantee that the live-in caregiver will remain employed for a significant period of time with the employer, which has affected the number of positions available. Thus, new policy problems can emerge from solving one policy issue.

Implications and conclusion

The above discussion provides several useful research and policy implications. Further research is needed on the downward occupational mobility of internationally educated nurses in Canada. Specifically, there is a need for research to shed light on the occupational trajectory and employment outcomes of nurses who migrate through the newly created Canada Caregiver Program as well as its precursor, the Live-in Caregiver Program. Comparative analysis on the employment outcomes from these two programs, while considering the changing nursing regulatory policy landscape, will provide useful insight into the influence of immigration policy on the integration of internationally educated nurses in Canada. Furthermore, while social scientists have discussed the experience of live-in caregivers, there is limited literature by health human resource researchers on the implications of the Live-in Caregiver Program or the Canada Caregiver Program on the homecare workforce in Canada. This is especially important at this time given that there is a stream within the Canada Caregiver Program that is created specifically for individuals with high medical needs.

There is a need to bridge policy gaps and address the shortcomings of the Caregiver Program to leverage the integration of internationally educated nurses in Canada who migrate through this program. The need to examine the links between immigration and

health human resources policy is especially important considering increasing globalization and migration. The issue of loss of global health human resources due to challenges in integration has been well discussed in the literature (Blythe et al., 2009). Of particular importance is the influence of migration routes and policies on the integration of these health professionals (Hawkins, 2013).

There is also a need for Canadian nursing regulators to examine the influence of regulatory policies on the integration of diverse groups of internationally educated nurses. Lack of consistency across Canadian provinces on entry into practice requirements for internationally educated nurses, including evidence of safe nursing practice, is problematic and requires policy attention. There is a need to take a closer look at the maximum length of time nurses can be out of clinical practice. Regulatory policy in some province that decreased this length of time from five to three years are likely to severely impact the integration of those who migrated as live-in caregivers, especially given that it takes three to seven years for internationally educated nurses to become eligible for nursing practice after arriving in Canada (Salami, 2014). Stone (1988) argues that policy makers (including nursing policy makers in Canada) must struggle between ideas of equity (in access to the profession) and the ideas of security and safety (of health services). This remains a complex terrain to balance without sufficient research evidence of safety in internationally educated nurse's clinical practice. Research is needed in this area to inform policy on issues of safety and the requirements related to recent nursing experience. Evidence-based policy making is needed to resolve the contradictions between health human resource and immigration policy in Canada.

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Author Biography

Bukola Salami is an assistant professor at the Faculty of Nursing, University of Alberta. Her program of research is focused on immigrants health and international nurse migration.