Nursing Skills and Mobility: Facilitating the Transfer and Tracking of Nurses Across Canada

Prepared for the Canadian Nurses Association

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Table of Contents

Glossary of Acronyms ........................................................................................................ iii
Executive Summary ........................................................................................................ iv

1. INTRODUCTION .................................................................................................. 1

2. METHODOLOGY ............................................................................................... 2

3. FACILITATING LABOUR MARKET MOBILITY FOR NURSES .............. 2
   3.1 International MRAs ....................................................................................... 3
      3.1.1 Mutual Recognition in the European Union ............................................. 4
      3.1.2 The Trans Tasman Trade Agreement and Mutual Recognition ............. 4
      3.1.3 Mutual Recognition with the U.S. and the Nursing Licence Compact ....... 5
   3.2 MRAs Under Canada’s Agreement on Internal Trade ......................... 6
   3.3 MRAs with Respect to Nursing in Canada ............................................... 8
      3.3.1 Mutual Recognition Agreement for Registered Nurses ......................... 8
      3.3.2 Mutual Recognition for Licensed Practical Nurses ............................... 9
      3.3.3 Endorsement Agreement for Registered Psychiatric Nurses ............... 10
      3.3.4 Mutual Recognition Agreement for Midwives ....................................... 10
      3.3.5 Mutual Recognition Agreement for Nurse Practitioner ....................... 10
   3.4 Discussion ......................................................................................................... 10

4. TRACKING NURSING MOBILITY ........................................................... 13
   4.1 Models for Tracking Mobility ....................................................................... 15
      4.1.1 Unique Provider Identifiers .................................................................... 16
      4.1.2 Medical Identification Number for Canada ............................................ 17
      4.1.3 Licensed Practical Nurses UPI Pilot ....................................................... 18
   4.2 Discussion ......................................................................................................... 19

5. RAPID MOVEMENT IN TIMES OF EMERGENCY ............................... 21
   5.1 Considerations Regarding the Rapid Deployment of Nurses .................. 21
   5.2 Canadian Nurses Emergency Response Models ...................................... 23
      5.2.1 Canadian Emergency Preparedness ....................................................... 23
      5.2.2 The Registered Nurses of Ontario VIANurse Portal ......................... 24
      5.2.3 College of Nurses of Ontario Registration Emergency ...................... 24
      5.2.4 Other Emergency Registration Protocols ............................................ 25
   5.3 International Emergency Response Models ............................................ 25
      5.3.1 American Nurses Association National Nurses Response Teams ......... 26
      5.3.2 Northeastern Forest Fire Protection Commission ................................. 26
      5.3.3 International Emergency Management Assistance MOU .................. 27
   5.4 Discussion ......................................................................................................... 28

6. CONCLUSIONS .................................................................................................. 30
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIT</td>
<td>Agreement on Internal Trade</td>
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<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
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<td>CNO</td>
<td>College of Nurses of Ontario</td>
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<td>CSA</td>
<td>Canadian Standards Association</td>
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<td>CRNE</td>
<td>Canadian Registered Nurse Examination (CRNE)</td>
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<td>EU</td>
<td>European Union</td>
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<td>FNIHB</td>
<td>First Nations and Inuit Health Branch</td>
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<td>FLMM</td>
<td>Forum of Labour Market Ministers</td>
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<td>GATS</td>
<td>General Agreement in Trades and Services</td>
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<td>HERT</td>
<td>Health Emergency Response Teams</td>
</tr>
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<td>IEMAC</td>
<td>International Emergency Management Assistance Memorandum of Understanding</td>
</tr>
<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
</tr>
<tr>
<td>MINC</td>
<td>Medical Identification Number for Canada</td>
</tr>
<tr>
<td>MRA</td>
<td>Mutual Recognition Agreement</td>
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<td>NAFTA</td>
<td>North American Free Trade Agreement</td>
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<tr>
<td>NFFPC</td>
<td>Northeastern Forest Fire Protection Commission</td>
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<td>NOHERT</td>
<td>National Office of Health Emergency Response Teams</td>
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<td>NP</td>
<td>Nurse Practitioner</td>
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<td>OIIQ</td>
<td>Ordre des Infirmières et Infirmiers du Québec</td>
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<td>PSEPC</td>
<td>Public Safety and Emergency Preparedness Canada</td>
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<td>PRN</td>
<td>Psychiatric Registered Nurse</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>RNABC</td>
<td>Registered Nurses Association of British Columbia</td>
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<td>RNAO</td>
<td>Registered Nurses Association of Ontario</td>
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<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<td>UPI</td>
<td>Unique Provider Identifier</td>
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Executive Summary

In the fall of 2005, the CPRN Health Network was contracted by the Canadian Nurses Association to explore the facilitation of cross-jurisdictional mobility as part of their overall project for the Pan-Canadian Health Human Resource Planning. There are two distinct but related dimensions to the issue of nurse mobility.

In the first instance, there is the question of how best to reduce barriers and facilitate the mobility of nurses who wish to move more or less permanently across jurisdictions, or from one job site to another within the same jurisdiction. In this case, we are talking about the need to streamline processes for credential and competency recognition to make such moves less cumbersome for both the nurse and the employer.

This can be distinguished from what can be called “emergency mobility” which is, almost by definition, temporary and situation-specific. In the aftermath of the SARS epidemic in Toronto, and in light of events like the destruction wrought by Hurricane Katrina in the United States, it has become apparent that there are significant barriers and obstacles to mobilizing nurses in times of emergency. And yet there is still a need to ensure that the nurses who are moved into emergency situations are in good standing with their professional regulatory body and have the skill sets and competencies needed.

In examining these issues the paper undertakes to provide an environmental scan of facilitators to mobility, including national and international nursing mutual recognition agreements, and models proposed, developed or implemented which are specific to the rapid mobilization of nurses during times of short-term emergencies.

The overall mobility of nurses within the labour market has clearly been enhanced through the MRAs adopted under the aegis of the Agreement on Internal Trade. The processes have been clarified, streamlined and appear to have been made much more user-friendly for both the individual nurse and for the employer. But there is very little empirical evidence that would tell us how much enhancement of mobility has been achieved to date. For instance, the environmental scan failed to turn up any documents which detail the experiences that nurses have when registering in another jurisdiction under the MRAs or when deployed at times of emergencies.

It is evident that efforts to track the mobility of nurses, both within and across jurisdictions, are not yet sufficient to support our attempts to reduce barriers to mobility. As the barriers to mobility have been reduced and the processes made easier one can expect higher levels of mobility within that workforce. This necessitates a greater attention be paid to building the data and information technology infrastructure necessary to track these more mobile workers. Human resource planning for the nursing workforce needs to be able to accurately understand which nurses are moving (both in terms of demographic information but also in terms of their education, skills and competencies), where they are moving from and to, how often they are moving and the reasons behind their movement (both at the individual and at the aggregate level).
The building of that data infrastructure to track nursing mobility is very closely linked with the desire to build processes and frameworks for the rapid deployment of nursing resources in times of health emergencies. The kind of information that would be collected to track the general mobility of nurses across job-sites or across provincial borders would also be invaluable in building data bases that would allow us to identify the skills and competencies needed in a particular kind of health care emergency.

But the development of frameworks and agreements for the emergency deployment of nurses also goes beyond the data needs met by a system capable of tracking the nursing workforce generally. There are very important “knock on” effects throughout the system that occur when some significant number of nurses leave one jurisdiction or work site for another during an emergency situation, not to mention the impact that a health emergency can have on the health workforce in the affected area (both as health professionals and as citizens).

There is a need, therefore, for greater consistency, agreement and collaboration within planning so that nurses are not reactionary but proactive in their approach to emergency assistance. First of all, this involves clarifying the roles and responsibilities of the various actors at the federal, provincial and regional levels to ensure that nurses with the right skills are deployed when needed. At the federal level, this may be the development of guidelines and a national framework or vision and a more careful synthesis of health human resource planning needs within emergency protocols. The latter point is seldom raised within planning yet it is critical. If we do not have enough people trained with the requisite skills sets given different disaster scenarios (e.g. public health nurse, epidemiology, trauma care, mental health) then the shortages will be heightened during disasters. A pandemic will put additional strains on human resource availability especially if it is simultaneously experienced across jurisdictions. Even more specific disasters (e.g. natural disasters) must take into consideration the staffing needs of the assisting jurisdiction. This may include the cancellation of elected surgeries, etc. These staffing needs and preparations could feasibly be part of the overall framework.

Although there was little appetite amongst key informants interviewed for moving at this time to a system of national licensure for nurses (and great resistance on the part of some of those interviewed) there was a consistent call for a greater level of coordination in both the tracking of nurse mobility and in the planning for deployment of nurses in times of emergency. There was more interest expressed in mechanisms like unique identifiers that would travel across jurisdictions with individual nurses and allow jurisdictions to know not only who is arriving in their jurisdictions but also who is leaving. But movement in this direction will depend on knowing more about why previous experiments were abandoned and in overcoming any of the problems encountered with those experiments. Further, there is a very strong need not only for more and better data, but perhaps more importantly for better coordination and compatibility between existing data sets and information technology. And this in turn, requires more attention to be paid to examining how well the current MRAs are working in facilitating the mobility of nurses across the country in terms of identifying those barriers that still exist.
1. INTRODUCTION

In the fall of 2005, the CPRN Health Network was contracted by the Canadian Nurses Association to explore the facilitation of cross-jurisdictional mobility as part of their overall project for the Pan-Canadian Health Human Resource Planning. There are two distinct but related dimensions to the issue of nurse mobility.

In the first instance there is the question of how best to reduce barriers and facilitate the mobility of nurses who wish to move more or less permanently across jurisdictions or from one job site to another within the same jurisdiction. In this case we are talking about the need to streamline processes for credential and competency recognition to make such moves less cumbersome for both the nurse and the employer. All Canadians enjoy a constitutionally guaranteed right to work and live in any part of the country they choose and such a right imposes a duty on governments, regulators and others not to erect unreasonable barriers that would compromise such mobility. For our purposes, then, this can be referred to as “nursing mobility within the labour market”.

This more generalized labour market mobility for nurses can be distinguished from what can be called “emergency mobility” which is, almost by definition, temporary and situation-specific. In the aftermath of the SARS epidemic in Toronto and in light of events like the destruction wrought by Hurricane Katrina in the United States, it has become apparent that there are significant barriers and obstacles to mobilizing nurses in times of emergency. When a nurse is planning a move from one province to another a process that resolves issues of credential and competency recognition in a few weeks is likely not a significant barrier, but in the midst of a health crisis like SARS or a bird-flu pandemic such a delay makes a swift response by health professionals impossible and can endanger the lives of citizens. And yet there is still a need to ensure that the nurses who are moved into emergency situations are in good standing with their professional regulatory body and have the skill sets and competencies needed in the particular emergency.

This paper, then, examines the issues raised both by the desire on the part of many health system actors, including individual nurses, to facilitate mobility within and across jurisdictions generally but also the need to have in place processes that can deal with mobility in the context of health emergencies of different types and durations. In examining these issues the paper undertakes to provide an environmental scan of facilitators to mobility, including national and international nursing mutual recognition agreements, and models proposed, developed or implemented which are specific to the rapid mobilization of nurses during times of short-term emergencies. As will become apparent below, what is needed is a more fulsome framework which is contextualized within the current nursing trends (e.g. casualization and worker shortages) and coordinates various factors related to the mobility of nurses during short-term emergency situations.

Following a discussion of the methodology employed in this study, the paper provides a detailed overview of both the international and domestic agreements designed to facilitate
the general mobility of nurses. This includes a detailed examination of the mutual recognition agreements that flow from the commitments made by governments in the Agreement on Internal Trade. From there the paper explores various models and proposed models for better tracking of nurse mobility in Canada and explores the reaction of the key informants interviewed to proposals such as unique provider identifiers (UPIs). The next section of the paper explores the issues involved in the rapid deployment of nurses in emergency situations and looks at both domestic and international attempts to better facilitate this movement. The paper concludes with a discussion of the next steps needed to be taken by health sector actors (including governments) to better facilitate both the general mobility of nurses in the labour market and their rapid deployment in emergency situations.

2. METHODOLOGY

The methodology included an environmental scan of Canadian and international grey literature and research documents between 2000 and 2005. Materials were located through a keyword Internet search and a search of various library publication search engines including PubMed, MEDLINE, Web of Science, and others. The information was verified through 10 key informant interviews of representatives from provincial and federal departments of Health and Intergovernmental Relations, Representatives(s) from the Federal/Provincial/Territorial Committee on Health Human Resource Planning; members of nursing regulatory bodies, representatives from nursing unions, the Canadian Institute on Health Information (CIHI), and employers, including representatives from health regions and hospital boards. The interview instrument was structured but also contained open-ended questions to elicit in-depth responses from the key informants.

The material from both the environmental scan and the key informant interviews was analyzed using the following general themes as analytical guides:

- Models for tracking short-term mobility;
- International and national nursing mutual recognition agreements; and
- Models and protocols for nurse mobility during times of emergency situations.

3. FACILITATING LABOUR MARKET MOBILITY FOR NURSES

The current status of nurse mobility in Canada is part of an overall international and national move towards the greater liberalization of labour mobility. There are a number of national and international agreements designed to facilitate labour market mobility generally across different workforces, the most important of which for our purposes is the Agreement on Internal Trade (AIT). In addition there are several national and international Nursing Mutual Recognition Agreements (MRAs) that have been developed specifically to facilitate the movement of nurses from one jurisdiction to another by avoiding the duplication of assessment and training. Both the pertinent nursing national and international MRAs are described below.
3.1 International MRAs

Mutual recognition agreements (MRAs) on labour mobility facilitate the ability of workers trained and registered in one jurisdiction to work in an equivalent occupation in other jurisdictions without any undue reassessments or re-qualification. MRAs generally involve the development of equivalencies or commonalities within training and core competencies of each occupational grouping and the removal of regulatory and impediments; therefore agreement must first be reached about what is acceptable as a competency or skill before allowing movement across borders. The development of MRAs is facilitated through cooperation between the parties when determining which training and requisites are transferable across borders. In general, most international recognition agreements:

- Leave considerable residual powers to the host country;
- Involve mutual monitoring between the regulatory authorities;
- Involve some pre-conditions before recognition is granted; and
- Include the possibility to reverse or remove recognition in view of changes to the other party's regulatory system.

Thus, recognition includes that of the development of “equivalences”, and “compatibilities” within the parties’ regulatory systems. Included within most MRAs are also often safeguards in place to “protect the public good”, giving parties the power to reassert jurisdictional regulations. This was seen, for instance, in the debates within the European Union over a provision that allows health care professionals trained in one EU country to practice in another for up to four months without registering with the necessary authorities. The lobbying against this loophole (mainly by the United Kingdom) was predicated on the possibility of threats to public safety.

Regional trade agreements (e.g. the Trans-Tasman Agreement between Australia and New Zealand, and the North American Free Trade Agreement (NAFTA) are predicated on the intensification of the free movement of goods and services across borders. Partly, this movement is captured within some trade agreements, such as the General Agreement in Trades and Services (GATS) and NAFTA which are based on the temporary movement of people across borders. However, as Blouin et al. (2004) point out, there are restrictions such as economic needs tests imposed by many World Trade Organization (WTO) members over the temporary mobility of health care professionals, including nurses, which hampers their mobility. It is also unclear what is specifically meant by “temporary”.

Relative to the liberalization of trade in goods and services within multilateral and bilateral trade agreements, the mutual recognition of nursing competencies is still in its infancy. Some of the current movement at both the national and international levels can be predicated on the identification of barriers which limit the movement of professionals across borders including language competency, which is especially an issue for health workers due to the necessity to effectively communicate with patients/clients. Another barrier noted to the liberalization of mobility is that of a lack of recognition of
qualifications and experience and difficulties in obtaining permits and/or visas within the free trade zone.

3.1.1 Mutual Recognition within the European Union
The European Union (EU) for instance, is predicated on the liberalization of services, goods, and people across European borders. Thus:

Every EU citizen has a fundamental, personal right to move and reside freely within the territory of other Member States (subject to some limitations and conditions). The freedom of movement includes access to employment; residence rights (with family) in other Member States (for those seeking employment, a six month time limit normally applies); and equality of treatment regarding working conditions and employment-related benefits.

The Treaty of Rome in 1957 effectively began the process of mutual recognition by calling for directives on the: “the mutual recognition of diplomas, certificates and other evidence of formal qualification”. It was not until later on that specific Sectoral Directives were developed around the mutual recognition of qualifications for health professionals. The Directives that relate to the recognition of nursing qualifications in the EU are as follows:

- The Midwifery Directive 80/154/EEC;
- The Nursing Directive 77/452/EEC which pertains to general care nurses.

The mutual recognition of specialist nurses is addressed by Council Directives 89/48/EEC which pertains to the recognition of higher-education diplomas awarded on completion of professional education and training of at least three years' duration. In principle, the recognition of qualifications between the EU countries is automatic. However, there are many issues which pose practical barriers to the mobility of nurses and other health care professionals across the EU borders including the diversity in health care systems, human resource capacities and languages. Moreover, at present, the EU can not adequately compare health professional training and qualifications across the member states due to a lack of a single database that makes apparent the equivalencies in training or qualifications across different health professions in different states. Furthermore, the extent to which employers insist on proof of qualifications is not readily available nor is there much information on how recognition procedures vary according to the public and private sectors.

3.1.2 The Trans Tasman Trade Agreement and Mutual Recognition
There are two different components to the MRA of nurses within and between Australia and New Zealand. First, there is an MRA in place to enhance the mobility of professionals across the eight Australian states and territories, the expressed purpose of which is to ensure that:
A person who is registered to practice an occupation in one jurisdiction is entitled to practice an equivalent occupation in any other jurisdiction without the need to undergo further testing or examination14.

Workers within this agreement must still comply with the rules and regulations within the states and territories which includes any requirements for ongoing registration in that occupation. The Australian Nursing Council as well takes a national approach to state and territory regulatory authorities. Nurses wishing to practice in a different jurisdiction or region must be registered or enrolled in the state or territory where their practice takes place. Mutual recognition agreements do allow nurses registered in one state or territory to be registered in another, the nurse often must pay a prescribed fee in all jurisdictions. There are waivers in place in all Australian regulatory authorities (except the Nurses Board of the Australian Capital Territory) which exempt the payment of fees in certain circumstances15. The key difficulty in drawing lessons for Canada from the Australian experience is that in Australia the regulation of the nursing profession is in the hands of the national government – making the facilitating mobility somewhat easier to accomplish – whereas in Canada this regulation is done provincially and requires greater collaboration between jurisdictions.

The Trans Tasman Agreement applies to the mobility of goods and services between Australia and New Zealand. Under the Trans Tasman Mutual Recognition Act, nurses who have the authority to practice as a registered nurse or enrolled nurse in New Zealand may apply for the mutual recognition of his or her qualifications within any Australian state or territory16. Nurse practitioners are currently developing core competencies for inclusion under the mutual recognition agreement. This, according to the Royal Society of Nursing, has led to a significant reduction in the administrative complexity for registering nurses from another jurisdiction as well as the inconveniences experienced through delays in registration17. However, there are costs involved in monitoring the legislation and in ensuring that the regulations are adhered to.

3.1.3. Mutual Recognition within the United States and the Nursing License Compact
A number of factors have pushed governments, employers and nurses in the United States to look for better ways to facilitate mutual recognition and mobility across state borders:

- The transition from independent hospitals and facilities to integrated multi-state delivery systems18;
- A greater reliance on “the practice of nursing over distance using telecommunications technology”19 or ‘telenursing’ which effectively shifts the loci of practice whereby a nurse living in one state provides services to clients in another;
- The existence of so-called ‘traveling nurses’ within the United States who move from location to location who require licensure within each destination state20; and,
- Nurses who live in one state and work within another, creating questions around whether the place of residence or the place of practice is the important variable21.
The model for mutual recognition within the United States is facilitated by a nurse license compact which essentially allows: “a nurse to have one license (in his or her state of residency) and to practice in other states (either physically or virtually), subject to each state’s practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted.” It is similar to a driver’s license compact in that nurses practicing in another nurse license compact state must still uphold and practice the laws and regulations within host state. The advantages of the Nursing Compact are that:

- It reduces barriers to interstate practice;
- It improves tracking for disciplinary purposes;
- It is cost effective;
- It is simple for the licensee; and
- It facilitates interstate commerce.

The issue of emergency response situations is stated as a rationale for the development of a development of the Nurse Compact License. Indeed, it will facilitate: “Improved access to licensed nurses during a disaster or other time of great need for qualified nursing services.” The experiences of utilizing nursing compacts during the Katrina hurricane disaster requires further exploration. Mississippi is signatory to the Nurse Compact while Louisiana is not.

The American Nursing Compact has several implications for the Canadian experience. First at least some of the rationales for the multi-state compact have resonance within Canada. The growth of provincial and territorial telehealth programs may eventually lead to the creation of networks which may cross boundaries in providing assistance. Secondly, the reality of traveling nurses in the Northern territories has been raised as an issue by the First Nations and Inuit Health Branch (FNIHB) – an area of nursing mobility that needs to be addressed in the context of the existing MRAs. Finally, much like the reality of living and working in different states within the United States, the experiences of Canadian nurses within border towns (e.g. Lloydminster) regarding mobility across worksites and provinces raises important questions about mobility across provincial borders within the context of MRAs and thus requires some requires further exploration.

3.2 MRAs Under Canada’s Agreement on Internal Trade (AIT)

In 1994, the First Ministers signed the Agreement on Internal Trade (AIT) which is predicated on the increased liberalization of the movement of goods, services, people and investments across Canada. Within this Agreement, a section or labour mobility (Chapter Seven) stipulates a need for the removal of barriers for labour mobility across provincial jurisdictions. Indeed, the purpose of Chapter Seven is to: “… enable any worker qualified for an occupation in the territory of a Party to be granted access to employment opportunities in that occupation in the territory of any other Party, as provided in this Chapter.”

The AIT has spawned a number of Mutual Recognition Agreements amongst different professions aimed at the labour mobility provisions of the AIT. Under the AIT, each
Party is required to ensure that any measure that it adopts or maintains relating to the licensing, certification or registration of workers of any other province:

- Relates principally to competence;
- Is published or otherwise readily accessible;
- Do not result in unnecessary delays in the provision of examinations, assessments, licenses, certificates, registration or other services that are occupational prerequisites for its own workers, and
- Except for actual cost differentials, does not impose fees or other costs that are more burdensome than those imposed on its own workers.

The principles of the Mutual Recognition Agreements in Canada for occupations requires that a high level of commonality (e.g. 80%) in the occupational standards required to practice the occupation exist according to two or more non-government bodies which have been delegated by law to set occupational standards (e.g. a regulatory body). The mutual recognition of standards includes the scope of practice, generic skills, specific skills, licensing, certification or registration requirements and other entry requirements and qualifications pertaining to the occupation. Any disputes or unfair trade practices between the provinces can be settled through a formal dispute resolution mechanism, though it is questionable whether this mechanism is backed by the rule of law.

The MRAs also provide for the development of accommodating mechanisms to ensure that, where such differences exist, a regulated professional moving from one jurisdiction to another may be granted a limited licensure/registration or may be required to undertake additional education to meet the requirements of the receiving jurisdiction. The development of such accommodating mechanisms has two purposes: to facilitate labour mobility and to ensure public protection. With regard to the latter, any additional education or training required ensures that a regulated professional meets the requirements for safe professional practice in the jurisdiction to which he/she is migrating.

There is evidence that, for the most part, there has been compliance with Chapter 7 of the AIT. For instance, the Forum of Labour Market Ministers (FLMM) (2005) found that most regulatory bodies in Canada (76%) compared their competency profiles and occupational standards with those in other provinces and there is a high degree of commonality (71%) among these occupational standards. However, only 65% of the workers who had moved between October, 2003 and September 2004 had their qualifications recognized under an MRA or mobility agreement and were issued a license to practice. The FLMM noted that the rationales for the lack of recognition for the remaining 35% may include residency requirements, non-compliance with the AIT and/or the need for regulation changes. For instance, while assessments are counterproductive to the AIT, according to one respondent, there is some evidence that they still exist. These assessments require a great deal of resources in terms of time and finances since the background of the employee would have to be scrutinized and then go to a committee within each regulatory body which may, in turn, only meet once or twice a month.
3.3 MRAs With Respect to Nursing in Canada

The nursing profession has historically held the gold standard for the development of endorsements and mutual recognition. Most of the MRAs for nursing were signed by the relevant regulatory bodies in 2001. The purpose of MRAs is to “establish the conditions under which a (regulated professional) who is licensed/certified/registered in one Canadian jurisdiction will have his/her qualifications recognized in another Canadian jurisdiction which is a Party to this Agreement”31. The nursing MRAs therefore recognize that scopes of practice and occupational requirements for registration between jurisdictions may vary. Any additional training required by provinces is incorporated into the MRAs.

Some general delays may occur through the process of credential recognition. For instance, a good character reference is needed from an employer; if this is not filled out correctly the recognition process for the nurse may be delayed. There is, however, a dearth of information about the experiences of nurses in the credential recognition process. The current data on mutual recognition within the context of the AIT supplied by the FLMM (described above), for instance, is not broken down by occupational grouping.

3.3.1 Mutual Recognition Agreement for Registered Nurses

Almost all of the jurisdictional regulatory bodies in Canada, with the exception of Ontario and Quebec, have signed an RN MRA32. The purpose of the RN MRA is to: “set out commonly held national registration standards throughout Canada and facilitate the mobility of RNs through registration endorsement”33. The College of Nurses of Ontario (CNO) and the OIIQ have a localized agreement in which they recognize registered nurses based on an acceptance of entry exams. Within this localized agreement, Ontario does not retest Quebec nurses, and Ontario nurses do not have to take the Quebec exam. According to the College of Nurses of Ontario:

*The examination requirement for registration in Ontario is completion of the Canadian Registered Nurse Examination (CRNE) or an examination approved as equivalent by the Registration Committee. The examination requirement for registration in Quebec is completion of the Quebec Professional Exam or an acceptable equivalent examination. Ontario is the only Canadian jurisdiction that accepts Quebec’s Professional Examination for this purpose, and is therefore the only jurisdiction that does not require Quebec RNs to complete the CRNE. While CNO endorses the principles of the RN MRA, because the RN MRA does not recognize the Quebec Professional Examination as being equivalent, and would therefore re-test the competencies of Quebec RNs by requiring them to complete the CRNE, CNO chose not to be a signatory. Signing the RN MRA would have created a barrier to the mobility of OIIQ-registered RNs into Ontario.*
Within the MRA, a registered nurse, who has registration in a Canadian jurisdiction prior to January 1, 2000, will be granted registration in another Canadian jurisdiction under certain conditions, including compliance with non-competency requirements (e.g. language, criminal background checks) and evidence of continued competency requirements.

According to the respondents, even with the MRA there are barriers to movement. Manitoba RNs are not able to practice in Ontario due to the fact that Manitoba runs both a two year and a four year program. This creates a situation of dual points of entry and the granting of the same license for different skill sets which is not consistent with other provinces. Another barrier is the different examination process in Québec. Québec RNs are not required to write the national exam; they have another assessment process set in place. Thus, a RN from Québec in good standing would be asked to sit the national exam upon moving. Conversely, a nurse of good standing and with years of experience in another province (e.g. Nova Scotia) would have to write the Québec exam if he or she were to move to Québec. This is characterized as a barrier under the AIT since it constitutes a reassessment though as noted by one respondent, it could be overcome if there was an equivalency assessment of those exams.

3.3.2 Mutual Recognition Agreement for Licensed Practical Nurses

In 2001, a mutual recognition agreement was agreed to by all the regulatory bodies for licensed/registered practical nurses in Canada. The following are signatories of the MRA for LPNs in Canada:

- Council of Licensed Practical Nurses of Newfoundland and Labrador;
- Prince Edward Island Nursing Assistant Registration Board;
- Practical Nurses Licensing Board of Nova Scotia;
- Association of New Brunswick Registered Nursing Assistants/L’Association des Infirmier(ère)s Auxiliaires Immatriculé(e)s du Nouveau Brunswick;
- Ordre des Infirmières et Infirmiers Auxiliaires du Québec;
- College of Nurses of Ontario;
- College of Licensed Practical Nurses of Manitoba;
- Saskatchewan Association of Licensed Practical Nurses;
- College of Licensed Practical Nurses of Alberta;
- College of Licensed Practical Nurses of British Columbia;
- Government of Northwest Territories;
- Government of Yukon (signatory of Registrar, Licensed Practical Nurses of Yukon); and
- Government of Nunavut

The purpose of the MRA was: “to establish the conditions under which a practical nurse who is registered/licensed in one Canadian jurisdiction will have his/her qualifications recognized in another Canadian jurisdiction which is Party to the agreement”. The following are examples of requirements agreed to by the regulatory bodies:
• Prince Edward Island requires additional competencies associated with Mental Health Nursing;
• Alberta, British Columbia, Manitoba, Nova Scotia, and Quebec require additional competencies in the area of Pharmacology/Medicine Administration;
• Alberta, Manitoba and Nova Scotia require additional competencies in the area of infusion therapy;
• Alberta and Manitoba require additional competencies in the area of Physical Assessment; and
• British Columbia requires additional competencies in the area of Community Care.

Nurses moving into these jurisdictions, therefore, must acquire these competencies through assessment and/or completion of educational component(s) and/or clinical practice. Thus, in some jurisdictions, LPNs may have to upgrade due to broader scopes of practice even with the MRAs in place. In jurisdictions where LPNs perform a wider range of duties, restricted licenses will be issued that would allow the incoming LPNs to perform specific duties and may specify a period of time by which s/he must complete training and assessment in “broader” duties”.

The MRA for LPNs is currently under review for further updates. One respondent noted that this review will be completed in June, 2006.

3.3.3 Endorsement Agreement for Registered Psychiatric Nurses
To date, psychiatric nurses have an Endorsement Agreement which states that:

Once a graduate of an approved program has established registration to practice or eligibility for registration in one of the four Western Canadian provinces, that person, upon making application, should be granted registration on the basis of having been registered or eligible to be registered in any of those four provinces, provided that the psychiatric nurse’s registration is in good standing or was in good standing at the date of last registration, that the psychiatric nurse has met the requirements regarding current practice in the province last registered, and that the psychiatric nurse can show proof of good character.

The fact that only four provinces (Manitoba, Saskatchewan, Alberta and British Columbia) regulate registered psychiatric nurses posits a structural barrier to their interprovincial mobility. There are no mechanisms in place for licensure within other provincial regulatory bodies such as those representing licensed practical nurses or registered nurses since registered psychiatric nurses are thought to have different skill sets and competencies.

3.3.4 Mutual Recognition Agreement for Midwives
While there are provincial/territorial differences in how midwifery is legislated, there is a high similarity in the model by which Canadian midwives practice. While it cannot be ascertained whether this high level of similarities resulted in a smooth development of an
MRA, it does point to a high degree of comparability in competencies and scopes of practice across Canada. The MRA for Midwives was signed in 2001 by the following provincial and territorial regulatory bodies:

- College of Midwives of British Columbia;
- Alberta Midwifery Health Disciplines Committee;
- College of Midwives of Manitoba;
- College of Midwives of Ontario;
- Department of Health & Social Services, Government of the Northwest Territories; and
- Ordre des Sages-Femmes du Québec.

Under the MRA, “an applicant who has general registration at the time of application, and has practiced one year or more in a regulated jurisdiction will be eligible for registration without additional assessment subject to… proof of good professional conduct… and clinical experience requirements”. There were no noted issues related to the mobility of midwives in Canada.

3.3.5 Mutual Recognition Agreement for Nurse Practitioners

What is interesting about the case of nurse practitioners is that despite there now being provincial/territorial agreement on the core competencies of nurse practitioners in principle, there is some significant variation across jurisdictions. For instance, one respondent commented that some provinces designate different categories of nurse practitioners based on client subgroups (for instance, differences between acute care for adults and acute care for children) while others may not make any special designations. These are exactly the kinds of differences that impose restrictions on mobility across provinces and are exactly the kinds of barriers that the AIT itself was supposed to work toward eliminating. Given that much of the legislation concerning nurse practitioners was developed and implemented after the AIT was in place it is difficult to understand how we seem to have wound up in a situation that appears to be similar to those that the AIT was designed to eliminate.

3.4 Discussion

As noted above, there has been significant progress both domestically and internationally around removing barriers on labour mobility generally and for the nursing profession specifically. In Canada, the nursing profession has been particularly successful in developing MRAs under the aegis of the Agreement on Internal Trade although it is also apparent that there remains more work to be done. In the first instance the profession is still evolving and the increased attention being paid to newer professions such as Nurse Practitioners and the integration of more traditional professions such as Midwives adds some new complexity to the issue of mobility and mutual recognition.

On the surface it might appear that the Canadian case more closely resembles that of the European Union, insofar as the issues of labour mobility have a strong “federalism” dimension with a supra-national body attempting to bring some commonality in standards across disparate labour markets. But, in the case of nursing at least, the differences between the professions and the health care systems between Canadian provinces are
relatively minor when measured against the different health care and educational systems and professional designations amongst EU member states. And indeed, the comparison becomes even more problematic as the EU grows to include former Eastern Bloc states with even greater differences in their economic and political development.

And of course Canada exists in geographic proximity to the United States which has long been a magnet for health care professionals, especially physicians and nurses. Indeed, one of the key goals of the AIT was to strengthen the east-west economic ties across the country in an effort to mitigate the traditional north-south pull of labour, goods and services that was strengthened with the adoption of NAFTA. There is much to be learned from the experiences of Australia and New Zealand which, despite their geographic isolation from Canada, share significant commonalities in their historical development and approach to public policy.

There was a general consensus amongst the key informants interviewed that barriers to mobility for nurses had, over the past decade or so, been significantly reduced and that the processes were far more streamlined and “user-friendly” than they had been before the introduction of the AIT. But there was still some significant concern that in at least some jurisdictions the process for the individual nurse wishing to move across jurisdictions was not as transparent as it could be. And there was at least some frustration expressed that compliance with the terms of the AIT appears to have ‘topped out’ within the profession with the remaining barriers seemingly resistant to further change. There may well be two explanations for this. The first is that the overall issue of facilitating general labour market mobility for nurses did not appear to be a top of mind issue for most of those interviewed and so the remaining barriers to mobility, while real, do not seem to have the attention of policy makers at this point. The second is that, as others have noted, there is always some level of protection of professional ‘turf’ on the part of the members of any profession and this may play some role in the fact that there are still some barriers to movement.

But what is most apparent from the progress being made in terms of facilitating labour market mobility for nurses in Canada is that it makes the issue of tracking that mobility much more important to policy makers and to stakeholders both inside and outside the profession. In a situation where the mobility of workers is highly constrained planning around human resource needs within a profession is easier in some respects. But as mobility increases it becomes much more important for those with an interest in the profession to know not only who is moving into one’s jurisdiction, but also who is leaving.

As human resource planning for the nursing profession grapples with the challenges involved in ensuring that enough nurses are being recruited into the profession, trained in the appropriate kind of nursing needed by the population being served, working to their full scope of practice and are being retained within the profession in the face of a myriad of factors that can tend to push them out, then tracking the mobility of nurses within and across jurisdictions becomes all the more crucial. Yet, if the all the work towards mutual recognition and facilitation of mobility has had any single serious shortcoming it is that it...
has been done with what appears to be very little thought about how one tracks those professionals once the barriers to their mobility within the labour market have been reduced.
4. TRACKING NURSING MOBILITY

Tracking the mobility of nurses is very complex. Most nurses migrate for the long-term, some return to their home provinces while others may move for short periods of time. Others regularly work at multiple worksites across health regional boundaries. Some, like a nurse in the Northwest Territories travel extensively to provide quality care to residents in remote regions. Added to this is the need to drill deeper into the data to get at different subspecialties within nursing. According to the key informants interviewed, Canada is making a good start in developing fulsome data sets but that there is a way to go in consistency and comprehensiveness. There is a clear gap in our knowledge around how to best track mobility across provinces, regions and worksites.

Monitoring inflows and outflows of nurses is difficult, mainly due to the lack of standardized indicators for tracking purposes and the lack of standardized databases through which to monitor labour mobility. This is not just a Canadian concern. Difficulties in measuring migration patterns due to a lack of reliable and consistent data collection processes and a lack of standardized data elements are also experienced by other countries and regions. There are also differences in how “migration” is defined and conceptualized. As Poulain and Perrin (2003) note:

> The Eurostat measurement of flows between Denmark and Germany in 1998 illustrates the difficulty of measuring migration flows. When the registered level of immigration in Germany is compared with the Danish equivalent, it appears that Denmark underestimates immigration flows by 50 percent. In fact, the definitions used in Germany and in Denmark are very different: Germany considers every entry an "immigration" after seven days, while Denmark requires an intended duration of three months. Therefore, very short-term migrations are included in Germany but not in Denmark. This example makes clear that among the challenges of improving the comparability of international migration statistics, harmonizing the concepts and definitions of migration are no less important than resolving the problems of poor reliability of data collection systems.

The same issues are also found within the Canadian context where the collection of data on nursing is a provincial and often a regional responsibility. Thus, there is a need for careful planning to ensure the coordination of data being collected from different levels.

According to Baumann et al (2004), “There is little literature on inter-jurisdictional mobility, and current statistical databases lack common definitions or shared categories.” There is an identified need, therefore, to create a common set of indicators and databases in order to more effectively monitor and measure the mobility of nurses across provincial borders, within provincial borders (e.g. urban to rural) and across worksites, especially short-term mobility. CIHI has a national registered nurse database based on a minimum dataset. Still, as one respondent notes: “From a policy perspective human resource planning information could be better – we provide data to a lot of planners, but we don’t have good information on the trends of mobility and this causes
planning problems”. This includes tracking information which contains more detailed and fulsome information on nursing competencies and subspecialties to improve the regions’ or provinces’ human resource planning capacity.

Other concerns raised by the respondents centred on the processes involved in the data collection process:

- Collecting data is difficult due to changes in nurses’ status. A nurse who ceases to be a member (e.g. through revocation or resignation) or is suspended through the non-payment of dues is difficult to track.
- Information on out-migration is difficult to capture. When nurses move to other jurisdictions, the regulatory body does not know where they are relocating unless the other jurisdiction asks for verification of good standing. This is especially an issue if the nurse moves to the United States, since not all American states require a verification of licenses from Canadian regulatory bodies.
- Data availability across job sites is difficult due to the nature of the health workplace; for instance, the casualization of nurses and the number who work multiple part-time jobs makes it difficult to track nurses.
- Information on nurses who choose to move because of spousal relocation is difficult to attain.
- It is difficult to tell the difference between someone who did not renew his or her license and someone who moved.
- There are concerns over the ability of employers to generate reliable figures about the number of nurses they employ. For instance, they may still have people on different payroll systems.

Given these concerns, there is much work to be done in first disentangling what information is needed, what it is being used for, and what is currently being collected. What emerges is a need for greater clarity around data collection procedures. One theme raised the interviews was the need for better collaboration between jurisdictions on data collection purposes, including an agreement on data definitions and consistency in data collection and collation.
4.1 Models for Tracking Mobility
Data collection can be facilitated through professional registration, and indeed, one proxy measure of mobility uses information collected at registration: if the place of graduation from basic nursing education differs from the current province of nursing registration, it is assumed that the nurse has migrated. A number of the respondents noted that this was the best means for tracking nurses that currently exists. However, as Baumann et al. (2004) note, there are several limitations to using this as an indicator including the following:

- It does not account for nurses who are not registered or not working in nursing.
- It does not link out-migration from one jurisdiction to in-migration in another Double counting occurs when a nurse is registered in two jurisdictions simultaneously.
- Nurses who spend time in other provinces and then return home are not tracked.
- Nurses who leave Canada can be counted only if they maintain their registration and if they do return to work in another province are counted as new immigrants.
- Nurses who attend school in other provinces with the intention of returning home to work are considered migrants.
- The practice of renewing memberships at the beginning of the year means that nurses who migrate later in the year are not tracked.
- It also does not account for intra-jurisdictional movement, which is particularly relevant for remote and rural populations.

There is a need for a common set of information gathered at the time of registration to facilitate the development of a useable and reliable database on nurse mobility; however, the various Canadian regulatory bodies collect different information upon registration making it difficult to ascertain the mobility of nurses. According to CIHI (2000), nurses register within their host province or territory and are assigned a new registration number which is not cross-referenced to the previous registration number. Using different identification processes makes it more difficult to track or correlate the movements of nurses. It is therefore unclear whether this is a good measurement for tracking short-term mobility, since it does not necessarily track multiple moves within short periods of time, nor does it capture nurses who work across different regions on a regular basis.

Other indicators of mobility include estimations by regulatory bodies in Canada that tabulate the number of requests for verification of credentials. This only measures, however, the intent to move, not the actual movement and creates inaccuracies in the counts. For instance, numbers may be based on request for ‘good standing’ letters. However, as one respondent noted, a nurse may request letters of good standing for five places, but only go to one jurisdiction. Other limitations include variations in the collection and management of data by various regulatory bodies.

What are needed are improved data sources and consistencies in measurements and indicators by which to monitor migration patterns. There has been some progress in this area. According to one respondent, the registered nurses associations are currently developing a data dictionary to ensure more consistency (e.g. defining “good standing”). There needs to be a commonality in interpretation. For instance, one respondent noted...
that new registrars may not interpret the terms in the same way or may not comply with the new standards – for instance, by letting someone with a questionable background practice in their jurisdiction.

CIHI (2005) has begun development of a framework by which to begin the process of developing and selecting indicators for tracking nurses. The priority national indicators developed by CIHI to track the migration of nurses between jurisdictions (including international migration) include:

- Percentage of health personnel workforce who move between provinces/territories in Canada annually;
- Percentage of the health personnel workforce who join the Canadian workforce annually as a result of immigration;
- Percentage of health care workforce who leave the workforce annually as a result of emigration from Canada;
- Annual net interprovincial migration rate, by personnel type and province/territory; and
- Annual net international migration rate, by personnel type and province/territory.

Collecting data on migration, emigration and immigration rates could be best facilitated through the use of a national unique provider identifier. CIHI also states that: “Monitoring migration patterns (all sources) is hampered and made much more complex due to the absence of a national unique personnel identifier.”

4.1.1 Unique Provider Identifiers (UPIs)

One of the most popular models for tracking both the short-term and long-term mobility of nurses is the Unique Provider Identifiers (UPI) which, according to CIHI, is a “unique, non-reused, lifetime number assigned on entry into an education program or on application for first licensure.” There was general support for the development of a national identifier by the respondents for facilitating planning by incorporating both short-term and long-term mobility. Indeed, one respondent commented that without an UPI, “we have to guess about mobility and dual registration is a real problem.” These issues are also raised by Baumann et al (2004) who argue that the development of UPIs would:

- Facilitate accurate tracking of nurses throughout their careers by preventing double- or under-counting;
- Allow individuals to be tracked inter-jurisdictionally, in and out of the profession and through changes in educational and practice status; and
- Provide accurate information for the construction of a database that would facilitate workforce projections and planning for educational places and health human resources.

Indeed, according to CIHI, a Unique Provider Identifier would also be useful for tracking the interprovincial movement of health care professionals and would provide the potential for linking data bases (e.g. college registry and utilization databases). It would
also assist in simplifying the data around the types of employment that nurses work within (e.g. nurses working in multiple jurisdictions).

There are other dimensions to the development of unique identifiers. For instance, a unique identifier would enhance public safety by ensuring that a nurse with outstanding disciplinary or other findings that have not been resolved in one jurisdiction would be blocked from successfully registering in another jurisdiction through a name change or other means. It would also enhance human resource planning by providing current and consistent information about the nurse even if s/he moves across provincial borders, and information about what programs and/or policy changes (e.g. quality workplace initiatives) worked to recruit and retain nurses within a province.

4.1.2 Medical Identification Number for Canada (MINC)

There are some national and international models which are currently in development or have been implemented around unique identifiers. In the United States, for instance, there is a recent movement towards the development of a National Provider Identifier (NPI) – the expressed intent of which is to facilitate administrative and financial transactions specified by the Health Insurance Portability and Accountability Act (HIPAA). Each provider is given an 8-digit alphanumeric code with a check digit in the last position to help detect keying errors. It does not contain confidential information about the health care provider, such as the type of health care provider, nor about the State of practice.

The development of the Medical Identification Number for Canada (MINC # NIMC) in 2000 was prompted by a need to reduce administrative complexity due to the development of unique identifiers by various medical/health organizations in Canada. The MINC # NIMC was introduced to develop a nationally-recognized standard identifier which:

- Is a unique lifetime identifier assigned to every individual who enters the Canadian medical educational or practice systems;
- Is recognized by medical organizations nation-wide;
- Is a simple serial number with no encoded information, e.g., M12-345-679
- Is issued by a central hub computer, at the request of one of the sponsoring agencies;
- Is considered confidential personal information;
- Does not replace the College registration number, LMCC numbers, or provincial billing number (if any), nor any other identification number that the physician has;
- Does not convey any status, rights or privileges; and
- Does not change the way in which any information concerning physicians is released.

The MINC numbers establish a common set of data and indicators which foster greater reliability for regulatory, administrative and research purposes. The not-for-profit corporation MINC#NIMC operates the MINC system and the Federation of Medical
Registry Authorities of Canada and the Medical Council of Canada are the members of MINC#NIMC.

It is not clear, however, if the MINC number system can be used to measure and monitor the movement of physicians. The MINC number, for instance, is only updated for name changes or data correction. It does not appear, at face value, to contain information about the site of practice or mobility. The development of this feature however, appears to be feasible, though it would be more cost intensive, since it would mean an update upon the movement of the provider. As well, the respondents expressed concern over the confidentiality and protection of privacy.

4.1.3 Licensed Practical Nurse UPI Pilot
The MINC and UPI were further developed by CIHI within their Licensed Practical Nurse pilot project implemented in 2001. The objectives of this pilot study were to:
- Determine the technical feasibility of developing a system of unique lifetime identifiers for LPNs in Canada, based on the MINC#NIMC model;
- Identify the data elements needed for the unique identification of LPNS;
- Test the creation of such identifiers in an environment where matching/duplication is expected;
- Identify any organizational issues involved with contracting a third party to administer the system including any privacy issues affecting the release of personal information; and
- Identify the implementation issues in terms of time and cost to the parties involved.

The three colleges, the College of Practical Nurses of Alberta (CLPNA), the College of Practical Nurses of British Columbia (CLPNBC) and the Practical Nurses Licensing Board of Nova Scotia (PNLBNS) which participated in the pilot were responsible for submitting core information to the MINC#NIMC on their respective nurses. They were also responsible for making any needed technical modifications to their system and for the development of the new data elements. MINC#NIMC was responsible in turn for the development of the data bases, the methodology for implementing UPIs and the identification and resolution of any remaining compatibility issues. The study, which was completed in 2002, revealed that the MINC methodology could be readily applied to the nursing community. As CIHI (2003) reports:

All three participating registrars successfully submitted records and received reports. The web interface was well received. The log-in procedure did not cause any significant problems except that participants had to ensure they were using Microsoft Internet Explorer 5.5 or higher on a Windows-type computer.

While the relative success of the MINC#NIMC infers that these unique provider numbers are doable within the Canadian context, there are some issues which need to be clarified pertaining mainly to security, the availability of resources and privacy issues.
There are important considerations around privacy and security which need to be recognized at the onset of the development of UPIs. The LPN pilot study for instance, stipulated that LPNs provided their consent to have their personal information included in the study which had an effect on data quality. The development of a unique identifier, for instance, must meet the criteria of a privacy impact assessment (PIA), completed within each jurisdiction or the principles from the Canadian Standards Association (CSA) Model Code for the Protection of Personal Information which provides an appropriate national standard.

Another model raised by one respondent is a behind-the-scenes system that can translate different numbers from different jurisdictions. For instance, the number from British Columbia could be translated into the number for Saskatchewan. This would require highly encrypted codification schemes and secure e-systems which already exist. Another possibility raised by the respondents is to use blind identifiers which contain only a number (such as a Social Insurance Number) and not any personal information.

Another important consideration raised by the respondents relates to the high costs associated with the development and maintenance of the UPI system - especially if it encompasses every nurse in every nursing category. For instance, the financial and human resource costs for maintaining and continually updating the UPI system may be prohibitive, although cost sharing between the provinces may reduce costs. Another important consideration is the management of the database. The LPN UPI experiment was facilitated within the MINC protocols. Thus it is feasible to employ a third-party organization to manage the UPI numbers.

Finally, the respondents noted that while the UPI would be an improvement in the tracking of nurses, it would still provide incomplete data. For instance, the UPIs would not capture nurses who move out of the country and may fail to distinguish whether a person did not renew their license or simply moved.

4.2 Discussion

As the movement of nurses across the country becomes easier, the importance of being able to track their movement both within jurisdictions and between jurisdictions and to understand both the short and longer term mobility patterns of the nursing workforce becomes more important. But it is also apparent that there are real costs involved in implementing any of the models noted above. One respondent, for instance, noted that the LPN UPI project did not get beyond the pilot stage because of the significant costs involved.

Moving toward unique identifiers for nurses needs to be understood in light of a fuller examination of the lessons learned from the LPN experiment. As well, careful consideration needs to be taken around cost sharing and collaborative efforts by Canadian regulatory bodies as well as issues pertinent to privacy and confidentiality. For instance, the costs and human resources needed could be ameliorated by collaboration between the
regulatory bodies. It is also feasible to develop UPIs which use numbers rather than personal information to protect confidentiality.

In addition, progress on the better tracking of nurse mobility is going to rely on a number of related factors being tackled before models such as a UPI system can be implemented, including:

- Promoting consistency in data collection across jurisdictions.
- Developing a common or compatible database which captures the same information at times of registration or movement for different nursing categories.
- Improvements need to be made in the information technology infrastructure for tracking nurses. According to the respondents, Canada currently lags behind other jurisdictions with regard to a solid IT infrastructure for data collection purposes.
- Revisit the frameworks for Unique Provider Identifiers for nurses since it would facilitate a more comprehensive database around nurse mobility in Canada.

According to many of the respondents, a more coordinated set of data being collected by the regulatory bodies would assist in the tracking of nurses. Common definitions and code books are being developed, though it is unknown how these are being translated into the data collection procedures or if they are being consistently used.
5. RAPID MOVEMENT IN TIMES OF EMERGENCIES

The mutual recognition agreements noted above have set the foundations for the mobility of nurses across borders. The respondents, for instance, for the most part, stated that the Agreement on Internal Trade was a positive step in the nurses’ ability to relocate across provincial borders and for the most part, the experiences with it have been positive. Ideally, we would have automatic recognition which could speed up credential recognition. Yet this is not always practical given regional needs and variations in credentialing. That said, time needed to process applications was raised as a concern and it is this point that is especially pertinent given the need to fast-track credential recognition during short-term disasters. Many of the respondents argued that the process for both the MRAs, and especially for the temporary licensure at times of emergency responses, needs to be streamlined, consistent, and coordinated. There are some models either being proposed or implemented which capture the principles and protocols which need to be established within an overall framework or vision for nurse emergency deployment. We first describe these issues and then describe how they have been implemented or are being implemented within emergency compacts and/or models. They range from different governance models to the use of a card which contains automatic information about the nurses’ credentials and licensure.

5.1 Considerations Regarding the Emergency Deployment of Nurses

It was evident from the key informant interviews that the further reduction of barriers to the general mobility of nurses within the labour market was not a ‘top of mind’ issue for most of them. But it was equally evident that the issue of how best to facilitate the rapid movement of nursing in times of health emergencies was something that had moved much higher up the policy agenda. This stems, according to the respondents, from Canada’s experience with the SARS outbreak in Toronto and the ongoing planning around pandemic preparedness that is occupying significant amounts of time in all Canadian jurisdictions. Again there is a surface simplicity to the issue – get Nurse X to Place Y quickly for the duration of the emergency and then allow the nurse to return home – that masks a highly complex problem with multiple dimensions and consequences for the individual nurse, the nurse’s home work site, the nurse’s emergency work site, the care of patients and the overall coordination of the emergency response.

According to the respondents we interviewed, there are a number of considerations that have to be taken into account in the development of a coordinated and consistent process for moving nurses into emergency situations:

Ethics
Protocols need to be in place to deal with loss and trauma felt by both patients and providers. Quarantined nurses during the SARS crisis, for instance, felt isolated from their families and co-workers.62 The Katrina hurricane disaster in Louisiana, for instance, highlighted the need to address the experiences of providers in host jurisdictions who have lost family members, their homes and/or their livelihoods. Some nurses, for
instance, needed to relocate to other jurisdictions. These ethical issues might be incorporated into training programs or communications structures.

Costs and Equipment
The delineation of costs related to equipment, the relocation of nurses and their living expenses, etc need to be agreed-upon in advance of emergencies. The development of set budgets may have to be reviewed annually.

Protocols around Nursing Availability
The identification and use of the services of non-practicing or non-registered nurses must be part of an overall plan. The deployment of students, nurses who have recently retired, or are on maternity leave, needs to be more fully developed. The protocols must also take into consideration the staffing needs and shortfalls of the assisting jurisdiction since employers must make up the differences in their staffing schedules.

Scopes of Practice
Variations in the scopes of practices and “controlled acts” within nursing legislation may hinder their mobilization during emergencies. This is especially true for nurse practitioners since their scopes of practice currently vary across the country. Thus, there is a need to ensure that up-to-date information is available on their requirements and limitations in order to ensure good planning.

Liability
Care must take place at the planning stage to ensure that cases of fraud or wilful misconduct are dealt with to assure public safety. The liability of all nurses involved in short-term mobilization needs to be set in place. Most registered nurses, for instance, are covered by the Canadian Nurses Protective Society; the exceptions are nurses in British Columbia (coverage is provided by the RNABC Captive Insurance Corporation) and Québec (coverage is provided by the Programme d’assurance responsabilité professionnelle). A consistent agreement on liability needs to be developed so that the liability concerns are addressed before an emergency.

Management of Nursing Volunteers
More effective coordination is needed to effectively match the available resources with the need. Too many volunteer nurses wishing to assist in an emergency situation may quickly overwhelm the system and may result in a situation whereby unqualified nurses are deployed, thus compromising public safety. For instance, one respondent noted that there are examples of “rogue” providers volunteering during emergencies which compromise public safety. What is needed is a pre-existing repository of available nurses across Canada which details their individual skills, competencies and knowledge so that they can then be deployed at the right time. Thus, employers need an accessible and comprehensive database which inventories peoples’ skills so that certain skills needed within a crisis situation are easily identified. Part of the RNAO ViaNurse project includes the development of a volunteer list of nurses who are willing to lend their expertise within Ontario. This could be expanded to include a Canadian repository, though it may
become unwieldy to keep it current and accurate, and be too costly in terms of both human and financial resources.

**Fast-Tracking Registration Protocols**
A consistency in protocols related to rapid credential recognition and their consistent adoption by all provinces would facilitate the rapid mobilization of nurses across the country. One suggestion raised by the respondents is the development of a national assessment centre which assesses credentials and competencies on behalf of all Canadian nursing regulatory bodies.

**Communications**
Finally, an area raised by the respondents for inclusion is that of a consistent and effective communications strategy which details the roles and responsibilities of each actor (from national level to the regional) in the dissemination of information about the nature of the emergency and what is needed. Deployed nurses require information on the nature of the emergency in order to make sound judgements on the best use of their services, their safety and the quality care of their patients. For instance, a pandemic could result in disease vectors within the nurses’ home community; thus their mobility may be severely restricted in this event. Communications may also include protocols for precautionary measures, immunizations, and trauma care.

### 5.2 Canadian Nurses Emergency Response Models

There is activity on emergency preparedness being undertaken throughout Canada at all levels from the national to the municipal levels. It is not possible to track all of these developments, thus, we limited the scope to key developments which emerged within the environmental scan and the interviews. The following discussion is a synopsis of the activities being undertaken nationally and internationally to incorporate either all or part of the protocols and principles noted above. The respondents were asked about models which emerged during the environmental scan and were asked whether they knew of any others. What emerged from both the scan and interviews is that while these models provide an excellent start, what is needed is an overall framework which sets in place what the liabilities are, what competencies are available, how to fast-track credential recognition, and how to effectively identify and use available nursing personnel.

#### 5.2.1 Canadian Emergency Preparedness

The intergovernmental National Framework for Health Emergency Management is predicated on the need to plan and respond to emergencies by fostering operational bridges based on shared principles, guidelines and operating procedures. It is based on an all-hazards approach (encompassing medical emergencies due to natural disasters, explosions, and/or chemical, biological or radio-nuclear incidents) and includes principles related to the resiliency and sustainability of programs and planning, and comprehensive management practice that balances mitigation, preparedness, response and recovery.

Moreover, the Federal/Provincial/Territorial Deputy Ministers of Health created the Special Task Force on Emergency Preparedness and Response to enhance the
effectiveness of the response capacity in the health sector across Canada. The Public Health Agency of Canada's National Office of Health Emergency Response Teams (NOHERT) has the mandate to establish and deploy Health Emergency Response teams (HERT) on a 24-hour basis to provide regional, provincial or territorial jurisdictions with an all-hazards emergency medical care. The services provided by the HERTs would include emergency medical care, mental health care and public health disaster risk identification, assessment and management. The current status of the HERT teams is unclear insofar as some of those organizations that had participated in their design and development have no clear indication of whether they are ready to be deployed or not. This is only one of the many instances where there appears to be a very real lack of communication about the details of the existing plans designed to meet the challenges presented by large-scale medical emergencies. A number of others are noted below.

5.2.2 The Registered Nurses of Ontario (RNAO) VIANurse Portal

The RNAO VIANurse is an electronic registry of RNs and RPNs who are registered in good standing who have volunteered to be deployed to a medical institution within Ontario during a time of emergency crisis as designated by the Ministry of Health and Long-Term Care (MOHLTC). VIANurse, which is maintained on the RNAO website, ensures that there is a rapid deployment of nurses, not to exceed 60 calendar days, with the proviso that an extension may be granted subject to the agreement of all the affected parties.

5.2.3 College of Nurses of Ontario (CNO) Registration Emergency

Out-of-province nurses registered in good standing can be rapidly deployed through the College of Nurses of Ontario (CNO) during times of emergency or disaster within Ontario, through a temporary registration process (maximum of 60 days). The Executive Director, under this by-law may issue these temporary licenses during emergency situations as defined by Emergency Measures Ontario. The eligibility criteria for temporary licenses include:

- Confirmation that she/he is applying to practise in Ontario for the sole purpose of providing assistance during an emergency situation;
- Provision of information respecting all requirements applicable to the Special Assignment Class of Registration;
- Authorizing her/his current employer and previous employers to provide information about current practice;
- Authorizing the nursing regulatory body with which she/he currently holds registration/licensure to provide information to confirm the applicant’s registration/licensure with that regulatory body; and
- Provision of a copy of her/his current Certificate of Registration or license from another jurisdiction and proof that she/he is the person who holds that Certificate/licensure.

According to the College of Nurses of Ontario, during the SARS crisis in 2004, only eight (8) nurses from outside the province of Ontario were registered with CNO through this process.
5.2.4 Other Emergency Registration Protocols

Provincial regulatory bodies often have some form of temporary or courtesy licensure offered to nurses from other provinces for a set time frame (e.g. six months or one year), but there is no consistency across the country. A nurse may be temporarily registered for a designated time frame, for instance, while awaiting confirmation of his/her “good standing” from their previous jurisdiction. Some jurisdictions have policies on temporary registration during times of emergency. Due to their experiences with an influx of refugees from Kosovo, Nova Scotia, for instance, grants temporary licenses to nurses from other provinces, without registration costs, in an emergency/disaster situation as defined by the Nova Scotia Department of Health.

The Alberta Association of Registered Nurses also expedites the registration of eligible Registered Nurses from other provinces in an emergency situation. Procedures for registration are also expedited in Prince Edward Island. Furthermore, according to one respondent, the expediting process could be further facilitated through the development of a dedicated application process. There is a need, therefore, for the further refining the process for expediting temporary licensure across the borders.

What is evident, though, from the above discussion is that there is no consistent attempt on the part of individual jurisdictions to deal in a comprehensive manner with the considerations raised at the outset of this discussion. Passive models that rely solely on the interested nurse to seek out how and where to register a willingness to travel to an emergency site in another jurisdiction will never have enough registrants to meet that jurisdiction’s needs in times of crisis. If the key informant interviews are any indication, it is clear that there remains much work to be done in terms of communicating to the nursing community what progress has been made, what models do exist and what work remains to be done. There was a widespread consensus that the issue of rapid deployment was more crucial now than ever before, but very little sense that the progress being made was either sufficient or sufficiently well known to serve as a guide to further policy development.

5.3 International Emergency Response Models

There are a number of international models suggested by the respondents and gleaned through the literature search on facilitating mobilization. This is not a comprehensive tally of the many models proposed and developed within the international community. What these models do provide are various examples of assistance compacts. Many of them, such as the International Emergency Management Assistance Memorandum of Understanding between some northeast American States and Canadian provinces illustrate models in which decisions about liability, costs, management of volunteers, training, etc were agreed upon in advance of emergency situations.
5.3.1 American Nurses Association National Nurses Response Teams

The 2001 terrorist attack and the Anthrax incidents prompted the development of the National Nurses Response Teams by the American Nurse Association (ANA) and the Office of Emergency Response, U.S. Department of Health & Human Services. The mandate of these teams is to develop ten (10) regionally based teams of 200 registered nurses who could be called upon to assist in chemoprophylaxis or vaccination of hundreds of thousands or millions of Americans, or when hundreds of nurses are required. Every team member will be enrolled in the National Disaster Medical System. Teams of nurses are encouraged to apply to ensure that nurses have the proper specialized training, are credentialed, have appropriate protective equipment and that the best use is made of skills and expertise.

5.3.2 Northeastern Forest Fire Protection Commission (NFFPC)

Due to the infrequency of forest fires, it is difficult for any one jurisdiction to maintain training, equipment and personnel needed. In 1949, after a series of major forest fires in North Eastern United States, the U.S. Congress passed An Act which provided a multi-state coordination for the prevention and control of forest fires. The first seven states, Maine, New Hampshire, Vermont, Connecticut, Massachusetts, Rhode Island and New York joined the compact with Quebec and New Brunswick joining in 1950. Nova Scotia joined the compact in 1996.

The mandate of the NFFPC is to:

- Provide resource sharing (mutual aid) among members and establish procedures to facilitate this aid. The sharing of resources may include fire crews, fire management (overhead) staff, fire equipment and fire aircraft;
- Provide fire related information and technology sharing among members;
- Support the development of integrated forest fire plans and the maintenance of appropriate forest fire fighting services by its members; and
- Maintain a central agency (the Compact) to coordinate the services needed by member states and provinces.

A unified and coordinated program assures the member states and provinces of assistance in the form of a full complement of trained personnel and necessary equipment during times of extreme forest fires. To this end, the NNFPC has 30 commissioners representing ten of the agencies. Each state has 3 commissions – the state forester, a state legislator and a governor’s representative. The Canadian provinces also have 3 designated commissioners. The Commissioners provide guidance and direction to the Compact Executive Committee, ensure communications with their respective bureaucracies and review and approve annual compact budgets.

In the event of a forest fire, members call the potential assisting member agencies and advise the Execute Director. After deployment, the member requesting assistance is responsible for reimbursing supplies used or any equipment destroyed, the wages for personnel and other costs.
5.3.3 International Emergency Management Assistance Memorandum of Understanding

An International Emergency Management Assistance Memorandum of Understanding (IEMAC) was developed in 2004 between six New England states (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut) and five Eastern Canadian provinces (New Brunswick, Nova Scotia, Quebec, Prince Edward Island, and Newfoundland & Labrador). The purpose of the IEMAC is to:

Provide for the possibility of mutual assistance among the jurisdictions entering into this compact in managing any emergency or disaster when the affected jurisdiction or jurisdictions ask for assistance, whether arising from natural disaster, technological hazard, man-made disaster or civil emergency aspects of resources shortages.

Within the IEMAC memorandum of understanding is an element of the mutual recognition of qualifications. Article V of the IEMAC, for instance, states that a license, certificate or permit issued by any jurisdiction party to the IEMAC is transferable to the jurisdiction requesting assistance subject to: “...such limitations and conditions as the requesting jurisdiction prescribes by executive order or otherwise.” Within this compact, a request is made by the province or state requesting emergency assistance. This request includes a description of the emergency, the amount and type of assistance needed, and the estimated time that it will be needed.

There are specific responsibilities assigned to the jurisdictions under Article III of the Compact including the following: a review of its emergency plans, the development of inter-jurisdictional procedures, the protection and delivery of services and resources when needed to the extent authorized by law, an inventory and agreed upon procedures for the inter-jurisdictional loan and delivery of human and other resources, and, to the extent authorized by law, the temporary suspension of any statutes or ordinances over which the province or state has jurisdiction. There is, therefore, a plan set in place to ensure the smooth process of human and resource mobilization when needed by another jurisdiction. Furthermore, there is a mutual agreement on the licensing of providers within the Compact:

Whenever a person holds a license, certificate or other permit issued by any jurisdiction party to the compact evidencing the meeting of qualifications for professional, mechanical or other skills, and when such assistance is requested by the receiving party jurisdiction, such person is deemed to be licensed, certified or permitted by the jurisdiction requesting assistance to render aid involving such skill to meet an emergency or disaster, subject to such limitations and conditions as the requesting jurisdiction prescribes by executive order or otherwise.

There are also agreements in place within this Compact to deal with tort liability in the event of unforeseen events. Within Article VI it states that: “Any person or entity rendering aid in another jurisdiction pursuant to this compact are [sic] not liable on
account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith.\textsuperscript{76}

This form of assistance compact was agreed upon within a regional framework. One respondent noted that pilot projects based on regional compacts may be more feasible at first to disentangle liabilities, processes for streamlining temporary licenses, etc.

\textbf{5.4 Discussion}

In looking at the kind of considerations raised by the key informant interviews at the outset of this discussion and the kinds of processes that are in place both domestically and internationally it is clear that the key element in designing processes for facilitating emergency mobility within the nursing profession is a very high level of coordination across jurisdictions. Moving significant numbers of nurses across jurisdictions on what will undoubtedly be very short notice has a host of reverberations throughout both the donor and host jurisdiction that must be taken into account well in advance of the need arising for the move. Though the goal is to make it appear as simple as “moving Nurse X to Place Y and then home again” there is a significant amount of coordination and agreement that must take place long before a nurse can board a plane for the site of the emergency.

What is apparent is that much of the current Canadian activity has not yet reached the level of coordination and agreement that is exemplified by some of the international agreements in other areas or for other professions. But it is also apparent that there is a significant amount of ongoing work that is leading us in the right direction.

The CNA is currently developing a Nurses Portal\textsuperscript{77} which will be operational in June of 2006. The Nurses Portal, which is being funded through Health Canada’s First Nations and Inuit Health Branch, will serve as a conduit for communications with nurses at times of emergency situations. The content of the emergency preparedness and security component is being developed with organizations such as Public Safety and Emergency Preparedness Canada (PSEPC); medical officers of health; and fire, police and government security officials. It will facilitate the following\textsuperscript{78}:

- Optimum linkages to best knowledge and practice;
- Competence framework with three levels (basic, intermediate and advanced);
- Resources: direct care/managers/educators;
- Self-assessment; and
- Toolkits.

It is not clear at the time of the writing of this report whether the site will include a cataloguing of nursing resources.

There is also, though, the issue of how effective such a portal can be if its existence is not communicated effectively to the profession. The Ontario College of Nurses Portal had only eight registrants from other jurisdictions which makes its effectiveness as a vehicle
to find the right nurse for the right emergency situation somewhat limited. This should serve as a bit of a cautionary tale for the CNA as it moves towards the roll-out of the portal – its effectiveness as a vehicle for coordination in times of emergency may be compromised if it is not effectively communicated to the individual nurses who may want to avail themselves of it.

In addition to looking at what was already in place or under development, respondents were asked about whether a national licensure body would facilitate short-term mobility and the tracking of nurses. The overwhelming response was that while it may have some practical value, it is limited by the provincial jurisdiction over the regulation of most professions including nursing. There were other concerns expressed about the accountability of the national body, and the separation of roles and responsibilities between the provincial and the national bodies. For instance, according to one respondent: “[This makes me] very concerned about usurping our role as the regulator – what would the relationship look like between the provincial and the national bodies? Where would the national organization’s mandate come from?”

However, some alternative models were suggested. One suggestion made by the respondents was to explore the federation model for regulatory bodies following the structures used by other professional groups such as chartered accountants. The federation model is premised on the development of a consensus around standards which are maintained by a centralized national body. The regulation of the profession and disciplinary action remains a provincial and territorial matter. Here, the central body’s leadership role is legitimized through the will of the provincial bodies. According to a respondent, the Canadian Nurses Association already fulfills some of the mandates of a federation, such as the development of a national exam, but there needs to be a stronger collaboration between all of the provinces. A federation model would be able to set in place a uniform set of standards by which to monitor and audit their progress. The Canadian Nurses Association, according to one respondent, could serve as a clearinghouse for these standards while the provinces would have the responsibility for their organization and processing.

Moreover, while a national licensure process may not be something for which there is currently a great deal of support, the processes involved in decision-making may set the stage for more consistent planning around nurse deployment. Through a federation model, sets of standards could be set up in advance and be predicated on mutual agreement. According to the respondents a set of standards and principles for nursing care, agreed to in advance by the regulatory bodies would promote:

- Effective fraud detection;
- More coordination for internationally trained nurses;
- A consistency in registration and licensing;
- More effective facilitation of movement and immigration (e.g. with national standards a person who is in good standing in one jurisdiction could practice in another at times of emergencies);
- Consistency in endorsements;
• Consistency in assessments; and
• Better and more consistent information for more effective planning.

A common framework for communicating competencies may also facilitate both the rapid transmission of information around a nurse’s competencies and skill sets. This would facilitate an understanding of available nursing skills and competencies at times of emergencies. One model mentioned by a couple of key informants consists of an electronic record of a nurse’s level of competency, clinical skills (e.g. having CPR training) and other skills (e.g. languages), stored on a magnetic strip similar to a banking card. Information stored in a data base could be accessed immediately in the same way one can access one’s bank account from across the world through an automatic teller. The data bases need only be linked, not centralized, in the same way that one can access one’s bank from virtually any other bank that is linked by a common network. Thus, under this model, the provincial regulatory bodies would provide the initial accreditation and on-going support to maintain the nurses’ accounts.

6. CONCLUSIONS

This paper has explored the issues surrounding the mobility of the nursing workforce in Canada in two different but related dimensions. The overall mobility of nurses within the labour market has clearly been enhanced through the MRAs adopted under the aegis of the Agreement on Internal Trade. The processes have been clarified, streamlined and appear to have been made much more user-friendly for both the individual nurse and for the employer. But there is very little empirical evidence that would tell us how much enhancement of mobility has been achieved to date. Nor is there evidence relating to the experience of nurses moving under MRAs with the new process. What evidence we have in this regard tends to be anecdotal in nature. For instance, the environmental scan failed to turn up any documents which detail the experiences that nurses have when registering in another jurisdiction under the MRAs or when deployed at times of emergencies.

It is evident that moves to track the mobility of nurses both within and across jurisdictions have not kept up with our efforts to reduce barriers to mobility. As was noted above, as the barriers to mobility have been reduced and the processes made easier one can expect higher levels of mobility within that workforce. This necessitates a greater attention be paid to building the data and information technology infrastructure necessary to track these more mobile workers. Human resource planning for the nursing workforce needs to be able to accurately understand which nurses are moving (both in terms of demographic information but also in terms of their education, skills and competencies), where they are moving from and to, how often they are moving and the reasons behind their movement (both at the individual and at the aggregate level).

The building of that data infrastructure to track nursing mobility is very closely linked with the desire to build processes and frameworks for the rapid deployment of nursing resources in times of health emergencies. The kind of information that would be collected to track the general mobility of nurses across job-sites or across provincial
borders would also be invaluable in building data bases that would allow us to identify
the skills and competencies needed in a particular kind of health care emergency.

But the development of frameworks and agreements for the emergency deployment of
nurses also goes beyond the data needs met by a system capable of tracking the nursing
workforce generally. As noted above there are very important “knock on” effects
throughout the system that occur when some significant number of nurses leave one
jurisdiction or work site for another during an emergency situation, not to mention the
impact that a health emergency can have on the health workforce in the affected area
(both as health professionals and as citizens). These kinds of effects, however, can, in
light of both domestic and international experiences, be managed through the
development of comprehensive and coordinated emergency planning programs that
provide pre-existing agreement on how to proceed.

There is a need, therefore, for greater consistency, agreement and collaboration within
planning so that nurses are not reactionary but proactive in their approach to emergency
assistance. First of all, this involves clarifying the roles and responsibilities of the various
actors at the federal, provincial and regional levels to ensure that nurses with the right
skills are deployed when needed. At the federal level, this may involve the development
of guidelines and a national framework or vision and a more careful synthesis of health
human resource planning needs within emergency protocols. The latter point is seldom
raised within planning yet it is critical. If we do not have enough people trained with the
requisite skills sets, given different disaster scenarios (e.g. public health nurse,
edemiology, trauma care, mental health), then the shortages will be heightened during
disasters. A pandemic will put additional strains on human resource availability,
especially if it is simultaneously experienced across jurisdictions. Even more specific
disasters (e.g. natural disasters) must take into consideration the staffing needs of the
assisting jurisdiction. This may include the cancellation of elected surgeries, etc. These
staffing needs and preparations could feasibly be part of the overall framework.

Although there was little appetite amongst key informants interviewed for moving at this
time to a system of national licensure for nurses (and great resistance on the part of some
of those interviewed), there was a consistent call for a greater level of coordination in
both the tracking of nurse mobility and in the planning for deployment of nurses in times
of emergency. There was more interest expressed in mechanisms like unique identifiers
that would travel across jurisdictions with individual nurses and allow jurisdictions to
know not only who is arriving in their jurisdictions but also who is leaving. But
movement in this direction will depend on knowing more about why previous
experiments were abandoned and in overcoming any of the problems encountered with
those experiments. Further, there is a very strong need not only for more and better data,
but perhaps more importantly for better coordination and compatibility between existing
data sets and information technology. And this in turn, requires some more attention to
be paid to examining how well the current MRAs are working in facilitating the mobility
of nurses across the country in terms of identifying those barriers that still exist.
REFERENCES

1 The keywords for the search include the following in various combinations: “emergency”; “crisis”; “disaster”; “pandemic”; “SARS”; “pandemic”; “response”; “preparedness”; “planning”; “models”; “framework”; “short-term”; “temporary”; “mobility”; “relocation”; “migration”; “movement”; “mutual recognition agreement”; “MRA”; “EU”; “European Union”; “Trans Tasman”; “American”; “United States”; “international”; “national”; “Canada”; “Canadian”; “interprovincial”; “border”; “province(s)”; “GATS”; “labour”; “labor”; “nurse(s)”; “midwife”; “licensed practical nurse”; “registered psychiatric nurse”; “nurse practitioner”; “registered nurse”; “CNA”; “regulatory”; “regulation”; “free trade”; “liberalization”; “barrier”; “facilitator”; “monitor”; “data”; “database”; “statistics”; “numbers”; “tracking”; and “quantifying”. Materials were also requested from provincial and federal departments of Health, Labour and Intergovernmental Relations, and professional colleges and regulatory bodies.

2 J. Neilson (2003). Trade Agreements and Recognition. OECD.

3 Ibid.


8 Treaty of Rome, Article 57.1.


15 Australian Nursing Council. Cross Border Nursing Practice: Waiver of Fees.
17 Ibid.
19 Ibid.
26 Ibid. Article 707.
28 Ibid.
29 Ibid.
30 Ibid.
39 Ibid.
40 Ibid. pp. 20.
42 Baumann et al (2004a)
What is a Unique Identifier?


Canadian Institute for Health Information for Health Information (2000).


55 Ibid. pp. 4.

56 Ibid.

57 CIHI at this time is not moving ahead with other pilot projects. The Health Human Resource may be working on the development of UPIs for health care providers in the future (CIHI, Personal Communication).


59 Ibid.

60 Ibid.

61 Ibid.


The Mandate of the Canadian Institute of Chartered Accountants is a cooperation of the national and provincial bodies. The following represents the governance model of CICA regulation. “Responsibilities for the CA profession are shared with the provincial and territorial institutes/ordre according to a Protocol adopted in 1998. Under this Protocol, the Board is responsible for the shared strategic direction and management of the common critical functions of the profession through effective leadership, proactive coordination and monitoring of performance. The Protocol defines the functions that are common to all the institutes/ordre and critical to the success of the Chartered Accountancy profession as being strategic planning, standard setting, public interest and integrity, communications, and education and qualification”. From the CICA website: http://www.cica.ca/index.cfm/ci_id/13/la_id/1.htm.

Some provinces, such as Ontario have a strong resource base which lessens their need to collaborate.