

**“A NURSE IS NOT A NURSE IS NOT A NURSE”: THE SOCIAL CONSTRUCTION OF
SKILL AMONG INTERNATIONALLY EDUCATED NURSES THROUGH THE LENS
OF FEMINIST POLITICAL ECONOMY AND DISABLEMENT**

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ABSTRACT

This dissertation examines policies from 2000 to 2024 regarding the assessment of internationally educated nurses' (IENs) skills, including credentials and work experience needed to enter Canadian nursing. I show that federal and provincial initiatives, like the National Nurses Assessment Service and fair access legislation, have made the process stricter, longer, and more expensive. As a result, many IENs are pushed into lower-tiered healthcare jobs, such as personal support work, characterized by high job insecurity, low wages, and increased risks of disability, including injuries, illnesses, and mental health distress.

I argue that IENs' downward occupational mobility extends beyond a policy failure or racial biases; it is intricately connected to the racialized and feminized segmentation of care work, underpinning Canada's development as a settler-colonial capitalist state. It is a continuation of a gatekeeping mechanism where (a) white nurses enhance their power and privilege—like better pay, benefits, and social status—by upholding masculinist and colonial beliefs about skill, often marginalizing labour associated with poor, non-white women, and (b) settlers access a pool of easily exploitable labour to fulfill the nation's social reproductive demands. Unlike past racially explicit exclusions, the current policy uses “managed” integration, marked by selectivity (higher scrutiny) and assimilation (limited to those who approximate Canadian nursing standards). This segmentation is masked by race-neutral policies focusing on public safety and upholding international applicants' rights to fairness.

Despite the advantages of racial segmentation processes, I illustrate how the downward occupational mobility of IENs adversely affects their health and the welfare of impoverished communities in their home countries, particularly the Philippines, and is closely linked to neoliberal privatization and declining care standards in Canada. By integrating insights from critical policy analysis, feminist political economy, critical race theory, and critical disability studies, I develop a framework to (a) examine the ideological and socioeconomic interests integration policy supports and (b) advocate for a fundamentally different approach to healthcare organization, specifically, one that challenges the hierarchical classification of skills (i.e., distinguishing between high-skilled and low-skilled jobs) as the mechanism that determines workers' unequal access to compensation, benefits, job security, legal protections, and social status.

DEDICATION

I dedicate this dissertation to all the healthcare workers who put their lives and bodies on the line every day to keep our crumbling system from collapsing under the weight of privatization. I especially want to dedicate this dissertation to those workers in the lowest tiers, whose labour is crucial to keeping us alive, yet they face the most dire conditions.

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LIST OF ACRONYMS

Canadian Nurses Association (CNA)
Chief Executive Officer (CEO)
College of Nurses of Ontario (CNO)
Coronavirus Disease 2019 (COVID-19)
Fair Access to Regulated Professions and Compulsory Trades Act (FARPCTA)
Fairness Commissioner (FC)
Foreign Credential Recognition (FCR)
Foreign Credential Recognition Program (FCRP)
Internationally Educated Nurses (IENs)
Internationally Educated Nurses Competency Assessment Program (IEN-CAP)
National Nurses Assessment Service (NNAS)
National Council Licensure Examination – Registered Nurses (NCLEX-RN)
National Occupational Classification (NOC)
Objective Structured Clinical Exam (OSCE)
Office of the Fairness Commissioner (OFC)
Personal Support Workers (PSWs)
Regulatory Exam – Practical Nurse (REx-PN)
Registered Nurses (RNs)
Registered Practical Nurses (RPNs)
Registered Nurses Association of Ontario (RNAO)
Registered Practical Nurses Association of Ontario (RPNAO)
Standing Committee on Citizenship and Immigration (CIMM)
Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities (HUMA)
Supervised Practice Experience Partnership (SPEP)
What is the Problem Represented to Be? (WPR)
United States (US)

CHAPTER ONE

The Problem of Foreign Credential Recognition and the Downward Occupational Mobility of IENs

“Recognition of foreign credentials has many objectives. It's not only about creating a labour force for the 21st century; it's also about social integration and cohesion. It is about the ability of immigrants to be able to integrate fully into the economic, social, political, and cultural life of Canada, to play their part and to help build a nation— which is what immigrants have done for all of our history. It's about productivity and economic development. And of course, as I said before, it's about global competitiveness...”

Parliamentary Secretary to the Minister of Citizenship and Immigration, Hedy Fry (*CIMM 05* - October, 2004, p. 3)

1. The Scale of the Problem

The figures of ‘doctor driving a taxi’ and ‘nurse working as a nanny’ are far too familiar in stories about immigration to Canada. Using Canadian census data from 1996, 2001, and 2006, Reitz, Curtis, and Elrick (2014) show that despite being better educated than domestically educated workers and past cohorts of immigrants, recent cohorts of immigrants are less able to access ‘high-skilled’ occupations. On the contrary, the proportion of highly educated immigrants in the ‘low-skilled’ employment categories (e.g., cashiers, kitchen helpers, cleaners) not only persists but grew from 1.5 to 2.4 times relative to domestically-born workers in these years. Immigrants in the same occupations with equal qualifications are more likely to be paid less than domestically educated workers (Guo, 2015, p. 245). This phenomenon of immigrants working in occupations below their level of education and training is variably referred to in the literature as ‘brain waste,’ ‘skill mismatch,’ ‘skill underutilization,’ or ‘deskilling.’ I use the term ‘downward occupational mobility,’ and this phenomenon forms the focus of this dissertation.

In the policy discourse, downward occupational mobility is primarily attributed to the difficulties immigrants encounter in getting their credentials assessed and recognized, or what is

usually referred to as the problem of foreign¹ credential recognition (hereafter, FCR) (Guo, 2015; Kolawole, 2009; Walton-Roberts, 2021). Broadly speaking, the lack of recognition of foreign credentials affects immigrants' capacity to earn decent wages, as they remain shut out of occupations and positions associated with high levels of socially recognized skill. For instance, a widely cited report by the Conference Board of Canada estimated that the lack of recognition of credentials, particularly among immigrants, resulted in approximately \$4.1 to \$6 billion annually in lost earnings (Bloom & Grant, 2001). A more recent study by Reitz et al. (2014) calculated that between 1996 and 2006, immigrants lost \$11.37 billion in earnings due to skill underutilization and that the loss of earnings for immigrant women was almost twice as much as for immigrant men.

The lack of recognition of foreign credentials also affects social cohesion and integration as immigrants and their families suffer the consequences of being unable to translate their education into jobs with higher earnings and social status. For instance, during a hearing on provincial legislation aimed at improving foreign credential assessment, the Executive Director of the London Cross Cultural Learner Centre, an immigrant-serving organization, noted the following:

We have so many internationally trained professionals and skilled workers who are sitting on unemployment, who are sitting on our welfare rolls. Look at the cost of not doing something. Look at the family breakdowns when they come here with so much hope, where the head of the household is here and has convinced family members to travel with him or her. They get here. They come with money to support them for a year because we've told them that that's about the amount of time it will take. The money is running out. The despair and the hopelessness is in their face, in their eyes. We see family breakdowns as a result of the conflict that their inability to engage in the labour market is causing. We see far too many divorces. We see far too many suicides. We see far too much mental anguish and emotional instability as a result of our inability to allow them in (Williamson, *Hansard T-19*, 2006, p. 280).

More broadly, policy actors, such as immigrant serving agencies, also raise concerns about the impact of unequal integration on Canada's competitiveness and its capacity to address labour

¹ In the late 2010s, the term 'foreign' slowly became replaced by 'international' because there was a growing acknowledgement that the term 'foreign' was mired with xenophobia. However, I purposely use the term 'foreign' in my writing to highlight the performativity of using more inclusive language while policies become more exclusionary.

market shortages. For instance, in an open letter signed by over two dozen immigrant-service organizations across Canada addressed to former Prime Minister Stephen Harper, they emphasized the importance of acting on this issue:

Canadian employers estimate that over 300,000 jobs go unfilled for lack of skilled workers. Canada's ability to compete effectively in the global marketplace is eroding due to our failure to fully employ skilled immigrant workers while our competitors do...Canada cannot afford to waste these national assets if we are to remain globally competitive, make advances on establishing a knowledge-based economy and replace skilled workers as they retire (*CIMM* 28, 2005, p. 25)

These statements highlight the deep concern with the wide-ranging, adverse effects of downward occupational mobility, not only on the earning capacity of immigrants but also on their mental and emotional health, the wider community, and Canada's capacity to meet its labour market needs.

While concerns about lost wages, social cohesion, and labour market competitiveness due to a lack of FCR are not new,² my policy analysis reveals a heightened sense of urgency to address these issues starting in the early 2000s. Specifically, there was a focus on addressing the problem of FCR to improve the integration³ of IENs⁴ into the nursing⁵ workforce. This urgency is a

² For instance, the 1984 Royal Commission on Equality in Employment identified FCR as one of the main factors for the unequal participation of recently arrived immigrants. The 1987 Task Force on Access to Professions and Trades in Ontario echoed this concern and offered some recommendations. In 1990, Canada ratified the United Nations Educational, Scientific and Cultural Organisation Convention on the Recognition of Studies, Diplomas and Degrees concerning Higher Education in the States belonging to the European Region.

³ Integration is defined as meeting the criteria for registration and securing work as a registered nurse. In Ontario, this includes working as Registered Nurses (RNs) or Registered Practical Nurses (RPNs).

⁴ In the policy documents I examined, an 'IEN' is defined as someone who received a baccalaureate, diploma, or equivalent educational degree and training in nursing abroad (i.e., not in Canada) and is or was at one point licensed to practice abroad as a registered nurse. As I further elaborate in the methods section of this chapter, since my dissertation focuses solely on the experiences of registered nurses from the Philippines, it does not lend itself to conclusions that may be generalized to the experiences of IENs as a whole.

Furthermore, in the Philippines, as there is uniquely only one general class or type of registered nurse, licensed at the national level by the Professional Regulation Commission and required to hold a baccalaureate degree in nursing, it is important to underline the extensive training that nurses receive on account partly of the government's commitment to the "exportation" of a health care workforce as a means of fostering development via securing remittances.

⁵ In Canada, three general classes or categories of registered nurses are educated and licensed to practice per provincial and territorial legislation. In Ontario, British Columbia, and Nova Scotia, all classes of nurses are regulated by a single regulatory body or college. Each nursing class has its own regulatory body in all other provinces and territories. These are (1) RNs who are required to hold a baccalaureate degree in nursing. RNs who pursue additional training to perform tasks within a widened scope of practice earn the title of Nurse Practitioner. (2) RPNs who are required to hold a college-level diploma in practical nursing. Only Ontario and Quebec use the title of

response to a dual process of a shrinking nursing workforce and an ageing generation of baby boomers, creating a context where the increase in demand for nurses is being met with a shrinking domestic supply. With the integrity of Canada's health care system at stake, federal and provincial governments, nursing regulatory bodies and professional associations, and immigrant-serving organizations collectively expressed the need to fund initiatives to study the problem of FCR and improve the integration of IENs.

After twenty years of studies, initiatives, and programs being put in place, the majority of IENs continue to experience some type of downward occupational mobility. Among those IENs who obtain their nursing licence, many fail to access the upper tiers of the profession as Registered Nurses (RNs). Instead, they are more likely to gain entry into the lower tier as Registered Practical Nurses (RPNs),⁶ be employed in the most precarious work settings (e.g. long-term and home care), and be underrepresented as nursing coordinators and supervisors (Armstrong et al., 2008; Block & Galabuzi, 2018; Bourgeault et al., 2010; Cornelissen, 2021; Covell et al., 2015; Kolawole, 2009; Salami et al., 2014; Salami & Nelson, 2014; Tregunno et al., 2009; M. Turcotte & Savage, 2020). In other words, access to the nursing profession often does not guarantee equal treatment or opportunity for IENs. Meanwhile, those who fail to obtain their licence, comprising most of the IENs,⁷ tend to be relegated to the subsidiary tiers of care provision as personal support workers

RPN. In all other provinces and territories, these nurses are known as Licensed Practical Nurses. And (3) Registered Psychiatric Nurses, who are trained to provide psychiatric nursing care, only exist in British Columbia, Alberta, Saskatchewan, Manitoba, and the Yukon Territory. This group of nurses also uses the title of RPN, but it should not be confused with Registered Practical Nurses (RPNs) in Ontario and Quebec. For the purposes of this dissertation, when I use the terms 'nurse(s),' 'nursing workforce,' and 'registered nurse(s)' in the national context, I refer to all three general types of registered nurses unless otherwise indicated. When I use these terms in the provincial context, I only refer to the two general types of registered nurses licensed to practice in Ontario: RNs and RPNs.

⁶ As per footnote 5, registered nurses with a practical nursing diploma are variably referred to as Licensed Practical Nurses or Registered Practical Nurses depending on the province or territory in which they practice.

⁷ Although measuring the total number of IENs outside the nursing workforce is difficult due to their multiple modes of entry into Canada—IENs often enter through the family or humanitarian categories or through temporary schemes where their education is not recognized or recorded—there is plenty of evidence that indicates that their numbers largely eclipse those who have achieved integration (Armstrong et al., 2008; Bourgeault et al., 2010; Cornelissen, 2021; Frank et al., 2023; Kolawole, 2009; Ogilvie et al., 2007; M. Turcotte & Savage, 2020; WES, 2024).

(PSWs)⁸ or doing other ancillary work⁹ (Armstrong et al., 2008; Cornelissen, 2021; Frank et al., 2023; M. Turcotte & Savage, 2020; WES, 2024).

This trend of downward occupational mobility has only grown over time and is highly gendered and racialized. For instance, a 2020 Statistics Canada study shows that between 1996 and 2016, the proportion of immigrants working in the subsidiary tiers of healthcare—as nurse aides, orderlies, and patient service associates—increased by 14% across Canada (from 22% to 36%) compared to an increase of 5% (from 19% to 24%) in all other occupations (M. Turcotte & Savage, 2020). In 2016, the proportion of immigrants in subsidiary tiers of healthcare was higher in Ontario (41.2%) and even higher in the Greater Metropolitan Area of Toronto (78.7%), of which 80% were women. Black and Filipino immigrant women, in particular, are overrepresented in

⁸ Personal support work is defined as providing “non-professional services involving personal assistance to older people, people with disabilities and/ or chronic health conditions and, in some cases, children” (Lum et al. 2010). According to the 2020 *Long-Term Care Staffing Study* by the Long-Term Care Staffing Study Advisory Group, as of 2018, there were over 100,000 people employed as personal support workers (PSWs) in Ontario across all healthcare sectors (Long-Term Care Staffing Study Advisory Group, 2020). However, because there is no agreed-upon definition for who should count as PSW—since it is a job done across multiple job titles and settings—their numbers are likely much higher. In the National Occupational Classification (NOC) system, for instance, personal support work is classified across *at least* four different categories: NOC 3413, which includes Nurse aides, orderlies and patient service associates; NOC 4412, which includes Home Support Workers, Housekeepers and Related Occupations; NOC 6471 Visiting Homemakers, Housekeepers and Related Occupations; or NOC 6474 Babysitters, Nannies and Parents' Helpers. PSWs who perform their work outside an institutional setting (long-term care facilities and hospitals), particularly in the home and community care settings, are often not counted or not considered healthcare workers (Armstrong et al. 2008; Church et al. 2004). Their high turnover rate (of around 60%) and the fact that personal support work tends to be done on contractual, part-time or on-call basis also makes tracking PSWs challenging (Armstrong et al., 2008; Banerjee et al., 2008; Church et al., 2004; Day, 2014; Ferguson, 2014; Hapsari et al., 2022; HPRAC, 2006; Lilly, 2008; Lum et al., 2010; Marani et al., 2021; Sethna, 2013; Wiens, 2016; Zagrodny et al., 2023; Zagrodny & Saks, 2017).

⁹ Ancillary workers are typically contrasted from those who provide clinical care, i.e., diagnoses and direct treatment provided by doctors, nurses, and other licensed professionals. In their analysis of how this distinction was developed and maintained and its consequences for the conditions of care, Armstrong et al. (2008) argue that this framing fails to capture the complexity and range of skills, tasks, conditions, and relations involved in health care provision, which make developing a full portrait of ancillary work challenging: “[i]ndeed, depending on where we draw the line, ancillary workers may account for the majority of those who work in the health and social service sector” (p. 6). They argue that the distinction reflects the types of workers, skills, and interventions historically and structurally prioritized or marginalized to count as ‘critical to care.’ With these methodological concerns in mind, they devised the following occupational categorization for the ancillary group as workers who “directly or indirectly support the diagnosing and treating work of health care professionals and paraprofessionals” (e.g. dental assistants or medical laboratory technicians); “develop and administer health care policy, research, and regulation” (e.g. inspectors in public health or health policy researchers); “maintain the physical infrastructure of health care delivery” (e.g. cleaners or laundry workers); support the “information infrastructure of health care delivery” (e.g. clerical workers); maintain the “interpersonal and organizational infrastructure of health care delivery” (e.g. orderlies or managers); and who “provide additional services critical to the smooth maintenance of a health care enterprise” (e.g. food service workers and security personnel) (pp. 186-7). Although there are exceptions, they argue that ancillary work is highly gendered, racialized, characterized by low social status, and disproportionately precarious. For the purposes of this project, I focus on those workers who fit this categorization.

these positions. Despite Black women making up only 8% and Filipinas 9% of immigrants in all other occupations, each group constitutes around 30% of immigrants working in subsidiary healthcare occupations (or 60% altogether). The study also found that nurse aides, orderlies, and patient service associates are highly educated: among immigrants working in these subsidiary healthcare occupations, 25% had at least a bachelor's degree compared to 5% of non-immigrants; notably, this percentage increased to 45% for recently settled immigrants (between 2011 and 2016). And among immigrant workers with at least a bachelor's degree, 69% had a degree in nursing. In other words, an increasing number of highly educated Black and Filipino women, many being nurses, are found in subsidiary healthcare roles compared to other occupations.

The COVID-19 pandemic has further exposed the dire state of the healthcare system. It reignited a sense of urgency to utilize the labour-power of IENs to compensate for the high attrition rates of frontline healthcare workers (Walton-Roberts, 2023). In response, nursing regulators, associations, and provincial governments across Canada have introduced programs and made changes to improve the integration of IENs,¹⁰ such as introducing alternative ways IENs can more quickly meet education, practice, and language requirements and various financial and mentorship supports (CNO, 2024c; Merali, 2022; RNAO, 2022a, 2022b; WES, 2023). While these may help improve integration into nursing, there is a continuing tendency to relegate IENs to the lower tiers of care provision. For instance, on January 17, 2022, the Ontario Ministry of Long-term Care and Health sent a memo encouraging long-term care licensees to collaborate with the College of Nurses of Ontario (CNO) to use the pool of international applicants to meet personal support work staffing needs. However, these IENs' work as PSWs does not count towards meeting the licensing requirements to become a registered nurse, a practice the CEO of the Registered Nurses Association of Ontario (RNAO) has called “exploitative” (Hannah & Hillmer, 2022; Merali, 2022).

2. Why did I choose to focus on the problem of foreign credential recognition?

I embarked on this research project to make sense of my family's migration experiences. My parents, brother, and I left Mexico for upward social mobility in the late 1990s. In some ways, we achieved this goal. But getting it has come at a cost, and our advances remain tenuous. In addition

¹⁰ See Chapter Six of this dissertation for further discussion of these programs and changes.

to the vast amounts of money and effort dedicated to migrating, upward social mobility required a long, arduous journey to get my mother's dietitian credentials recognized. For six years, I watched my mother battle against a frustrating, obtuse, and downright discriminatory system licensing system. There were many phone calls and visits to the College of Dietitians of Ontario, thousands of dollars spent on registration, tuition, courier, translation, and other fees, and seemingly endless additional requirements to fulfil. She was forced to return to school and complete hundreds of hours of unpaid internship work, all while working full-time. The worst part of the process was the more overt forms of racism from the College that she had to contend with. About four years into the process, the College accused her of plagiarizing a report because she had not adequately cited a few paragraphs and consequently denied her registration. On appeal, the judge faulted the supervising dietitians for providing no guidance and signing off on work they did not correctly assess. He also repudiated the College for behaving in a grossly discriminatory and invasive manner by sending a registration committee member to our home to physically check her computer files to determine whether she had written those reports herself. Despite being absolved of any responsibility for the mistake, she was directed to repeat her internship under alternate supervision. Two years later, she succeeded in getting her dietitian licence.

Throughout this journey, the private nursing home where she worked saved tens of thousands of dollars by employing her as a food service supervisor while informally using her skills as a dietitian. Meanwhile, my dad—a former lawyer—toiled away, working multiple back-breaking minimum-wage jobs; he was overlooked for jobs that paid better because of his poor command of the English language. To this day, my parents get very emotional when they recount all the terrible experiences they had and continue to endure in Canada. They also scoff at the insistence from white Canadians that 'racism doesn't exist in Canada.' At the same time, they cope by justifying their experiences as part of the sacrifices needed to provide better opportunities for their children. The hope was that the Canadian credentials my brother and I would obtain here would translate into well-paying, fulfilling jobs and also come with international recognition.¹¹ However, like many people of my generation, this dream seems further away from becoming a reality.

¹¹ It is a common perception in Mexico that credentials from a 'first world' country like Canada are immediately recognized for the purposes of employment or pursuing additional education all around the world, whereas credentials from a Mexican institution are only recognized in Mexico. Anecdotally, I have heard of several

Beyond motivating this project, these experiences enabled me to develop a rapport with the migrant nurses I interviewed. The commonalities between our stories of struggle and frustration navigating these systems and surviving in this country were plentiful. I feel very grateful that they entrusted me with their stories even though I was only a stranger to many of them. But, as they shared their stories, what became clear to me was that if my parents had applied for landed immigrant status just a few years later (we arrived circa 1997), we would not have been able to come. The immigration process has become both more stringent and expensive.

3. Research Objectives

IENs need and deserve to be fully, equitably, and quickly integrated into the nursing workforce. However, unlike other scholars,¹² my objective is not simply to determine how to improve their access to the profession. The sole focus on ameliorating barriers to access leaves unaddressed the reality of the rapidly deteriorating working conditions faced by nurses and those in the lower tiers of health care provision. In the context of the pandemic, especially, working to increase access to ‘front line’ work without improving working conditions is reminiscent of how racialized men were swiftly recruited into the military during periods of war as a form of ‘cannon fodder’ (Delgado et al., 2017).

Thus, my objective is to explore how the downward occupational mobility of IENs and the government’s failure to reverse this trend over the last twenty years are intimately tied to problematic understandings of the notion of skill as an objective measure of value, which are fundamental to the broader racialized and feminized segmentation of care provision. In particular, in undertaking this research, I am interested in challenging the hierarchical notion of skill (i.e., that jobs can be distinguished as high-skilled and low-skilled) as a sorting mechanism through which workers enjoy differential access to compensation, benefits, job security, legal and statutory protections, and social status. Moreover, as an anti-racist feminist political economist and critical

Mexicans who have experienced significant barriers when attempting to get their Mexican credentials recognized abroad, and of others who experienced few or no barriers when using their Canadian credentials to secure employment or pursue additional education in Mexico. My statement is not meant as an empirically proven fact, rather to help illustrate the subjective character of the process of credential recognition and to what extent it informed my parents’ decision to migrate.

¹² See, for instance, the work of: Bourgeault et al., 2010; Covell et al., 2017; Neiterman & Bourgeault, 2013; Ogilvie et al., 2007; Salami & Nelson, 2014.

disability scholar, I am interested in centring the modalities of race, gender, and disability as mutually constitutive and interlocking forces of oppression and surplus extraction.

With these objectives in mind, my research examines gendered and racialized norms around skill and their effects. Ultimately, therefore, I both uncover and further query how the subordination of feminized and racialized forms of labour (a) produce inter- and intra-occupational hierarchical segmentation in healthcare, (b) disproportionately channel racialized nurses into the lower tiers, (c) limit workplace assurances to occupations characterized as ‘high-skilled’ (e.g., future job security, decent income, access to regulatory protections and statutory entitlements, and control over working conditions); and, (d) disproportionately disable (broadly including injuries, illness, violence, mental health distress, and other types of physical and psychological harm) those in the lower tiers of care provision. To achieve these research objectives, I build on Armstrong’s (2013) feminist political economy analysis of the social construction of skill, Gorman’s (2016) disablement framework, and Bacchi’s (1999, 2009; Bacchi & Goodwin, 2016) critical approach to policy analysis.

4. Theoretical Framework

4.1. Feminist Political Economy and the Social Construction of Skill

My feminist political economy theoretical framework is informed by scholars of anti-racist, historical materialist feminist political economy—such as Vosko (2006, 2010, 2019), Chartrand & Vosko (2021), Acker (2004, 2006), Arat-Koç (1999, 2006, 2010, 2012), Bannerji (2005), Gabriel (2011, 2013), Galabuzi (2011, 2018; 2004, 2006), Valiani (2011, 2012), Armstrong & Armstrong (2010), Wright (2006), and others — who unpack how the social relations, such as race, gender and (dis)ability, shape divisions of labour, drawing attention, in particular, to the false

separation of production,¹³ the production of hegemonic masculinities,¹⁴ and the use of such social categories, and the relations of inequality they engender and reproduce, as resources for capital accumulation.¹⁵ I am drawn especially to how the notion of ‘skill’ is constructed in the context of healthcare provision, contributing to patterns of gendered and racialized stratification; in this sector, the gender and race-coded differences in the treatment and rewards workers receive in so-called ‘high-skilled’ versus ‘low-skilled’ jobs and the disproportionate sorting of racialized women into the latter. In this work, I rely especially on Armstrong’s feminist political economy analysis of the

¹³ Within capitalism, the separation of production and reproduction is characterized as the gearing of production of commodities and provision of services towards capital accumulation rather than towards meeting people’s daily and intergenerational needs. Although production depends on the reproduction of the workforce, there is an almost complete disavowal of responsibility on the part of capitalists to meet the social reproductive needs of society (Acker, 2004; Picchio, 2000; Vosko, 2002, 2006). The gender-coded separation between production and social reproduction has become an underlying principle in “the conceptual and actual physical organization of work, the spatial and time relationships between unpaid domestic and paid work, bodily movements through time and space, the general organization of daily life, and the ways that groups and individuals constructed meaning and identities” (Acker, 2004, p. 24). For example, in policies regulating the healthcare workforce, this separation takes form in the gendered segmentation of care provision, the bifurcation of care into ancillary and clinical care, the de-prioritization of care for people with dubious productive value (e.g. seniors, disabled people), the prioritization of cost-savings or efficiencies over the provision of quality care, and, in the era of neoliberalism, increasing responsabilization of the individual and the household for the maintenance and provision of care, alongside the increasing use of for-profit providers, and the adoption of corporate managerial practices in the non-profit sector. In immigration policy, the separation between production and social reproduction manifests in the growing emphasis on economic over family reunification and humanitarian forms of migration, policies prioritizing employers’ need for labour-power over the emotional needs of families, and the ethical responsibility to settle refugees escaping violence.

¹⁴ Connell (2013) defines masculinities as “configurations of practice within gender relations, a structure that includes large-scale institutions and economic relations as well as face-to-face relationships and sexuality” (p. 29). She traces hegemonic or “globalizing” masculinities as intrinsically linked with colonialism, particularly with the “unusual level of violence and egocentric individualism” that characterized conquest and settlement of the eighteenth and nineteenth centuries (p. 47). In today’s world, hegemonic masculinities continue to be characterized by aggression, ruthlessness, competitiveness, a desire to control, and the exaltation of rationality devoid of human emotion. For example, the proliferation of hegemonic masculinities in the healthcare labour policy is evident in the valorization of masculinized skills or forms knowledge (mechanistic, objective, scientific knowledge abstracted from the complexity of the human experience) over feminized forms (empirical, emotional, bodily), a process which is in many ways a continuation of the displacement of folk-healers/witches through the rise of professional medicine in the advent of the industrial revolution (Federici, 2014). In immigration policy, hegemonic masculinities are reproduced through the ethos of competition for “high-skilled” workers.

¹⁵ Viewing gender and race relationally also allows for a conception that understands such socially relations as inextricably linked to social class. As Bannerji (2005, p. 149) writes, “‘race’, gender, and patriarchy are inseparable from class, as any social organization rests on inter-subjective relations of bodies and minds marked with socially constructed difference on the terrain of private property and capital.” Treating gender and race as social relations also reveals the paradox of desirability/undesirability as embedded in the goals of capital accumulation. The perception that (cis) women, especially racialized women, are naturally docile—able to endure tedious, repetitive work—and naturally nurturing—apt for the provision of care—makes them a cheap source of labour not simply because their skills become devalued but instead because their worthlessness and disposability as assumedly unskilled workers makes them valuable (Wright, 2006). Therefore, the process of valorizing work along gendered or racialized lines is not simply a problem of perception or “recognition” but is intimately tied to the extraction of surplus value and thus to capital accumulation.

social construction of skill (see in particular: Armstrong, 2013; Armstrong et al., 2008; Armstrong & Armstrong, 2010; Armstrong & Day, 2017).

Before delving into Armstrong's approach to the social construction of skill, it is crucial to clarify my approach to race (and racialization) and gender (and gendering), two concepts that I conceive of relationally (i.e., as social relations). Here, I build upon Acker's (2004, p. 20) understanding of gender as "neither an essential attribute of individuals nor a constant in social life... constantly produced and reproduced in the course of ongoing social activities and practices." Rather, in this work, gender is understood as a "basic organizing principle in social life, a principle for the allocation of duties, rights, rewards, and power, including the means of violence... involv[ing] bodies of actual people and the ways that they see and experience themselves and their identities." This definition recognizes gender not as an innate characteristic but as a dynamic social relation, acknowledging the existence of various masculinities and femininities that manifest differently across diverse contexts. Defining gender in this way also helps reveal how, contemporaneously, the concept is structured around a binary and is thus heteronormative; as such, women/femininity are typically subordinated in so far as their limited access to power, status, and material rewards. Understanding gender as a social relation is valuable in grasping how nursing has evolved into a highly feminized occupation (both numerically and structurally) and the implications this feminization holds not only for women but also for men, especially men who are racialized non-white, working as nurses (on the phenomenon of the racialized gendering of jobs that unfolds in this process, see Vosko 2000).

In a parallel vein, I understand race as a socially constructed category and racialization as involving the "delineation of racial difference and allocation of individuals into groupings through historically and geographically specific practices of classification, representation, and signification as an organizing principle in social life" (Vosko, 2025, p. 10) one in which those constructed as 'white'¹⁶ are oft treated as "citizen-subjects" (Thobani, 2007) in relation to, and at the expense of,

¹⁶ I recognize that who is racialized as 'white' and whiteness are socially and historically contingent processes. In contemporary terms, those who count as 'white' are not the same as those who counted as white in the past. With those caveats in mind, in this work, a 'white' person or people broadly refers to those designated as non-visible minorities and usually comprises settlers of Western European descent who form part one of Canada's dominant identities and enjoy the associated privileges and benefits of this identification. For an exploration of whiteness as a process of racialization in the American context, please see J. Sakai's (1983) *Settlers: The Mythology of the White Proletariat* and Roediger's (1999) *The Wages of Whiteness: Race and the Making of the American Working Class*.

those (a) othered and marginalized as ‘visible minorities’ and ‘foreigners’ (outsiders to the nation-state) (b) exploited as “racialized dependent labour,” or (c) “expropriated” as “colonized, dispossessed and enslaved” populations through processes that “precede and/or make possible the exploitation of wage labour” (Chartrand & Vosko, 2021, p. 5).

Conceiving race as a social relation helps reveal that racialization is a process irreducible to (one or multiple) differences in phenotype, nationality, ethnicity or legal status and also that hierarchies and distinctions exist within and among groups that manifest differently in different contexts. With this understanding in mind and in recognition of anti-Indigenous (McCallum, 2014; McPherson, 2003b) and anti-Black racism in Canadian nursing (Calliste, 1996; Das Gupta, 2009; Flynn, 2009), it is also essential to note that while all IENs—regardless of their country of origin—experience racialization and generally face a relatively more challenging integration process than domestically educated nurses by virtue of their credentials being construed as ‘foreign,’ racialization also operates beyond the IEN workforce, reflecting specific histories and power dynamics. For example, Filipino IENs—the social group of focus in this dissertation—experience processes of racialization differently than Black nurses (be they IENs or domestically-educated) whose proximity to whiteness (not just in terms of skin colour but also factors such as assimilability, (im)migration pathways available historically and contemporaneously) is more distant. Although in my analysis, I use terms such as “white nurses” as a short form as compared to IENs, a group presumed to be composed principally of nurses who racialized non-white, I adopt this approach principally for readability, having defined my terms in a more nuanced way above. That is, these terms serve as an analytical shortcut in highlighting ongoing processes of racial differentiation, even though I acknowledge the potential oversimplification to which binaries can contribute.

With these definitions and considerations in mind, I will now explain how Armstrong’s feminist political economy framework of skill informs my examination of the gendered and racialized segmentation of nursing professions. According to Armstrong (2013, p. 257), how we conceptualize and understand the notion of skill has “fundamental consequences not only for how work is organized and rewarded but also for the quality of goods and services that result.” In

healthcare provision, the lower wages and constrained authority of nurses¹⁷ (an occupation primarily composed of women)¹⁸ relative to male-dominated occupations, such as physicians,¹⁹ are mainly attributed to a perceived difference in their skill levels—the greater length and intensity of physicians’ formal education and training are seen as commensurate with their more significant levels of compensation and authority. Similarly, the disparities between RNs (who are primarily racialized as white)²⁰ and subsidiary occupations (who, as mentioned above, are disproportionately and increasingly comprised of workers who are racialized non-white) are said to be a result of their relative skill levels. For instance, although they perform most of the same duties, RPNs are said to lack the “depth and breadth of foundational knowledge” that RNs acquire with a four-year degree (RPNAO, 2021). PSWs’ jobs are characterized as menial, routine, lacking a distinct body of knowledge, and not requiring critical and reflective thinking (Armstrong et al., 2008; Day, 2014; HPRAC, 2006).

Meanwhile, as it relates to IENs, only those recognized as possessing equivalent skills to domestically educated nurses, in accordance with entry-to-practice standards or competencies,²¹ are deemed as capable of providing safe and ethical care and, by extension, deserving of access to the nursing profession and its associated benefits and protections. This process of skill-based sorting is the *raison d’être* of provincial regulatory bodies, which assume such categorization as a

¹⁷ Physicians earn between three to 13 times more per hour than nurses, even when doing similar duties, and exercise more significant levels of authority in the workplace. According to a recent report by CTV News, physicians deployed in the intensive care unit in Ontario earn up to \$450/hr, or \$165/hr for administrative assignments. Meanwhile, a Registered Nurse (RN) earns between \$33 and \$48/hr, depending on years of experience. This disparity exists even when they do similar work (DeClerq, 2021).

¹⁸ Despite the growing supply of men becoming nurses in recent years (15.4% increase in men versus 3.9% women from 2014-2019), women make up 91% of the nursing workforce (CNA, 2021).

¹⁹ Although the proportion of women physicians in Canada has grown rapidly (from 11% in 1978 to 43% in 2018), it remains male-dominated. Women physicians occupy fewer positions in governance bodies, their work is relatively undervalued, and they earn significantly less than male physicians even when working the same amount of hours (Cohen & Kiran, 2020).

²⁰ According to Turcotte and Savage (2020), in 2016, only 21% of registered nurses were designated as visible minorities; as such, the profession is comprised disproportionately of white women.

²¹ Entry-to-practice standards or competencies describe the “required knowledge, skills, and judgment expected of new graduates entering practice to provide safe, ethical care in various settings [and] are used as a guide for curriculum development in nursing education programs” (Shaffer et al., 2016, p. 53). This is determined by assessing an applicant’s educational credentials, practice experience, and character. The entry-to-practice competencies for RNs (revised in 2018) comprise a total of 101 competencies organized thematically under nine roles: (1) Clinician; (2) Professional; (3) Communicator; (4) Collaborator; (5) Coordinator; (6) Leader; (7) Advocate; (8) Educator; and, (9) Scholar (CNO, 2018a). For RPNs, (revised in 2019), these comprise a total of 79 competencies organized into five categories: (1) professional practice, (2) legal practice, (3) ethical practice, (4) foundations of practice, and (5) collaborative practice (CNO, 2019a).

form of risk management for Canadians. Applicants whose skills do not conform to the Canadian standard of nursing are sorted into lower-tiered occupations, where risks related to their inferior and deficient skills can be contained through regulatory practices and legal limits on what they are allowed to do (otherwise known as ‘scopes of practice’).

According to Armstrong (2013), the underlying assumptions in skill-based sorting are that (a) value, in this case, concretized as wages and authority, is derived from the inherent worth of skills and (b) that skills constitute capacities that are independently acquired (i.e., through individualized formal education and training) and objectively measurable (e.g., credentials). She challenges this understanding of skill and instead argues that skill is a social construct embedded in particular historical, discursive, and structural forces (e.g., capitalist accumulation, technological changes, law and institutions, and beliefs and norms about gender, race, and disability) that shape how it is understood, organized, and valued. Understanding skill as a social construct does not imply it loses its significance or becomes an “empty signifier”; instead, it should be recognized as a “floating signifier,” one that “obscures context, inequities, and the social nature of the learning process itself” (Guo, 2015, p. 238).

Based on this understanding of skill as a social construct, the variations in salary and workplace benefits arise not merely from disparities in formal education or “some intrinsic job worth” but, rather, “negotiated worth based to a large extent on power [...] related to both collective strength and the availability of alternative workers” (Armstrong & Armstrong, 2010, p. 28). In other words, the subordination of particular sets of workers in the context of labour market segmentation is not the result of their inferior or deficient skills. Instead, it stems from various factors, primarily the ideological and material subordination of labour historically associated with marginalized social groups, undermining their capacity to organize and demand better workplace assurances and conditions, rendering them more exploitable.

Recognizing skill as rooted in the social relations of gender and race is essential for my analysis of FCR policies and practices involving the integration of IENs. It allows me to identify and analyze the processes involved in shaping how IENs’ skills (broadly understood to include credentials, work experience, and other qualifications) are understood, recognized, organized, and rewarded. In particular, it enables me to unpack the racialized dichotomization of nursing skills and the regulatory regime that underpins it by examining where these understandings of skill

originated and what they obfuscate, particularly what ideological and socioeconomic interests are supported through these depictions.

4.2 Disablement

As I elaborate in *Chapter Five*, subsidiary healthcare occupations such as personal support work, where many IENs end up employed, are highly disabling. PSWs, in particular, are reportedly exposed to injuries, illness, violence, and other types of physical and psychological distress and harm more than any other healthcare worker (Armstrong et al., 2008; Banerjee et al., 2008, 2015; CIHI, 2021; D'Hondt et al., 2012; Keith & Brophy, 2021; Kontos et al., 2010; Marani et al., 2021; Rossiter & Godderis, 2020; Syed et al., 2016; WSIB, 2024; Yassi et al., 2005; Zagrodney & Saks, 2017).

To understand how these disabling conditions are produced and how they are co-constitutive of race-based exploitation, I turn to Gorman's (2016) framework of disablement. Disablement understands racism (particularly in settler-colonial contexts) and the production of disability as mutually constitutive forces of oppression and exploitation. Looking through this lens reveals how racist governance strategies disproportionately disable racialized people (by exposing them to injuries, illness, violence, and other types of physical and psychological distress and harm) while also effectively barring them from accessing disability identity or status (and the benefits and protections conferred by this status). More specifically, they state that,

[I]n a context where immigration and federal temporary foreign worker programmes mean that disabled people either never arrive or are disappeared, deported, or detained when a disability is acquired. Increasingly, 'the disabled' are those whose formal relationship to the state enables them to claim benefits, while others with similar embodied experiences continue to work through injury and illness or languish without benefits or status. In settler colonial contexts, both the articulation of disabled subjects as a reserve army and the disqualification of racialized populations as disabled subjects are organized by/through the nation-state (Gorman, 2016, p. 254).

In other words, racism, as articulated through state policies, concurrently exposes racialized people who serve as a "reserve army" of labour to a higher risk of becoming disabled while complicating

their claim to disability status, resulting in an “ongoing re-constitution of the disabled subject as a white subject” (p. 254).

The conceptualization of disability through the lens of disablement differs from the medical and social models’ conceptualization of disability as either a medical reality (i.e., a problem located within the body) or as a social status (i.e., a problem located in social structures in the interaction with ‘natural’ impairments). The framework of disablement shares the social model’s focus on social processes that produce disability. But it differs insofar as disablement denaturalizes impairments²² and understands the distinction between disabled/non-disabled itself as a (re)production of relations of power, specifically as part of the “totality of state policies related to national race/class formation” wherein the “state organizes categories of disability in coordination with other aspects of citizenship (non)-status” (Gorman, 2016, p. 256). This understanding of disability differs from how it is understood within the social determinants of health model as the unfortunate, epiphenomenal effect of gender and race-based oppression and exploitation. Instead, disablement understands disability as being in a dialectical relationship with these relations of oppression and exploitation.

²² The social model has been instrumental in understanding the role of social processes such as built environments and socioeconomic status in producing disability (i.e., social determinants of health); in advancing rights to accommodation as well as preventative and compensatory techniques (i.e., occupational safety and health protections, and social security schemes); and, in conceptualizing alternative forms of employment and income security (e.g. life course approach, guaranteed income, reverse remuneration). It has also had some positive effects in building a sense of collective identity that validates some disabled people’s experiences. However, the social model is limited in its dichotomization between disability and impairment, wherein the latter is naturalized. By naturalizing impairment as an “objective, transhistorical and transcultural entity of which modern bio-medicine has acquired knowledge and understanding and which it can accurately represent” (Tremain, 2006, p. 185), the social model treats impairment as largely irrelevant or as a problem that can be easily accommodated by removing social barriers (Shakespeare, 2006). Moreover, insofar as it relies on dyadic and repressive (juridical) notions of power and the distinction between disabled/non-disabled, the social model also reproduces the ongoing assessment and surveillance of ‘impairment’ and ‘the impaired.’ That is, instead of challenging the supremacy of the norm, it reproduces the disciplinary authority of biomedicine. In other words, by treating impairments as universalized attributes, they are “naturalized as an interior identity or essence on which culture acts to camouflage the historically contingent power relations that materialized them as natural” (Tremain, 2006, p. 192). For these reasons, the social model cannot address disableism beyond the scope of rights-based accessibility and inclusion, approaches which themselves have historically relied on the racialized disablement of care providers. In contrast, disablement understands impairment not merely as a biological, fixed, transhistorical reality but instead as a “manner of becoming-in-the-world that reorganized lived space and time as well as the social relations between the self and other bodies... [it] is simultaneously historical, social, and biological” (Erevelles, 2011, p. 36). While there is risk in associating disability with a violent and oppressive history, considering that disability is already conceived of as ‘abject,’ by conceptualizing disability “not as the condition of being but of becoming, and this becoming a historical event,” Erevelles (2011) argues that we can reject the “ahistorical association [of disability] with lack” (29). In other words, I am not interested in what disability *is* but rather how it *becomes*, for it is “material context that is critical in the theorizing of disabled bodies/subjectivities” (pp. 27-28).

To further the understanding of the dialectical relationship between gender, race, and disability, I draw from Erevelle's (2011) historical materialist conceptualization of disability as a commodity fetish, which aligns with Gorman's (2006) critique of the exclusion/inclusion framework of disability. In traditional historical materialist understandings of disability, like Gleeson's (1997),²³ disability is understood as emerging from the devaluation of physically different people through their exclusion from the labour market and their ideological marginalization following mass institutionalization (Gorman, 2006). While Gorman (2006) and Erevelles (2011) accept the materialist reading of disability as a historical event, they reject the idea that it is produced merely by excluding disabled people from the context of production.

Erevelles (2011, p. 196), in particular, expands on Robert Young's (2009) theorization of race as a "commodity fetish"²⁴ to examine how the disabled body is also "deployed as a commodity fetish to enable capitalist accumulation of profit and justify the social organization of difference in oppressive ways in transnational contexts." She argues that the use value of disability, like the use value of race and gender, is not only to create divisions within the working classes but, more importantly, to (a) lower the exchange value (wage) of workers through their disablement, and (b) "fetishiz[e] our conception of the social," that is, "occlud[e] a critical understanding of the historicity of social relations where race [or in this case disability] is deployed in the calculus of surplus extraction (its exchange value)" (Erevelles, 2011, p. 62). Keeping this understanding of disability's use value in mind enables me to examine what ideological and socioeconomic interests are being obfuscated and supported through the disablement of IENs as they get integrated into the labour market.

As Gorman (2006) points out, this materialist understanding of disability requires that our conceptualization goes beyond understanding it as a form of social exclusion. The dichotomy of

²³ Historical materialism understands the subject—its "body, consciousness, and meanings"—as produced by and through how "society organizes its basic material activities (work, transport, leisure, domestic activities)" (Gleeson, 1997 p. 194 cited in Erevelles, 2011, p. 181).

²⁴ According to Marxist theory, labour within the context of capitalism becomes a commodity (i.e., something to be traded in the marketplace), with use value (i.e., being of use to someone) and exchange value (i.e., compensated by a wage). Taking up this concept, Young (2009) argues that "what links racism to capitalism is not just the creation of racial divisions within the working classes, but rather that 'it is the very commodity structure where race is useful precisely because it can be exchanged for less'" (Young 2009, p. 8 cited in Erevelles, 2011, p. 62). But race is not just a commodity but also a commodity fetish. This means that its value is fetishized (i.e., obscured, mystified, and inverted) to facilitate the extraction of surplus. As such, the use value of race "fetishizes our conception of the social, and as a result, this occludes a critical understanding of the historicity of social relations where race is deployed in the calculus of surplus extraction (its exchange value)" (Erevelles, 2011, p. 62).

exclusion/inclusion in the discourse around disability is “both a *partial understanding* of social relations based on the appearance of these social relations and a concept that *masks contradictions* that are inherent in these social relations” (2006, p. 196). In other words, this dichotomy narrows our understanding of oppression and exploitation as simply resulting from the exclusion of certain people from accessing power, thereby framing solutions around removing ‘barriers’ to inclusion. As such, this dichotomous understanding not only fails to address the oppression and exploitation that persists after inclusion, but it also obscures the material and ideological conditions that are being supported by framing liberation along the lines of inclusion.

Through this conceptual framing that goes beyond understanding disability as simply a form of social exclusion, the disablement of IENs is understood not just as the result of being sorted into inherently disabling ‘low-skilled’ jobs (i.e., the exclusion from ‘high-skilled’ jobs, which offer better workplace assurances) but, rather, as a result of constructing these jobs in ways that obscure relations of exploitation. Similar to Wright’s (2006, p. 2) observation that the value of racialized women’s labour is derived from their rendering as disposable, that “she generates widespread prosperity through her own destruction,” IENs in subsidiary occupations also function as “shock absorbers,” “cushion[ing] the effects of [neoliberal] restructuring,” thereby “at a minimum, fail[ing] to encourage more collective and structural reforms” (Armstrong et al., 2008, p. 118). In other words, rather than excluding or failing to recognize their value, the transnational capitalist system “depend[s] on the devaluation of racial, female, and disabled bodies to sustain [it]” (Erevelles 2011, p. 143).

In addition to historical materialism, the lens of disablement allows for integrating key frameworks adopted by critical race scholars, such as Mbembe’s (2003) necropolitics and Thobani’s (2007) conceptualization of “exalted subjects,” into theorizations of disability. In disability studies, necropolitics is defined as the “uneven biopolitical incorporation...of disabled subjects who in certain times and places are made representative and ‘targeted for life’ even as others are disabled in different ways...or targeted for death” (McRuer, 2010, p. 171 cited in Gorman, 2016, p. 255). To admit necropolitics into theorizations of disability means to “acknowledge that racial violence might be internal to liberal projects of disability rights” (p. 255). In the context of IENs, this means understanding their being ‘targeted’ or ‘marked’ for disability through their downward occupational mobility as internal to the process that supports Canadians’

claims to disability status and entitlements (in this case, their access to health care as dwindling as it may be). In this sense, disablement also aligns with Thobani's (2007, p. 6) analysis of the fabrications of Canadian nationhood, particularly how state policies and discursive practices produce certain subjects as "exalted" while "marking" others, such as Indigenous peoples, for "physical and cultural extinction or utter marginalization" and others, such as immigrants, for "perpetual estrangement or conditional inclusion as supplicants."

Moreover, to examine the global reach of disablement in terms of reproducing broader global wealth and health inequalities, my framework also builds on critical race and anti-racist feminist political economy theorists such as Arat-Koç (2009), Gabriel (2011, 2013), Kolářová (2015), Ortiga and Rivero (2019), Parreñas (2015), Valiani (2012), Yeates (2009) and others who explore how exploitation is produced and organized through transnational circuits of care labour, i.e., by displacing or transforming care from impoverished communities in the Global South to benefit those in the Global North.

To summarize, I apply the framework of disablement in conjunction with feminist political economy analysis of 'skill' to shed light on the disability that IENs experience not only as an epiphenomenal effect of their downward occupational mobility, which, in turn, enables us to transcend the approach of viewing solutions only through an inclusivity lens that prioritizes barrier removal integration. This framework facilitates comprehension of how the racialization of IENs complicates their claims to disability status and entitlements, while also scrutinizing how this dynamic fosters capitalist prosperity and reinforces settler-colonial disabled subjectivities.

5. Methodology and Methods

5.1. Critical Policy Analysis: What is the Problem Represented to Be? Approach

In search of an analytical strategy in critical policy studies that would attend to all of my theoretical and political commitments, I was drawn to Bacchi's *What is the Problem Represented to be?* (WPR) approach as articulated across various publications (in particular, Bacchi, 1999, 2009; Bacchi & Goodwin, 2016). Conventional forms of policy analysis assume that the role of public policy²⁵ (hereafter policy) is to solve social problems that exist 'out there' in society awaiting

²⁵ Broadly understood as governmental practices within and in relation to the state, such as legislation, laws, regulations, initiatives, programs, agendas, and even lack thereof.

intervention. In contrast, the WPR approach assumes that governmental practices “produce ‘problems’ as particular kinds of problems” by framing or representing these problems and the target subjects in a certain way. These framings or representations are ingrained with deep-seated, often unproblematized beliefs (e.g., about how the problem emerged, who the target population is, or what will solve the problem), producing particular policy consequences (Bacchi & Goodwin, 2016, p. 14). In Bacchi’s words, “[m]ethodologically we need to find ways to uncover the implicit (and sometimes explicit) characterizations of policy ‘targets’ and to reflect upon the implications of those characterizations, particularly for members of these ‘target’ groups” (Bacchi, 1999, p. 93).

In other words, WPR is an analytic strategy of problematization, understood in two ways: “*either* to signal a form of critical analysis, putting something into question, *or* to refer to the products of governmental practices, that is, how issues are problematized” (Bacchi & Goodwin, 2016, p. 16). It is a process of “teasing out the conceptual premises underpinning problem representations, tracing their genealogy, reflecting on the practices that sustain them and considering their effects” (p. 17). Herein, effects are understood in three overlapping ways: (1) *discursive effects*, meaning those “which follow from the limits imposed on what can be thought and said;” (2) *subjectification effects*, meaning “the ways in which subjects and subjectivities are constituted in discourse;” and, (3) *lived effects*, broadly understood as the “impact on the life and death” (Dean, 2006 in Bacchi, 2009, p. 38).

In developing this methodology, Bacchi (1999, 2009; Bacchi & Goodwin, 2016) provides guiding questions that I slightly modified to suit the flow of my analysis. Although there is some overlap between these questions, following them as successive steps enabled me to identify, interrogate, and systematically reconstruct the problem of FCR. These are:

1. What is the problem of FCR represented to be in Canadian policies related to the immigration and labour market integration of IENs?
2. How and where has this representation been produced, disseminated, and defended?
3. What are the deep-seated assumptions about this representation?
4. What are the effects (discursive, subjectification, lived) of this representation? Specifically, how has it framed or imposed limits on what can be said about the issue? How are IENs and their skills constituted in relation to domestically educated nurses? How has it impacted the lived reality of IENs?

5. What is left unproblematic in this representation? What are the silences?
6. How can the problem be reconceptualized, disrupted, or replaced? And what can be done to challenge and mitigate the negative effects of these representations?

By asking these questions, the goal of the WPR approach is not merely to assess whether a certain policy is working as intended, that is, to “identify some ‘promises’ as empty.” Instead, it is to “draw attention to the assumptions and presuppositions that made it possible to make those ‘promises’ and develop those policies” (Bacchi, 2009, p. 10). With this in mind, I do not set out to merely reform regulatory frameworks, an approach that, to follow Vosko’s (2010, p. 2) critique, “do[es] little more than manage the precarious margins of late-capitalist labour markets.” My task instead is to find ways to abolish²⁶ regulatory frameworks by tracing how the problem of FCR came to be represented as a particular type of problem in the first place. The WPR approach allows me to examine the deep-seated assumptions underlying the representation of the problem, the silences in this representation, and its effects. Upon completing this deconstructive analysis, I present an alternative representation of the problem using the analytic and prescriptive frameworks of anti-racist, historical materialist feminist political economy and disablement.

5.2. Methods

5.2.1. Semi-Structured Interviews

I began my research (Ethics Certificate No. STU 2018-085)²⁷ by seeking out IENs and others who had worked closely with IENs in various capacities. I divided my conversations with all 19 participants into three categories, which took the form of semi-structured interviews in English.²⁸

The first group consists of eleven Filipino IENs (eight women and three men) who arrived in Canada through various entry pathways after 2002 and had, at some point, worked in the lower tiers of care provision as PSWs or performed other ancillary work. I found these participants through pre-existing personal contacts and public call-outs on two Facebook groups, which snowballed into other contacts.²⁹ The Facebook groups include one where potential employers and

²⁶ Following the ethos of prison abolitionist movements, where abolition means that “everyone is welcome and everyone is valued,” abolishing regulatory frameworks is a process that “involves building communities that keep us safe where we take care of and value each other” (Fricker in Gardner, 2023, p. 169).

²⁷ See Appendix A: Ethics Approval

²⁸ See Appendix B: Interview Data

²⁹ See Appendix C: Sample Informed Consent

fellow PSWs post job advertisements looking for PSWs and another administered by Filipino nurses in Canada. The latter group was created to provide information, community connection, and peer-to-peer assistance. These groups helped me recruit participants and allowed me to observe the kinds of struggles, questions, and concerns that IENs are experiencing through their posts and interactions, which I used to generate more comprehensive interview questions. In addition to providing support in navigating immigration and licensing processes and finding employment, IENs also use these spaces to form connections, vent, cheer each other up, and organize around the issues that affect them. At first, I encountered some hesitation from participants who had never met me. However, upon sharing my own story of migration and the intentions of my research, they opened up about their shared struggles. They expressed appreciation for research that aimed to understand and help them in their situation.

There are two key reasons why I focus on Filipino nurses. First, they constitute one of the largest groups of nurses among IENs. According to 2023 data, Filipinos make up Ontario's second largest group of IENs registered to work as nurses (32%, or 11,162 out of 34,847), and the Philippines constitutes one of the top two³⁰ source countries of international applicants for licensure in Ontario (29% of non-US international applicants) (CNO, 2023a). Filipinos are also significantly over-represented in the lower tiers of care provision (30% compared to 9% among immigrants in all other occupations) (Armstrong et al., 2008; Stasiulis & Bakan, 2003; M. Turcotte & Savage, 2020). Although Filipino nurses are neither a monolithic group nor the only demographic of migrant nurses, the long history of their development as a migrant labour force in the context of American and Canadian imperialism makes their experiences emblematic of racialized and gendered globalized capitalism. The Philippines is recognized as one of the leading producers of migrant nurses because, since the late 1960s, their emigration has been adopted as a labour market strategy to address unemployment and increase access to foreign currency. In fact, by the 1990s, remittances made up the second largest source of foreign exchange entering the Philippines, directly supporting 34% to 54% of the population. On the part of recipient nations, governments have also long adopted political and economic agreements and incentives that

³⁰ India overtook the Philippines as the top source country of non-US international applicants to register in Ontario in 2013 (CNO, 2013b). In 2023, 58% of non-US international applicants were from India (CNO, 2023a).

encourage and facilitate the inflow of Filipino nurses, making Canada one of the top destinations for Filipino nurses (Choy, 2003; Jeans et al., 2005; Kingma, 2006; Ronquillo, 2012; Valiani, 2012).

The second reason for my focus is the cultural affinity and the longstanding existence of personal connections with members of the Filipino community. As someone who grew up in Toronto and attended the Catholic public school system, many of my friends are Filipino. Due to similar colonial histories between the Philippines and Mexico, we share similar last names, foods, and watch the same television shows. Their stories of migration and downward occupational mobility mirror my family's, which sparked a very early interest in understanding our shared experiences further. These longstanding relationships also made it easier to find participants.

The second group of participants consists of three people who work for organizations which develop or implement policies related to IENs. One is a Registered Practical Nurses Association of Ontario (RPNAO) representative who has also worked for the CARE Centre for Internationally Educated Nurses. Another is a representative from the CARE Centre for Internationally Educated Nurses, an immigrant-serving organization which offers IENs support in the licensing process. The third is a representative from the Canadian Association of Schools of Nursing, which represents nursing schools nationwide and offers accreditation for IEN-bridging programs. I contacted these participants via email, and they were very interested in research on IEN integration. I also contacted the RNAO, the CNO, the Office of the Fairness Commissioner, and a former Fairness Commissioner. However, I was unable to secure interviews with anyone from these organizations.

The third group of participants consists of five individuals who work alongside IENs in various capacities. There are two senior managers: one who works at an Ontario-based hospital and oversees recruiting, hiring, and supervising IENs in the food and hospitality department, and another who works at a long-term care home in Ontario and oversees hiring and supervising nursing and personal support staff. I also interviewed a person who receives home care provided by an agency. She has some decision-making power over who provides her care and the type of care she receives. Over a few years, she has received care from several PSWs with a nursing background. The last two participants are domestically educated, Black registered nurses who work in the long-term care setting alongside many IENs who work as RPNs or PSWs. I knew all

of these participants from pre-existing contacts, and they enthusiastically volunteered to be interviewed as long as their identities were kept anonymous.

Despite the small sample size, primarily consisting of Filipino IENs, which limits the generalizability of my conclusions, these in-depth discussions support the results of my documentary analysis and offer valuable insights that larger survey-based studies often overlook. After conducting my documentary analysis, in line with Mohanty's sentiment (2006, p. 1) that "ideas are always communally wrought, not privately owned," I re-visited my participants' individual stories and testimonials to develop (a) a more profound understanding of how these affirmed, reconstituted, and challenged dominant representations of the problem of FCR and, (b) to assess the discursive, subjectification, and lived effects of these representations of the problem at various points in their integration journey.

In particular, my interviews with non-IENs show how those in charge of developing and implementing policy and those involved in hiring and working alongside IENs construct nursing skills and under which conditions. My interviews with IENs bring forth context-specific, embodied, experiential knowledge of how immigration and labour market integration policies reproduce gendered and racialized disablement. The stories of their daily lives, struggles, and aspirations reveal how attempts to improve credential recognition systems fail to address integration issues and further contribute to their downward occupational mobility. At the same time, their stories also show how they navigate, cope with, and challenge the racialized depictions of their skills in their desire to provide better-quality care for their clients, patients, and residents, even though this comes at the cost of their own well-being. My deep obligation to make the stories they entrusted me with known, perhaps hoping they could lead to positive change, kept me motivated to finish this project.

5.2.2. Documentary Analysis

Upon concluding my interviews, I mapped out which statutes and regulations, governmental departments and programs, institutions, agencies, and organizations IENs came into contact with, even if indirectly, throughout their integration journey, specifically those related to their immigration, the assessment of their credentials, licensing, and employment. I then collected documents from the relevant government and organizations' websites; all of these were publicly

available, although some had to be retrieved using the Internet Archive's Wayback Machine. To locate relevant documents, I used variations of the following search terms: 'foreign or international credential recognition,' 'international or foreign credentials,' 'IENs or internationally educated nurses,' 'internationally educated health professionals,' 'migrant nurses,' 'personal support workers,' and 'unregulated health professionals.' I downloaded all documents that mentioned these search terms and located additional documents cited within these. These documents included statutes and regulations, reports, strategy documents, presentations, information or descriptions about programs or initiatives, frameworks, guidelines and manuals, program evaluations, appeal court case files, and committee evidence minutes produced by the Federal and Ontario ministries and departments of immigration, employment, and health, by professional associations, regulatory bodies, non-governmental organizations such as third-party assessment agencies, public policy think tanks, and academics.

Although I located a few key documents published before 2000, my analysis primarily focuses on those published between 2000 and 2024. There are three main reasons for choosing this time period. First, every one of my participants immigrated during this period. Since I take their experiences as the basis of my analysis, it makes sense to focus on the historical period they lived through. Second, in the early 2000s, there was a notable increase in attention and urgency surrounding the issues faced by IENs, resulting in a proliferation of documents on the topic during this period. Third, although I locate the problem of FCR as part of the long history of the gendered and racialized occupational segmentation of nursing, my access to policy documents from earlier decades was limited as most of these documents have not yet been digitized.

Keeping the WPR approach and questions in mind, I reviewed and analyzed over 800 documents. I coded them for themes using NVivo across over 40 nodes, which emerged inductively over the period of a year. In particular, I took notice of how internationally educated immigrants, including IENs, were discussed and in what context, the various initiatives and programs related to FCR, the framing and logic behind these, as well as which representations came to dominate and which were absent or marginalized. As I developed my analysis, some nodes became noticeably more populated and significant to my argument, such as: 'harmonization and coordination,' 'fairness and procedural justice,' 'strategies, initiatives, and programs,' 'regulatory bodies,' 'third-party agencies,' 'information barriers,' 'language barriers,' 'skill loss, mismatch,

or underutilization,’ ‘need for skills,’ ‘scope of practice and interprofessional collaboration,’ ‘competency-based approach,’ ‘unregulated care professionals,’ ‘workforce statistics,’ ‘care drain,’ ‘privatization,’ ‘patient or public safety,’ ‘resistance,’ ‘racism,’ and ‘disablement.’ I subsequently revisited the transcripts of my interviews to triangulate my findings.

6. Main Arguments

My critical policy analysis of federal and provincial IEN integration policies demonstrates that the dominant explanation for why IENs disproportionately experience this downward occupational mobility is not that entry-to-practice standards are problematic; on the contrary, the consensus is that these standards should be maintained and even strengthened, as they constitute indispensable and objective measures of nursing skill and public safety. Instead, integration issues are blamed on IEN skills being assessed in a procedurally unfair way (i.e., according to the principles of transparency, consistency, timeliness, and accountability), resulting in an ineffective and inefficient FCR process and the underutilization and eventual loss of their skills.

In *Chapter Two*, I discuss how these procedural fairness issues with the assessment process are primarily blamed on a lack of coordination and harmonization between federal immigration policies responsible for recruiting and admitting IENs into the country and provincial regulatory policies responsible for integrating IENs into the nursing profession. In *Chapter Three*, I discuss how issues with the assessment process are primarily blamed on poor regulatory oversight over provincial regulators. Within this problem framing, which blames how standards are being applied rather than the standards themselves, the understanding is that otherwise competent IENs are unfairly excluded from entry into the profession but that their swift integration should not come at the expense of lowering occupational standards.

To more effectively and efficiently sort IENs into occupations matching their skills, policy efforts have thus been primarily focused on improving skill recognition processes by making them more procedurally fair and enabling IENs to access these processes earlier, preferably pre-arrival. At the federal level, discussed in *Chapter Two*, one of the most significant policy efforts to improve IEN skill recognition was developing a standardized and centralized information and assessment centre exclusively for IENs called the National Nurses Assessment Service. At the provincial level, discussed in *Chapter Three*, the government of Ontario passed legislation establishing criteria and

an oversight body to ensure regulators and third-party assessment agencies respect international applicants' right to an assessment process that is transparent, timely, applied consistently using objective criteria and without regard to the applicant's particularities (e.g. their race, country of origin, or country of education and training), and appealable.

As I demonstrate, policy efforts within this problem framing, however, are not only insufficient, but they also further solidify the downward occupational mobility of IENs by making the licensing process increasingly selective and assimilative, meaning that there is heightened scrutiny of international applicants and access to the profession is limited to those who can meet the increasing demands for time, effort, and money to approximate Canadian nursing standards. This approach to integration, which represents a shift away from outright, racially explicit forms of exclusion towards race-neutral forms of managed integration based on selectivity and assimilation, is aligned with what Galabuzi (2004, p. 178) identifies as the three goals of immigration policy, which are responsible for deepening racial stratification in Canada: "managed growth" to prevent hardship to the existing workforce, "selectivity" by maintaining administrative categories of (un)desirability, and "assimilation" by heightening demand for specific skills in determining eligibility.

In *Chapter Four*, I trace this policy framing and approach to explicitly gendered and racialized governance strategies of the past, responsible for developing nursing as a profession for white women. In particular, I argue that the dichotomous construction of, on the one hand, IEN skills as undesirable and threatening and, on the other hand, Canadian nursing standards as indispensable and objective measures of nursing skill and public safety represents reconfigurations of long-standing ideologies, norms, policies, and practices related to the gendered and racial segmentation of nursing and care provision more broadly; not simply as unfortunate remnants of prejudice but as prominent features of settler-colonial capitalist structures. Despite claiming to be about improving integration, contemporary integration policy is actually a continuation of a long history of white nurses elevating their relative power and privilege through the continuous reassertion of masculinist and colonial norms and beliefs about skill and deservingness, and the subordination of feminized and racialized forms of labour, in part, to contend with the gendered subordination of their skills. Although racial segmentation may not afford nurses socioeconomic advancements akin to those in other male-dominated professions, it enables white nurses to play

an essential role in the colonial project of nation-building as reproducers of settlers, racial distinctions, and colonial beliefs and practices. Racial segmentation also facilitates the widespread availability of cheaper and more easily exploitable sets of subsidiary workers to meet the nation's growing social reproductive needs.

After locating the downward occupational mobility of IENs within the broader history of racial segmentation of nursing, in *Chapter Five*, I challenge the assumption underlying the current approach to FCR policy that facilitating IEN integration and protecting public safety are at odds. Contrary to the claim that gatekeeping IENs is about protecting public safety, I build on Gorman's (2016) disablement framework to examine how policies promoting IEN integration constitute a far more critical risk by (a) producing the disablement of IENs by channelling them into precarious, subsidiary healthcare occupations where they are exposed to greater levels of risk as this risk is rendered invisible and unmanageable; (b) producing the disablement of poor communities in the sending state by displacing and transforming care (broadly defined) to prioritize the healthcare needs of Canadians, while also effectively barring poor, disabled people from ever immigrating; and (c) facilitating the neoliberal privatization of care in Canada, which is intimately tied to the deterioration of care.

As such, the downward occupational mobility of IENs and its attendant policy initiatives, which socially construct their skills, must be understood not as a result of procedurally unfair assessment and recognition policies and practices. Similarly, their disablement must not be understood as a secondary effect of downward occupational mobility. Rather, their downward occupational mobility and disablement are essential sites of profitability and the reproduction of settler-colonial subjectivities as they make readily available a large group of highly educated, highly flexible, and exploitable workers so that disabled citizen subjects can continue to access care, albeit increasingly privatized.

After considering how integration policy affects not only IENs and their communities back home but also contributes to the deterioration of care conditions in Canada, in *Chapter Six*, I offer a radically different approach to integration that involves divesting from upholding nursing standards as a proxy for public safety and hierarchical notions of skill as a criterion for deservingness (i.e., as objective measures of safety and value). Instead, we need to put our efforts into approaches which, as described by Armstrong (2013, p. 258), reconceptualize skill by

incorporating not only formal credentials but also considerations of time, risk, and other factors in our skill assessment processes. My primary recommendation is to flatten job hierarchies in healthcare by closing the gaps in wages, benefits, and protections among practitioners; this is a fundamental shift that opposes the profitability-focused mindset prevalent in healthcare provision.

7. Chapter Outline

Although I analyze federal/national-level and provincial-level policies separately, this dissertation does not adopt a scalar approach per se; rather, I begin with the federal level, as immigration policy is an arena in which the federal government holds paramountcy and reflects the order in which IENs would usually encounter policies as they move through the integration process: an IEN usually first encounters immigration policy, which is primarily a federal responsibility, before applying to the provincial regulatory bodies that handle the last steps of the licensing process. Moreover, the policy responses I examined—the National Nurses Assessment Service and fair access legislation—roughly correspond to each level of government’s particular jurisdictional mandate. This is why *Chapter Two* and *Chapter Three* are dedicated to analyzing each level of government separately. Since these separate analyses reveal that federal and provincial policy initiatives share the same deep-seated assumptions about the problem of FCR, I tackle these assumptions together in subsequent chapters.

Chapter Two pursued questions one through four of my modified version of Bacchi’s (1999, 2009; Bacchi & Goodwin, 2016) WPR approach to federal-level FCR policy. The first part of the analysis begins by tracing how the problem of FCR became represented in federal immigration, health care, and labour market policy as a problem of lack of coordination and harmonization leading up to the development of the National Nurses Assessment Service. This assessment agency centralizes, standardizes, and streamlines the initial steps of the assessment process for IENs to address issues of transparency, consistency, timeliness, and accountability related to a lack of coordinated and harmonized FCR policy. While the development of this agency is touted as a successful initiative, this commendation starkly contrasts with the lived experiences of many IENs who express that it not only fails to improve integration substantially but also makes the licensing process stricter, lengthier, and more expensive.

In the second part of *Chapter Two*, I explore the deep-seated assumptions underlying the representation of the problem and their discursive and subjectification effects. I argue that framing the lack of coordination and harmonization as a procedural problem—i.e., one which could be addressed by providing better information and a streamlined and standardized assessment process—normalizes the notion that facilitating the swift integration of IENs and protecting public safety are inherently contradictory policy objectives. I contend that this framing of the problem reproduces the racialized dichotomization of nursing skills, which simultaneously renders IENs and their skills as undesirable and threatening to public safety, while positioning Canadian nursing standards as the desired norm and synonymous with public safety. This dichotomization, in turn, heightens the scrutiny and assimilation of IENs' skills and legitimizes resistance to their integration. The result is an increased burden (in terms of added time, effort, and cost) of navigating a complex system for individual IENs and discourages their swift integration in favour of a managed approach that prioritizes domestic supply, thus further entrenching their downward occupational mobility.

Chapter Three follows a similar methodological trajectory to *Chapter Two*, addressing questions one through four of the WPR approach but instead focusing on examining how the problem of FCR became represented at the provincial level, specifically in Ontario. It begins by tracing how the problem of FCR became represented as a problem of lack of fair access, leading to the passing of the *Fair Access to Regulated Professions and Compulsory Trades Act* in 2006. This statute establishes procedural criteria for regulators and third-party assessment agencies to ensure their registration practices are procedurally fair. It also establishes the Office of the Fairness Commissioner to oversee compliance. While fair access interventions are touted as improving the integration process by increasing access to the professions and making regulators accountable, this commendation contrasts with the lived experiences of IENs who continue to face a strict, lengthy, and expensive assessment process.

In the second part of *Chapter Three*, I explore the deep-seated assumptions underlying the representation of the problem and their discursive and subjectification effects. I argue that framing the lack of fair access as a procedural problem—specifically, a lack of oversight over regulators' entry criteria (or assessment methods)—as opposed to a problem located in entry-to-practice standards (or competencies), circumscribes policy interventions to procedural minutiae

and unenforceable recommendations, legitimizes Canadian nursing standards as universal and objective measures of skill and patient safety, and upholds regulators' power and position as the best arbiters of competence. Consequently, fair access interventions not only fail to improve integration substantially but, by painting the process with a veneer of fairness, also further obfuscate an increasingly selective and assimilative process; that is, one that heightens scrutiny of IENs by reproducing racialized dichotomies of skill and limits access to those IENs who can spend the necessary time, effort, and money to approximate Canadian nursing standards; thus further entrenching their downward occupational mobility.

Chapter Four explores the fifth and the first part of the sixth question of my modified WPR approach: What is left unproblematic in dominant representations of the problem of FCR, and what are the silences? How can the problem of FCR be reconceptualized, disrupted, or replaced? Building on Armstrong's (2013) feminist political economy analysis of the social construction of skill, this chapter tackles one of the unproblematic assumptions underlying the representations of the problem of FCR established in the previous chapters: the racialized dichotomization of nursing skills, which depicts IENs and their skills as undesirable and threatening, while Canadian nursing skills are framed as objective and universal measures of skill and patient safety. Through a brief historical overview of the development of nursing as a racially segmented occupation, I demonstrate that this dichotomous depiction is a reconfiguration of long-standing mechanisms of control mobilized against racialized women. In particular, I argue that white nurses have consistently elevated their relative power and privilege through the law and institutions, in part to contend with the gendered subordination of their skills. This process involves the continuous reassertion of masculinist and colonial norms and beliefs about skill, and the subordination of labour historically associated with poor and racialized women. Compared to the racially explicit exclusionary methods of the past, the goal within the current regulatory regime is "managed" or constrained integration through selectivity and assimilation, mystified through race-neutral discourses such as the appeal to protect public safety and respect applicants' right to a fair assessment. This approach allows me to understand the downward occupational mobility of IENs as not simply an unfortunate remnant of prejudice but rather as foundational to developing, expanding, and maintaining the settler-colonial capitalist state.

Chapter Five also pursues the fifth and the first part of the sixth question characteristic of the WPR approach, focusing on the second related unproblematic assumption underlying the representations of the FCR problem: the swift integration of IENs and protecting public safety as inherently contradictory goals. On the contrary, building on Gorman's (2016) disablement framework, I argue that policies promoting IEN integration constitute a more significant threat to public safety by producing the disablement of IENs and poor communities in sending states, and by facilitating the neoliberal privatization of healthcare, which is intimately tied to the deterioration of conditions of care. Rather than epiphenomenal effects, the downward occupational mobility of IENs and the production of disablement are persistent features of Canadian integration policy because they support the conditions (i.e., making available a reserve army of highly educated, flexible, cheap workers) to facilitate disabled citizen-subjects' access to care, albeit in ever-dwindling, privatized conditions. Notwithstanding the relative privilege that integration policy provides to citizen-subjects, I argue we all (except those interested in profiting from healthcare) have a vested interest in a radically different approach to integration that involves divesting from upholding nursing standards as a proxy for public safety and hierarchical notions of skill as an objective measure of value and deservingness.

Chapter Six begins by summarizing each chapter's findings and considering the implications of my research for the most recent changes made to integration policy. Subsequently, corresponding to the second part of the WPR question about what can be done to challenge and mitigate the adverse effects of dominant representations, this chapter also articulates recommendations and discusses further areas of study. While the most recent changes made to IEN integration policy, such as admitting passing the NCLEX-RN as proof of educational equivalence and the introduction of employment placements to help IENs meet evidence of practice requirements, translate into thousands of IENs accessing the upper tiers of nursing much faster, I argue that these changes have opened up new opportunities for exploitation. In particular, they reflect a growing, "market-driven convergence" in healthcare and risk only fueling the deterioration of care conditions by failing to address the underlying issues for nurses' high attrition rates and pitting nurses against each other. Building on Armstrong's (2013) reconceptualization of skill, I make a case for a radically different approach to integration that involves (a) divesting from upholding nursing standards as a proxy for public safety and skill as an objective measure of value and, instead, (b) factors in time, risk, and other demands

(e.g. how tedious and repetitive some jobs can be) into how we assess skills in addition to formal education and training; and, (c) shifts how we govern skill towards developing capacities that are actually needed for a given job to meet the social reproductive needs of society instead of profitability. In the immediate term, I recommend easing evidence of practice requirements for IENs in recognition that they utilize their nursing skills when practicing as PSWs. In the long term, I recommend flattening job hierarchies by closing the disparities in wages, benefits, and protections among different healthcare practitioners.

CHAPTER TWO

“The System is Fragmented from the Beginning”: The Problem of Foreign Credential Recognition as Lack of Coordination and Harmonization

Introduction

In this chapter, I focus on how the problem of FCR became represented in immigration and labour market policies at the federal level. In the early 2000s, a lack of coordination and harmonization of policy related to the assessment and recognition of foreign credentials emerged as one of the dominant explanations for why so many IENs failed to integrate. More specifically, there was a lack of coordination (i.e., ongoing collaboration, communication, and information sharing) between federal governance bodies and institutions³¹ responsible for recruiting and selecting IENs for immigration and provincial regulatory policies responsible for assessing and recognizing their credentials. This lack of coordination inhibited the development and implementation of a consistent approach to assessing and recognizing their credentials. As a result, IENs were recruited and immigrated to Canada expecting to practice as nurses. However, upon arrival, they were confronted with confusing, incoherent, and fragmented credential assessment and recognition processes described as “analogous to entering a large and complex maze” (Jeans et al., 2005, p. 43). They struggled to get the right information from immigration officials and Canadian regulators about how to become licensed, duplicated their efforts and costs when applying to be assessed as different classes of nurses and/or to practice in multiple provinces, and were subject to inconsistent assessments from different provincial regulators and agencies. To make matters worse, the support available to help IENs with integration—such as mentorship and bridging programs—was also sporadic and uneven. The great deal of effort, time, and money required to navigate this complex and inconsistent process thus acted as the “first in a series of barriers,” as many took years to get licensed or stopped trying altogether (p. 24).

³¹ Governance bodies identified in policy documents include the relevant ministries and departments at all levels of government, regulatory bodies, professional associations, immigrant serving organizations (ISOs), third-party assessment agencies, educational institutions, and employers.

In response to these difficulties faced by IENs, federal policy focused on facilitating coordination and harmonization between the relevant governance bodies. Coordinating and harmonizing policy, however, would require navigating a jurisdictionally complex field: there were hundreds of governmental bodies and agencies involved in FCR, each with their own and, at times, competing mandates. In particular, it meant contending with the fact that provincial regulators acting at arms-length from the government had the sole authority to establish and maintain occupational standards. The approach of the federal government was two-fold. First, it would provide centralized sources of information about the regulatory system and the Canadian labour market and “path-finding” services that IENs could access pre-arrival. These would help them manage their expectations and navigate the complexities of the licensing process so they could prepare requirements for entry into their occupation in advance or identify how their skills could be transferable to other jobs. Second, it would facilitate streamlining and standardizing FCR processes across provinces to make these processes more efficient and consistent. A handful of initiatives and programs were developed within this problem framing, but the National Nursing Assessment Service (NNAS) is the most significant for IENs.

NNAS is an assessment agency that serves as a centralized source of information and the first point of contact for all IENs seeking licensure within any of the nine jurisdictions in Canada³² and for any of the three classes of nurses.³³ The development of this agency standardized and streamlined the early steps of the assessment process to help minimize confusion and allow IENs to prepare requirements in advance, make assessments coherent, reliable, and thus acceptable across provinces, and facilitate a more efficient allocation of resources. In other words, the aim is to improve IEN integration rates by making their credentials’ initial validation and assessment more transparent, consistent, and timely within a framework that respects the provincial regulators’ authority to determine and maintain entry-to-practice standards as part of their mandate to protect public safety.

From the beginning, nursing regulators, associations, and program evaluators have touted NNAS as a successful initiative by pointing to the high level of collaboration required to develop it, the transparency, consistency, fairness, and efficiencies introduced to the assessment process,

³² With exception of Québec, Yukon, Nunavut, and the Northwest Territories.

³³ The three classes of nurses in Canada include Registered Nurses, Licensed or Registered Practical Nurses, and Registered Psychiatric Nurses.

and the steadily growing demand for its services. This commendation, however, stands in stark contrast with the lived experiences of many IENs who express that NNAS has not only failed to improve integration issues substantially but has also made the licensing process more strict, lengthy, and expensive. Rather than characterizing NNAS as an empty promise or an initiative poorly implemented, the WPR approach instead asks to analyze the deep-seated assumptions underlying the framing of the problem.

In this chapter, I am interested in how framing the lack of coordination and harmonization of FCR policy (and its associated issues of lack of transparency, consistency, timeliness, and accountability) as a problem that could be mitigated through procedural fixes (i.e., by providing better information and a streamlined and standardized assessment process) normalizes the notion that facilitating the swift integration of IENs and protecting public safety are inherently contradictory policy objectives. I argue that this framing of the problem reproduces the racialized dichotomization of nursing skills, which simultaneously renders IENs and their skills as undesirable and threatening to public safety and Canadian nursing standards as the desired norm and synonymous with public safety. This dichotomization, in turn, heightens the scrutiny and assimilation of IENs' skills and legitimizes resistance to their integration. The result is an increased burden (in terms of added time, effort, and cost) on individual IENs navigating a complex system and discourages their swift integration in favour of a "managed" approach that prioritizes domestic supply, thus further entrenching their downward occupational mobility.

This chapter's analysis applies questions one through four of my modified version of Bacchi's (1999, 2009; Bacchi & Goodwin, 2016) WPR approach to federal-level FCR policy: (1) What is the problem of FCR represented to be in federal policies related to the immigration and labour market integration of IENs? (2) How and where has this representation been produced, disseminated, and defended? (3) What are the deep-seated assumptions about this representation? (4) What are the effects (discursive, subjectification, lived) of this representation? Specifically, how has this representation framed or imposed limits on what can be said about the issue? How are IENs and their skills constituted in relation to domestically educated nurses? How has it impacted the lived reality of IENs?

The first part of the analysis begins by tracing how the problem of FCR became represented in federal immigration, health care, and labour market policy as a problem of lack of coordination

and harmonization leading up to the development of NNAS. To motivate and ground the subsequent analysis, the first section concludes by discussing some of the lived effects of NNAS on IENs. In part two, I explore the deep-seated assumptions underlying the representation of the problem and their discursive and subjectification effects. The second section concludes by discussing some of the silences in this problem representation, corresponding to question five of the WPR approach. However, I do not tackle these silences more substantially until *Chapter Four* and *Chapter Five*.

PART ONE

1. The Problem of FCR: A Problem of Lack of Coordination and Harmonization

In Bourgeault's (2006) analysis of the demographic and policy contexts of nurse migration in and out of Canada, she points out that in the early 2000s, as the focus shifted away from preventing the emigration of nurses to increasing the effective and efficient integration of immigrant nurses, the "lack of coordinated policy for health labour immigration [became] much more salient in the political landscape across Canada" (2006b, p. 7). Indeed, upon examining hundreds of documents in the realms of immigration, health care, and labour market policy, the lack of coordination and harmonization—between federal and provincial policies and between provincial assessment practices themselves—is consistently offered as one of the main reasons why so many highly-educated immigrants, such as IENs, fail to become fully integrated into the Canadian nursing market. While this chapter focuses solely on NNAS, as it is by far the most important product of the desire for increased coordination and harmonization of policies affecting the assessment of IEN credentials, it is important to note that its development occurred within a broader policy context.

In health care policy, the representation of the problem of FCR as a lack of coordination and harmonization can be found in the two seminal health policy reports of the turn of the century, the Kirby Report (2002) and the Romanow Commission (2002). These reports blamed issues such as inter-provincial competition for domestic and international graduates and the failure to integrate internationally educated healthcare professionals on the absence of a coordinated and harmonized healthcare labour policy strategy. Although these reports discouraged increasing the "active" and "unethical" recruitment of nurses, especially from countries facing shortages, they maintained that it was important to integrate IENs already in Canada. To this end, the Kirby Report recommended "examining the possibilities for greater coordination of licensing and immigration requirements between the various levels of government" (Kirby, 2002, p. 190). Meanwhile, the Romanow Commission recommended streamlining the assessment and recognition of credentials to reduce delays caused by the system's complexity and to provide additional training when necessary (Romanow, 2002, p. 102).

In the realm of immigration policy, in numerous studies and reports between 2002 to 2005 by the Standing Committee on Citizenship and Immigration (CIMM), immigrants and immigrant-serving organizations consistently targetted the dissonance between immigration policies and labour market integration policies as giving high-skilled immigrants the false impression that they would be able to work in their field of expertise upon arrival, only to find that their credentials were not recognized for the purposes of licensing and employment (*CIMM* 25, 2005; *CIMM* 44, 2005; Fontana, 2002a, 2002b, 2003). Many such organizations called this lack of policy coordination and harmonization “immoral,” especially considering previous immigrants had not faced such circumstances (*CIMM* 25, 2005). The Committee concurred that immigrants’ expectation to work in their field upon arrival is “not an unreasonable assumption,” acknowledged the impacts of policy dissonance on their capacity to translate their education into an economic advantage and integrate into Canadian society, and validated their disillusionment and feeling that their skills were being wasted (Fontana, 2002a, p. 15).

To help mitigate these impacts, although also likely out of a growing concern for liability,³⁴ the Committee recommended that applicants for permanent residence be required to sign form IMM 1455³⁵ to confirm their understanding that gaining entry to the country would not guarantee entry to their profession or occupation (Fontana, 2002b). In recognition that more substantial efforts were needed to facilitate integration, the Committee also recommended the establishment of a federal office to coordinate the federal, provincial and territorial bodies involved in the assessment of foreign credentials and to help identify existing barriers to licensing (Fontana, 2002a, 2002b, 2003).

Meanwhile, in the realm of labour market policy, in several studies and reports by the Standing Committee on Human Resources Development and the Status of Persons with Disabilities (HUMA), the “absence of a national system for recognizing foreign credentials” was identified as an issue that “surfaced frequently” among immigrants (Longfield, 2002, p. 21). In a

³⁴ In 2003, an immigrant couple sued the Government of Canada for being misled and not properly informed about the lack of recognition of their credentials, and litigation funds had to be put aside in case other immigrants would seek similar redress (*CIMM* 79, 2003; Jimenez, 2003).

³⁵ The IMM 1455 form reads: “I fully understand that the issuance of an immigrant visa to me in no way assures my eventual acceptance into the practice of my profession or occupation in Canada. I realize that such acceptance is at the sole discretion of the licensing authority in the province in which I wish to work or practise. I further understand that acceptance by the licensing authority in any province or provinces of Canada is not an assurance of acceptance in other provinces” (Fontana, 2002b, p. 27).

2002 study cited in one of the hearings entitled *Fulfilling the Promise: Integration Immigrants Skills into the Canadian Economy*,³⁶ it was pointed out that while some initiatives assisting immigrants in entering the Canadian labour market were “excellent” and could be “used as models for more systemic implementation,” they were, for the most part, ad hoc, pilot, short-term projects that only serve specific occupations in very few locations (Alboim, 2002, p. 1).

The study recommended implementing a comprehensive and integrated system that would begin overseas by providing accurate information about the Canadian labour market and professions’ specific entry requirements and offering self-assessment tools and opportunities to upgrade qualifications if necessary. To develop this system, however, “there need[ed] to be new relationships between departments and levels of government” as well as “increased horizontal and vertical coordination” (McIsaac, *HUMA* 25, 2003). The Committee subsequently recommended encouraging visa officers to inform immigrants pre-departure to contact the relevant certification organizations and that the Federal government “vigorously pursue discussions with provincial and territorial governments and professional associations to develop a system for recognizing foreign credentials, while recognizing provincial jurisdiction in this matter” (Longfield, 2002, p. 23).

These calls for greater coordination and harmonization of FCR policy were followed by three main initiatives developed in collaboration with and operating across the federal departments responsible for immigration, health care, and labour market policy. In 2003, the Federal government launched the Foreign Credential Recognition Program (FCRP) to operate under the Department of Human Resources and Skills Development Canada (currently known as Employment and Skills Development Canada). Its mandate is to fund programs and projects that “facilitate the entry of foreign-trained professionals into the labour market and their mobility within it by developing a pan-Canadian approach to assessing and recognizing a range of foreign credentials” (Jeans et al., 2005, p. 25).

³⁶ This study consisted of an environmental scan of the projects and programs assisting immigrants in entering the Canadian labour market and feedback gathered via one-on-one interviews, focus groups, and conference presentations and discussions from dozens of immigrants and representatives from colleges, universities, regulators, service providers, employers and governments (Alboim, 2002). It was conducted by the Caledon Institute of Social Policy, a social policy think-tank funded by the Maytree Foundation. The Maytree Foundation also funds the CARE Centre for Internationally Educated Nurses.

In 2005, as part of Health Canada's Health Human Resources Strategy,³⁷ the Federal government launched the Internationally Educated Health Professionals Initiative to “support health human resource projects focused on maintaining and optimizing the health system's workforce and integrating internationally educated health professionals” (Health Canada, 2008, p. 7). Both of these initiatives, the FCRP and the Internationally Educated Health Professionals Initiative, also form components of the broader Internationally Trained Workers Initiative,³⁸ which is a “coordinated strategy to bring the skills and experience of internationally trained professionals into the Canadian labour market” (Government of Canada, 2005; Jeans et al., 2005).

In 2007, the Federal government launched the Foreign Credential Recognition Office³⁹ under the Department of Citizenship and Immigration Canada (currently known as Immigration, Refugees and Citizenship Canada). This office was founded over an identified need by “key stakeholders” for an organization that would “respect jurisdictions; complement but not duplicate existing programs and services; fill gaps in the [FCR] process; collaborate with provinces, territories and stakeholders; engage employers; and reach prospective immigrants overseas early in their immigration process” (FCRO, 2008, pp. 5–6). At launch, this office offered immigrants information, pathfinding, and referral services through its website (credentials.gc.ca), phone, or in person at Service Canada centres. However, since 2010, it primarily funds pre-arrival support

³⁷ The Health Human Resource Strategy is a component of the Health Care Policy Contribution Program, and it is one of the primary initiatives to come out of the 2004 Health Accord, entitled *A 10-year Plan To Strengthen Health Care*. The Accord was a shared agenda or action plan developed by the First Ministers, which committed governments to collaborate to improve access to healthcare and reduce wait times through various means, including investments to increase the supply of healthcare professionals (Health Canada, 2006). Two key projects receiving funding from the Internationally Educated Health Professionals Initiative relevant to IENs include the Access Centre and the Canadian Association of Schools of Nursing Accreditation Program. See Appendix D: Overview of Other Federally-Funded FCR Initiatives for a further description of these two projects.

³⁸ The Internationally Trained Workers Initiative comprised several components: the FCRP, the Internationally Educated Health Professionals Initiative, the Going to Canada Immigration Portal, and funding for language training and the Canadian Heritage's Action Plan Against Racism (Government of Canada, 2005, 2018). The Going to Canada Immigration Portal consisted of two interlinked websites: the Going to Canada site (goingtocanada.gc.ca), operated by Citizenship and Immigration Canada, and the Working in Canada site (workingincanada.gc.ca), operated by Human Resources and Skills Development Canada. However, since 2011, both websites have begun redirecting visitors to the Immigration, Refugees and Citizenship Canada and JobBank websites. Canadian Heritage's Action Plan Against Racism was a five-year plan (2005-2010) to combat discrimination in the workplace. However, after the 2010 evaluation of the program, limitations in the plan's design and delivery were identified, and in measuring the overall impact, the federal government did not renew or replace the action plan until 2019. While the 2005 plan included a \$1 million investment in supporting FCR, the 2019 plan does not offer any funding concerning FCR (Canadian Heritage, 2005, 2019; CIC - Evaluation Division, 2010).

³⁹ See Appendix D: Overview of Other Federally-Funded FCR Initiatives for further description of this initiative.

programs such as the Canadian Immigration Integration Project, currently known as Planning for Canada.⁴⁰

Stemming from these broader initiatives, three key collaborative projects are relevant to the development, implementation, and evaluation of NNAS: (1) the 2005 study *Navigating to Become a Nurse in Canada: Assessment of International Nurse Applicants*, which identified the need for a centralized agency to provide information and conduct assessments, (2) the subsequent project *Moving Ahead: Assessment of Internationally Educated Nurses* that took place between 2009 and 2011, where regulators worked together to harmonize registration requirements; and (3) the 2009 *Pan-Canadian Framework for Foreign Qualification Recognition*,⁴¹ which established the fundamental principles, priorities, and desired outcomes guiding the FCRP and the projects it funds.

2. Addressing Lack of Coordination and Harmonization in IEN Assessments

The 2005 study *Navigating to Become a Nurse in Canada: Assessment of International Nurse Applicants* was funded by the FCRP and completed through the collaborative efforts of several nursing regulatory and professional associations, as well as representatives from the federal and provincial departments of immigration, health, and employment. It consisted of a diagnostic analysis of the policies, practices, and procedures used by nursing regulatory bodies across the country to assess IENs, and it included findings from focus group discussions with IENs about the barriers they faced to integration.

According to this study, because 23 of the 25 regulatory bodies across the country conducted their own initial authentication and assessment of nursing credentials, a lack of coordination and harmonization was “leading to [a] duplication of effort and costs” (Jeans et al., 2005, p. 50). IENs would sometimes apply to the wrong regulator or repeat the process several times when applying in different provinces. The study also noted examples of nurses found ineligible in one province but eligible in another. This lack of consistency, which also plagued assessments conducted by third-party agencies, was inefficient and could ultimately undermine the integrity of the process and threaten public safety by encouraging applicants to “shop around”

⁴⁰ See Appendix D: Overview of Other Federally-Funded FCR Initiatives for further program description.

⁴¹ The 2009 Framework was drafted by the Foreign Qualifications Recognition Working Group, overseen by the Forum of Labour Market Ministers, a group composed of federal, provincial, and territorial ministers, deputy ministers, and officials with labour market responsibilities. The working group was provided with \$50 million by FCRP to guide and support the implementation of the 2009 Framework (FLMM, 2014).

for a preferable assessment. The lack of communication between regulators made it difficult to accurately track the number of applicants nationally, further hindering government human resource planning.

The study offered nine recommendations⁴² intended to “improve the process of immigration for IENs, reduce duplication of effort and burden on nursing regulatory bodies, increase the supply of nurses, and facilitate their integration into the Canadian nursing workforce” (Jeans et al., 2005, p. 50). The development of NNAS corresponds to two recommendations in particular: (1) to establish a “national assessment service to create a standard evidence-based approach to the assessment of IENs that includes educational preparation, Prior Learning and Assessment Recognition,⁴³ clinical competency through supervised practice or an Objective Structured Clinical Examination, and a standard language test such as Canadian English Language Benchmarks Assessment for Nurses;” and (2) to develop a “central source of information such as a Web site specific to IENs to access complete and easily understood information related to immigration, nursing licensure/registration, and the Canadian nursing workforce” (Jeans et al., 2005, pp. 6–7).

Implementing these recommendations was expected to achieve many goals. It would minimize confusion and improve human resource planning by centralizing the provision and collection of information on IENs. It would facilitate a more efficient allocation of resources by eliminating unnecessary duplication, inconsistencies, and costs associated with licensing. It would standardize a competency-based assessment approach, accounting for educational credentials, employment experience, and clinical competency. It would further add legitimacy to the

⁴² The report’s nine recommendations are summarized as follows: 1) the establishment of a national assessment service; 2) the acceleration of the national and international implementation of the standard language test (the Canadian English Language Benchmarks Assessment for Nurses or CELBAN); 3) consensus on a principled, comprehensive, and collaborative approach to assessment and recruitment; 4) nationally-standardized flexible bridging programs; 5) review of existing bridging programs to develop standardized programs; 6) develop strategies to address financial challenges faced by IENs; 7) a centralized source of information related to immigration, licensing, and the Canadian nursing workforce; 8) standardized record-keeping; and, 9) a national unique identifier for all nurses, including IENs.

⁴³ Prior Learning Assessment Recognition is also known as Previous Learning Assessment Recognition or Recognition of Prior Learning. While some version of this type of assessment can be traced to the 16th century, in Canada it emerged in the 1980s as a means to enable adults to earn academic credit based on their previous knowledge and experience. The assessment relies on multiple tools such as self-assessment, oral interviews, structured simulations and demonstrations, examinations, and others to assess the competence of individuals (CAPLA, 2011; Guo & Shan, 2013).

assessment process by ensuring correct nursing designation.⁴⁴ And it would allow IENs to begin the overseas assessment process, thus mitigating false expectations and streamlining the post-arrival integration process. Overall, a national assessment service was touted as the best way to improve the success rate for IENs while also allowing policymakers to reliably track the number of IENs in the country (Jeans et al., 2005).

In 2009, the CNO received over \$776 thousand in funding from the FCRP to collaborate with other nursing regulators to act on the recommendations of the study in a two-part project called *Moving Ahead: Assessment of Internationally Educated Nurses* (Government of Canada, 2010; Shaffer et al., 2016, pp. 52–53). The first part of the project involved preliminary research on regulatory bodies’ registration and assessment practices to develop a “more efficient, user-friendly process for both IENs and the regulatory bodies” (Shaffer et al., 2016, p. 52). In the second part of the project, regulatory bodies across Canada worked together to “harmonize national registration requirements” for IENs and to develop a database of international nursing education programs that would provide a “fairer and faster assessment of international education” (Government of Canada, 2010). Registrar and Chief Executive Officer of the College of Registered Nurses of British Columbia and Chair of the National Nursing Assessment Service Steering Committee, stated that this initiative would “foster greater labour mobility, retention and recruitment of licensed nurses while helping to reduce some barriers currently faced by internationally educated applicants” (Government of Canada, 2010).

In 2009, the federal government also launched the *Pan-Canadian Framework for Foreign Qualification Recognition* (hereafter, the 2009 Framework). The 2009 Framework is a document that articulates a “new, joint vision for governments to take concerted action to improve the integration of immigrants and other internationally-trained workers into the Canadian labour market” (FLMM, 2009, p. 4). Unlike the recently amended Agreement on Internal Trade,⁴⁵ the

⁴⁴ Prior to NNAS, nursing regulators relied on external credentialing services to assess the legitimacy and authenticity of the applicant’s documents, primarily the International Qualifications Assessment Service which is an Alberta government service designated by the Federal government to provide Educational Credential Assessment (ECA) for Express Entry. However, regulators had stated, “fairly emphatically, that these services [could not] evaluate the nursing content of programs” (Jeans et al., 2005, p. 29).

⁴⁵ In 2009, the federal, provincial, and territorial governments agreed to amend the 1994 Agreement on Internal Trade to achieve full labour mobility for workers in regulated professions and trades. Chapter 7 of the Agreement, as amended, required that recognition of credentials (whether domestic or foreign) in one jurisdiction is respected, upon application, in another jurisdiction if the worker wishes to relocate (albeit some exceptions allowed for public,

2009 Framework is not a legally binding document. Nonetheless, it communicates a public commitment by all levels of government, regulatory authorities, and other bodies and agencies involved in assessing and recognizing foreign credentials to adhere to the principles of “transparency,” “consistency,” “timeliness,” “fairness,” and “collaboration” on the basis of respecting the jurisdictional autonomy of regulatory authorities to recognize qualifications and set occupational standards (FLMM, 2009; Komarnicki, 2012). At the recommendation of Health Canada, the 2009 Framework also establishes nursing as one of the targeted priority occupations.⁴⁶ Together, the 2005 study, the two-part project, and the 2009 Framework provide the infrastructure upon which NNAS was developed, implemented, and evaluated.

3. The Role and Mandate of NNAS

Since 2014, NNAS has acted as the primary point of contact for all IENs seeking licensure within any of the nine jurisdictions in Canada it is mandated to operate within.⁴⁷ It is a fully virtual organization representing 18 regulatory bodies and governed by a 12-member board of directors representing the three regulated nursing groups: registered nurses, licensed (or registered) practical nurses, and registered psychiatric nurses. It operates on a fee-for-service business model to “ensure viability and sustainability,” but it is categorized as a non-profit organization (Shaffer et al., 2016, p. 53). Its mandate is to “coordinate a consistent national approach to the assessment of internationally educated nurses’ education credentials to support registration/licensure by the provincial nursing regulatory bodies” (NNAS, 2021a, p. 17).

NNAS fulfills its mandate by conducting the first four steps of the assessment process: (1) online registration, payment⁴⁸ and form completion; (2) receiving and storing of all documentation; (3) validation and authentication of documents provided by the IEN outlining their

consumer, or environmental protection) (FLMM, 2009) By 2012, most regulators had revised their regulations accordingly (OFC, 2012a).

⁴⁶ At the recommendation of Health Canada, five of the first set of eight targeted priority occupations and four of the six on the second set are in the field of health (Komarnicki, 2012, p. 7).

⁴⁷ With exception of Québec, Yukon, Nunavut, and the Northwest Territories.

⁴⁸ According to NNAS Applicant Handbook (2020b), the fee for the main application order, which includes an advisory report for one nursing group for one province, is \$650. Applying to an additional province is \$55 and to an additional nursing group is \$220. The fee expires after 12 months if all required documents are not submitted after that time and re-activation costs an additional \$180. If documents need to be translated, NNAS charges \$85 per page. Appeals cost \$500, are handled internally, and are only refunded if the appeal is successful. All other fees are non-refundable.

education, language and employment history;⁴⁹ and (4) an assessment of comparability or equivalency to Canadian standards for entry-to-practice, which is completed through a comparative analysis of curriculum content to determine if the applicants' education is *comparable*, *somewhat comparable*, or *not comparable* to the national entry-to-practice standards or competencies.

Importantly, NNAS does not conduct the comparability assessment itself. Instead, the Commission on Graduates of Foreign Nursing Schools International—an American organization created in 1977 to evaluate, test, and certify Filipino IENs before migration into the US—holds the contract to conduct the assessments.⁵⁰ This organization reviews and stores documents, verifies their authenticity, ensures all the required documents have been submitted, determines compatibility with Canadian standards, and sends documents to the designated regulatory body or bodies.

After completing these four steps, NNAS prepares an advisory report for the regulatory body or bodies where the applicant wants to get licensed, identifying whether the applicant's education is equivalent to that of a domestically-trained nurse (NNAS, 2015, p. 8). For those applicants whose education is determined to be not comparable, the regulatory bodies can offer alternative ways applicants can fill competency gaps, such as completing further education, training, assessment, or work experience.⁵¹

⁴⁹ IENs are required to submit two forms of identification that are notarized, and all documents outlining educational credentials and employment history which have to be sent directly from the institution (NNAS, 2020b).

⁵⁰ According to its website, the Commission on Graduates of Foreign Nursing Schools International was established following the recommendations of two national studies assembled to examine why many IENs failed the US licensure exam. It continues to operate as an “independent, non-profit, immigration-neutral organization.” It is the only organization authorized to screen and certify healthcare professionals seeking occupational visas covered under Section 343 of the 1996 Illegal Immigration Reform and Immigrant Responsibility Act. Along with the International Council of Nurses, it founded the International Centre on Nurse Migration in 2005 to serve as a “portal for policy, research and other information regarding global nurse migration trends and statistics.” In 2013, it was commissioned by the ILO to conduct a “comparative study of nursing education in the Philippines and that of Norway, Denmark, and Finland” under the Decent Work Across Borders Program and was granted consultative status to the United Nations in 2015 (CGFNS International, 2021).

⁵¹ For instance, applicants to the College of Nurses of Ontario whose education is not deemed equivalent have the option of taking the IEN-CAP, an Objective Structured Clinical Exam (OSCE) which includes a multiple choice test and a structured clinical examination (this option is only available for RNs); can complete a self-report which provides information about the application of competencies in a practice setting (this option is only available to RPNs); or, since June 2020, complete the NCLEX-RN (only eligible if taken after 2013) (CNO, 2016c).

In sum, the role and mandate of NNAS is to act as a centralized hub of information and primary assessment body for all IENs seeking licensure in Canada. It seeks to improve the integration process by making the initial steps of the assessment process more streamlined and consistent across regulators and accessible prior to immigration.

4. How is NNAS Evaluated and Rationalized Relative to its Effects, as Experienced by IENs?

The objective of the WPR approach is not to “assess the distance between promised changes and the failure to deliver those changes,” meaning it is “not contrasting stated ‘solutions’ with stated ‘problems,’ and finding the ‘solutions’ wanting” (Bacchi & Goodwin, 2016, p. 21). However, we can further investigate the implicit problematizations in said solutions by examining how different policy actors evaluate and defend them, especially relative to how policy subjects experience them. Since its incorporation, NNAS has been broadly represented by nursing regulators and associations, NNAS representatives, and program evaluators as a successful initiative in accordance with the principles outlined in the 2009 Framework, which stands starkly in contrast to the lived experience of IENs.

For instance, as the agency was being incorporated, the Director of the College and Association of Registered Nurses of Alberta praised the level of collaboration required to develop it:

When the project first started, I was extremely skeptical that we would come to consensus on anything. However, by getting people together in a room for a common purpose over time, we've seen that we have all agreed on what sort of portfolio information should be presented to any regulator for consideration of eligibility for registration. That sounds like a small thing, but it was a tremendous hurdle for all of us to overcome (Giblin, *HUMA 10*, 2011, p. 5).

She further praised NNAS' potential to address duplication and discoordination of services and information and said it “put the best use of available resources at the forefront” (Giblin, *HUMA 10*, 2011, p. 5).

After one full year of operations, regulators and representatives of NNAS commended the coherence and efficiencies it introduced to the assessment process. For instance, NNAS representatives claimed that its “streamlined approach” to the application process had “reduced

the application workload for IENs, compared to the system prior to NNAS' establishment," as well as "reduced workload for our [regulatory body] members in the form of IEN inquiries, and calls and reduced file and document tracking and management" (NNAS, 2016, p. 5). The Executive Director of the Association of Registered Nurses of Prince Edward Island similarly commended the "total success" of NNAS in "creating a standardized approach to assessing education" and laying a "great foundation that can be further built upon in the vision towards harmonization (NNAS, 2015, p. 10). This support for NNAS was further solidified by a 2016 CNO decision to no longer challenge the findings of the advisory report.⁵² In particular, the CNO council stated that it had "come to the determination that the tool [was] valid and [was] the most fair and consistent way of assessing applicants as a first step in the assessment process" (CNO, 2016d, p. 6).

NNAS also asserts that it has improved the assessment process through various performance metrics. In particular, it points to the increasing volume of applications filed,⁵³ advisory reports issued,⁵⁴ IENs applying to more than one nursing discipline,⁵⁵ inquiries, improvements made in the average processing time for applications,⁵⁶ high levels of IEN satisfaction,⁵⁷ and the organization's financial sustainability.

⁵² During the first two years after launching, over an abundance of caution, the CNO warned applicants that it could challenge the findings of the advisory report, which meant they would have to submit additional information. However, on September 2016, CNO council determined that only applicants who did not meet the requirement educational equivalence by NNAS would undergo further assessment (CNO, 2016d, p. 6).

⁵³ The number of applications initiated from 2014 to 2015 was 4027. From 2015 to 2016 it was 5278. From 2016 to 2017, NNAS has listed three different figures: 5488 in the 2017 report, 5289 in the 2018 report, and 5378 in the 2019 report. From 2017 to 2018 it was 6217. From 2018 to 2019 it was 6679. From 2019 to 2020 it dropped to 6250. And, increased again from 2020 to 2021 to 6969 (NNAS, 2015, 2016, 2017, 2018, 2019, 2020a, 2021a).

⁵⁴ From 2016 to 2017 there were 7590 advisory reports issued. From 2017 to 2018, NNAS has listed two different figures: 7801 in the 2018 report and 6891 in the 2019 report. From 2018 to 2019 there were 7123. From 2019 to 2020 there were 8360. And, from 2020 to 2021 there were 8491 (NNAS, 2017, 2018, 2019, 2020a, 2021a).

⁵⁵ From 2014 to 2015, the number of IENs who applied to more than one nursing discipline was 447. From 2015, 2016, it was 1547. From 2016 to 2017, NNAS has listed two different figures: 1986 in the 2017 report and 2260 in the 2018 report. From 2017 to 2018, NNAS has listed two different figures: 2934 in the 2018 report and 1939 in the 2019 report. From 2018 to 2019, NNAS has listed two different figures: 2166 in the 2019 report and 3432 in the 2020 report. From 2019 to 2020, it dropped to 3342. And, increased again from 2020 to 2021 to 3417 (NNAS, 2015, 2016, 2017, 2018, 2019, 2020a, 2021a).

⁵⁶ The average processing time for applications after all documentation was received in 2014 was 14.5 weeks, 12 weeks by 2016, and 10 weeks by 2017 (NNAS, 2016, 2017). In 2018, there was a change in how the average IEN report delivery time was reported, but NNAS indicated some slight improvements from the previous year. From 2019 to 2020, there was a slight increase in the average time, which NNAS attributed to the "high volume of applications" and the "added complexity that some reviews require and a refinement in the way this indicator is measured" (NNAS, 2020a, p. 4). However, from 2020 to 2021, a "notable improvement" was expected to continue with 85% of reports issued within 12 weeks (NNAS, 2021a, p. 4).

⁵⁷ Percentage of IENs who strongly agreed or agreed that their overall experience with NNAS had been positive was 89% from 2014 to 2015, 92.5% from 2015 to 2016, and dropped to 90% from 2016 to 2017 (NNAS, 2015, 2016,

This representation as a successful initiative starkly contrasts with the lived experience of IENs that NNAS has made the process stricter, lengthier, and more expensive. Take, for example, the experiences of three of my interviewees, Martha, Mike, and Laura. When Martha applied for her nursing licence in 2010, prior to the formation of NNAS, her credentials and work experience were deemed equivalent to those of a domestically educated RN, making her eligible to take the entrance exam. However, because she could not secure a work permit in time, she had to re-apply in 2016 after the implementation of NNAS. While the time needed to gather documents was always a barrier, she said that she “had to go back to square one, and NNAS has a very stringent process,” which significantly prolonged the process (Interview 5, 2019). Her nursing education was subsequently deemed not equivalent, which meant she had to pursue additional education, adding years to her process. At the time of the interview, she had abandoned her dream of becoming a nurse in Canada and instead chose to support her partner’s nursing licensing journey. Her story is one of the thousands negatively affected by the transition to NNAS. In fact, in 2016, the Ontario Office of the Fairness Commissioner (discussed more fully in *Chapter Three*) attributed the massive drop in the number of IEN applications to the CNO (from over five thousand in 2012 to over one thousand in 2015) to the introduction of the NNAS (OFC, 2016c, p. 13).

Other interviewees, such as Laura and Mike, had no personal experience with the assessment process before NNAS. However, they expressed that rather than removing barriers to integration, NNAS creates redundancies and increases costs. Laura, for instance, who graduated in 2013 and landed in 2018 through the Interim Pathway for Caregivers, attributed delays in getting her nursing licence to the excessive amount of documentation required, the number of times she was required to re-submit, and the high cost of the process. Indeed, the introduction of NNAS represents an increase of nearly 500% in registration and assessment fees alone, not including the costs incurred from courier fees, translations, and other related processes.⁵⁸ Like many Filipino nurses, Laura’s migration journey was not linear, meaning she worked in multiple countries before coming to

2017). While NNAS acknowledges this drop, it argued that it was still above the “current standard for overall customer satisfaction” which was 80% (NNAS, 2017, p. 6). There is no data available going forward.

⁵⁸ In 2014, before the introduction of NNAS, the fee for international applicants at the CNO was \$226, including the registration fee and the assessment of their credentials by World Education Services. After NNAS, the CNO registration fee was lowered to \$169.50, equivalent to domestic applicants’ fees, but international applicants now have to pay an additional 650 USD (approximately 900 CAD) for an NNAS assessment.

Canada. Since not all employers were cooperative or easy to contact, gathering all documentation was impossible.

There's been a lot of people who gave up pursuing the nursing dream here in Canada because the process is very draining mentally and financially. It's really hard cause they ask a lot with the assessment process. The first step is NNAS. They ask us for IDs, education, and employment, but when we get to CNO, they're going to ask us the same thing again. You need to ask your employers again. A lot of people have been having trouble since most Filipino nurses came from the Middle East or Singapore or other countries before coming here, so it's hard for them to get in touch with their previous employers, especially in Saudi Arabia. I've been reading a lot of people having trouble with that that some of them just give up. The point of NNAS was to make it easier, but it's not. It's so expensive. Plus, there are so many exams (Interview 10, 2019).

Mike, who arrived in 2018 and had a Master's in Nursing and seven years of nursing experience, said that he had also heard "horror stories" about the length and cost of the assessment process. Since NNAS requires applicants to pay an additional fee if they do not submit all their documents within a year of initiating an application, many applicants take years before starting their application. These delays, however, are not captured by NNAS data, which only track processing times once all required documentation has been submitted. Unlike others I interviewed, Mike's NNAS assessment was relatively quick, credited to his research skills as a graduate student, having worked for a single employer, and his supportive family back home, all of which helped him gather the documents needed before starting the application. Nonetheless, his experience led him to question the existence of NNAS; he called it a "big hurdle," a "money-making scheme," and a way for regulators to absolve themselves from the responsibility of doing assessments.

I don't really see the advantage or why the regulatory bodies came up with NNAS. I had heard some horror stories that [for many IENs] it had taken them at least two years to collect all documents and that, on average, it would be more than a year to receive an advisory report from NNAS. And that they would give you updates with regards to your process to tell you your application passed the deadline and you need to pay another renewal fee. Good thing for me I did not experience that because I'm the kind of person who prepares everything beforehand. I prepared everything beyond the basic requirements just to make sure NNAS would not find any loophole with regard to what I had submitted...So NNAS is a big hurdle;

it's like the big wall of China, and after you pass that wall, it's still a long way ahead. I really don't see their point. It's just a money-making scheme, they're just after money. They also differ in the way of assessing IENs. So why not bring back the old to apply directly to the regulatory body to save you effort, time and money because the regulatory body just wants to wash their hands and not do that job anymore. It's a big hurdle to the IENs" (Interview 7, 2019).

These negative experiences and frustrations with NNAS assessments are also echoed by IENs interviewed elsewhere. For instance, in an article for New Canadian Media, an immigrant-focused news platform, a nurse from the Netherlands complained that the documentation issued by the schools back home was "not written [with] the level of detail and the format that will satisfy NNAS." After submitting her documents over two and half years, the NNAS advisory report deemed her education "not comparable" to that in Canada. She subsequently became a paramedic instead. A French IEN with 14 years of nursing experience said, "You hear all this immigration policy to get qualified nurses to come to Canada. It's like a promise that you will get your licence, but it's not the case." After two years of trying, he gave up on the process because he "was unable to present the documents they were asking for." He further added, "They refused to assess my case based on the documents that my school did provide. It's not a matter of how good of a nurse you are. It's a matter of if you can present the right paperwork." Another IEN from the UK pointed out how the pandemic had made matters more difficult. After months of gathering documents, it took months for NNAS to inform him that a form was incomplete or incorrectly filled out and months to redo and resend the forms, having to pay postage every time (Baylon, 2021).

Meanwhile, in the government's 2020 evaluation of the FCRP, IENs also identify issues with transparency, redundancy, consistency, fairness, cost, and timeliness related to the assessments completed by NNAS (ESDC - Evaluation Division, 2020). In particular, IENs identify a lack of transparency about "the basis on which the credentials are assessed; how comparability is determined, and reasons why education and credential are deemed as not comparable" (ESDC - Evaluation Division, 2020, p. 12). They also indicate that the process is "duplicative or contradictory, despite harmonization of some of the steps for requalification through the [NNAS];" for instance, they say that "two applicants with the same credentials may receive different assessment results from the same organization," and that different sources are giving them inconsistent information (ESDC - Evaluation Division, 2020, p. 13). Many IENs also feel that the

FCR process is unfair either at NNAS or at the regulatory body level and that assessments at NNAS are “conducted without proper understanding of the variations between nursing programs, thus underestimating candidates’ experiences” (ESDC - Evaluation Division, 2020, p. 15). Regarding timeliness, evaluators of the FCRP conclude that “the introduction of [NNAS] has not improved the timeliness of the foreign credential recognition process” (p. 33). On the contrary, many IENs “perceived that the [NNAS] prolongs the foreign credential recognition process” (ESDC - Evaluation Division, 2020, p. 14). Moreover, IENs also identify a persistent and broader dissonance between immigration and labour market integration policies, that they “still struggle to get comprehensive and clear information on what the foreign credential recognition process entails for nursing,” that many do not know how or are unable to prepare requirements in advance, that the cost of the process continues to be a significant barrier, and that the bridging training landscape in Ontario is “complex” making it difficult for IENs to fill competency gaps (p. 33).

Rather than taking these testimonials as evidence of the NNAS’s inadequacy or its responsibility for, paradoxically, making integration more difficult, however, evaluators attribute these issues to lapses in leadership and coordination efforts, difficulties in gathering data within a multi-jurisdictional regime, or factors outside the scope of federal authority – creating a ‘jurisdictional football.’ Notwithstanding ongoing integration issues and a lack of clarity regarding the FCRP’s effectiveness in attenuating them, program evaluators conclude that there have been improvements in the fairness, consistency, timeliness and transparency of FCR processes and that the current approach was “functioning and appropriate” (ESDC - Evaluation Division, 2020, p. 24).

Similarly, during its 2019-2021 strategic review, while NNAS identifies some areas for further improvement (e.g. increasing the speed, transparency, and uniformity of the assessment process), representatives claim that NNAS is a “trailblazer in regulation collaboration and national credentialing,” with a “proven track record in managing an innovative federally funded project.” They claim it is “recognized around the world as the gold standard for assessing nurses” (NNAS, 2021b, pp. 7–8).

5. Summary

I highlight the dissonance between how policymakers conceptualize NNAS and the lived experiences of IENs, neither to make the case that NNAS introduced these issues nor that these IENs would have fared much better within the previous system of applying directly to the regulatory body. Rather, the disjunct suggests that the representation of NNAS as a successful initiative is contrary to the experience of IENs and is, instead, based on a series of tautologies or feedback loops, such as (a) it is a successful example of collaboration because it requires regulators to work together, (b) it makes the assessment process more consistent because it standardizes entry requirements, (c) it makes the assessment process more transparent because IENs are increasingly consuming the service and information it provides, (d) it makes the assessment process more timely because it reduces regulators' workload and advisory reports are being issued more quickly over time.

In this framing of success, however, there is no consideration for the methodological limitations of its market-based performance metrics, such as (a) the fact that increased consumption is meaningless in a context where an applicant can only choose that service or (b) that processing timelines do not account for the time IENs take to prepare documents before applying or how their applications fare at the level of the regulator after the advisory report has been issued. While the standardization of assessments made the process more consistent, there is also no consideration for how this change introduced new barriers, such as additional costs and layers of bureaucracy.

To understand how NNAS has, for many IENs, not only failed to improve integration but made the licensing process more selective and assimilative, we need to go beyond evaluating it in relation to its stated intentions. Instead, we need to analyze the “deep conceptual premises operating within problem representations,” not intending to “identify some 'promises' as empty, but to draw attention to the assumptions and presuppositions that made it possible to make those 'promises' and develop those policies” (Bacchi, 2009, p. 10). In this case, I argue that the problem of lack of coordination and harmonization is primarily understood as a procedural problem rooted in jurisdictional complexity. The following section identifies the deep-seated assumptions in this framing and their discursive and subjectification effects.

PART TWO

1. A Procedural Problem Rooted in Jurisdictional Complexity

As the foregoing discussion suggests, NNAS forms part of a broader policy strategy that seeks to mitigate the confusion, inconsistencies, and delays caused by the lack of coordination and harmonization of FCR policy by providing centralized information, path-finding services, and a more streamlined and standardized assessment process. It responds to the concern that a lack of coordination and harmonization acts as a barrier to integration because it makes assessing and recognizing credentials procedurally problematic, particularly lacking transparency, consistency, and timeliness. As evident in the lived experiences of many IENs, NNAS has not only failed to improve integration substantially but has made the licensing process stricter, lengthier, and more expensive.

In this section, I investigate the deep-seated assumptions underlying this framing of the problem as a procedural one rooted in institutional or jurisdictional complexity; more specifically, the inevitable result of a vast and growing number of departments, governments, agencies, and non-governmental organizations involved in the FCR process, each with its own scope of authority and mandate, acting relatively independently and sometimes in contravention of one another. At this point in my dissertation, my intent is not yet to challenge these assumptions—this is a task I take on in *Chapter Four*, where I tackle the silences shared across federal and provincial policy; rather, I aim to flesh out these assumptions and their discursive and subjectification effects, i.e., how they set limits on what could be said and done about the problem and how they produced IENs as particular kinds of subjects.

I argue that the framing of jurisdictional complexity initially delayed the development of a coordinated and harmonized approach to the assessment and recognition of IEN credentials, leaving IENs to fend for themselves. Subsequently, federal policy became committed to procedural fixes, such as (a) providing centralized information and path-finding services to help individual IENs manage their expectations and navigate the inherent complexities of the system and (b) facilitating collaborative projects to develop a more streamlined and standardized assessment process. This approach takes shape within a framework that leaves unchallenged the authority and expertise of regulators to solely determine occupational standards as part of their mandate to

protect public safety. Subsequent initiatives developed thus further individualize integration problems by downloading the added responsibility— in terms of added administrative burden, time, and cost— of navigating the integration process to individual IENs and leaving systemic barriers in place. Moreover, by dichotomizing, on the one hand, IENs and their skills as undesirable and potential threats to public safety and, on the other hand, Canadian nursing standards as the desired norm and synonymous with public safety, this approach simultaneously legitimizes the scrutinization and assimilation of IENs’ skills and resistance to their swift integration as necessary and reasonable.

2. Addressing Jurisdictional Complexity Via Procedural Fixes

Across all the policy documents I analyzed, policymakers often refer to the hundreds of governance bodies involved in assessing and recognizing international credentials. In a 2010 report commissioned by the federal department of immigration, for instance, it identifies over 13 jurisdictions, 55 ministries, 50 regulated occupations, 440 regulatory bodies, five provincially mandated assessment agencies, 240 post-secondary institutions, hundreds of thousands of employers, and a large non-governmental community of about 235 service agencies dedicated to immigrant labour market integration (TASC, 2010). This jurisdictional complexity (i.e., the vast number of governance bodies involved, often acting independently or at odds with each other) is said to inhibit collaboration and the development of a nationally aligned and coherent approach to assessing and recognizing international credentials, especially in the case of regulated professions such as nursing, where occupational standards are governed by provincial regulators operating at arm’s length from the government. For instance, in the aforementioned 2005 study *Navigating to Become a Nurse in Canada*, the authors said the following about how jurisdictional complexity acted as the “first in a series of barriers” to integration:

For most regulated professions, the regulatory authority is at the provincial level, as ascribed in the Constitution in 1867. In addition, many other stakeholders are involved in foreign credential assessment. Over the years, various occupations, governments, educational institutions, professional organizations, and community agencies have developed assessment practices and procedures, mostly independent of each other. The resulting haphazard set of procedures has led to serious confusion and frustration for

internationally educated people and is the first in a series of barriers that lead to a protracted process (Jeans et al., 2005, p. 24).

Attributing or locating the problem of FCR in the institutional complexity of the governance structures meant that policymakers could express sympathy for the plight of immigrants facing a “complex and often frustrating system” and also recognize the need for systemic solutions that target the problem throughout their integration journey, starting from before they came to Canada (FLMM, 2009, p. 1). In the 2005 study *Navigating to Become a Nurse in Canada*, the authors stated that “the entire assessment process need[ed] to be addressed...fixing only one part of the system is not likely to lead to success” (Jeans et al., 2005, p. 45). Developing systemic solutions, however, required levels of collaboration that were considered difficult for the federal government to manage, a process that a representative of the now-defunct National Organization of Immigrant and Visible Minority Women of Canada described as “somewhat like herding cats” (Bose, *HUMA* 65, 2007, p. 25).

As successive governments each claimed to struggle with addressing a jurisdictionally complex problem, the result was to delay systemic solutions, akin to “passing the political football” (Bose, *HUMA* 65, 2007, p. 25; Samuel, 2004). For example, when pressed at a committee hearing to explain why the Federal government was taking so long to address the problem of FCR, the Parliamentary Secretary to the Minister of Citizenship and Immigration, with special emphasis on Foreign Credentials, consistently called FCR a “complex file” (Fry, *CIMM* 05 - March, 2004). Commenting on the issue six years later, the Alliance of Sector Councils⁵⁹ maintained that “such institutional complexity comprising multiple authorities and providers ma[de] FCR daunting to address” (TASC, 2010, p. 1). When asked how the federal government could improve FCR processes, the Law Clerk and Parliamentary Counsel for the House of Commons stated that as “urgent and as pressing and as worthy as the goal [of integration] may be,” exercising the federal government’s powers of “moral” and “fiscal” suasion⁶⁰ was “a very difficult area to deal with”

⁵⁹ The Alliance of Sector Councils or TASC is the national coordinating body for Canada's sector councils. Sector councils are “partnership organizations that address skills development issues in key sectors of the economy” (TASC, 2010, p. iii).

⁶⁰ Moral suasion was defined as “trying to convince the provincial authorities that it's in their interest as much as in the federal government's interest to assist these immigrants to gain the appropriate qualifications.” Fiscal suasion was defined as “funding enhancements that would persuade the various levels or jurisdictions to try to meet a certain standard” (Walsh, *HUMA* 05, 2011, pp. 4, 7).

(Walsh, *HUMA 05*, 2011, p. 5). The 2009 Framework also stated, “Governments recognize that improvements to a set of systems as complex as those related to the assessment and recognition of foreign qualifications will take time, resources, and a sustained commitment from a range of key stakeholders” (FLMM, 2009, p. 9).

Within this framing of the problem, the federal government’s role is subsequently confined to making the FCR process more transparent, consistent, and timely by (a) providing centralized sources of information that IENs could ideally access pre-arrival to help them manage their expectations and better navigate the system's complexity, and (b) encouraging and funding collaborative projects that aim to develop a more coordinated and harmonized approach to IEN assessments. As discussed in the previous section, the three main federal initiatives—the FCRP, the Internationally Educated Health Professionals Initiative, and the Foreign Credential Recognition Office—follow this dual approach. While lack of coordination and harmonization is recognized as a systemic issue, the initial response was thus to create individualized solutions, leaving systemic barriers in place until a more systemic solution could be developed through collaborative efforts. As the next section will discuss, the type of collaborative systemic solution developed, however, would come to reaffirm systemic barriers of its own.

3. Facilitating Access vis-a-vis Protecting Public Safety

As governments, regulators, and other policy actors worked together to develop a more streamlined and standardized assessment approach, jurisdictional complexity also came to define the kind of collaborative approach that became possible. To recall, collaboration was circumscribed not only by the difficult task of coordinating amongst the vast number of governance bodies involved but also by the need to contend with independent scopes of authority and mandates often in conflict. In particular, the mandate to integrate IENs as quickly as possible became framed as acting in contravention of the mandate to protect public safety.

For instance, in a 2004 standing committee on the importance of FCR, a representative from the Canadian Nurses Association (CNA) concluded her statement by highlighting that the assessment of IENs was “clearly complex” and that there were “improvements to be made to ensure that each immigrant achieves their full potential,” but that “these improvements must be made within a framework of ensuring patient safety” (Little, *CIMM 05 - March*, 2004). The

guidelines developed by the Ontario Regulators for Access Consortium⁶¹ to help regulators improve access for internationally educated applicants also stated that there was a “line regulators should not cross in order to avoid a conflict between their public safety mandate and supporting individual candidates.” They warned regulators of “the need to be cautious not to create conflict with their public safety role by advocating for or assisting international candidates.” They called this balancing act a “complex process to manage [that] must be constantly monitored” (Ontario Regulators for Access, 2003a, p. 8). In sum, the jurisdictionally complex task of balancing the conflicting goals of swift integration and protecting public safety was normalized as an inherent component of FCR policy.

This bifurcation between facilitating swift integration and protecting public safety is itself based on two unquestioned assumptions about IENs and their skills: (1) that their skills are potentially inferior (lower quality), deficient (lacking in some way), or fraudulent (inauthentic), and (2) that relying on integrating them to fill domestic labour demands has adverse implications for the nursing workforce here and abroad and subsequently for healthy public policy. On this basis, it is considered necessary and reasonable to manage or constrain their integration by scrutinizing and assimilating IENs, thereby discouraging their swift and equal integration. Let’s investigate these assumptions and their effects.

4. International Applicants Warrant Scrutiny and Assimilation

As it relates to the first assumption about IENs’ skills, the CNA maintains that part of the complexity in assessing IENs’ qualifications is that we cannot rely on their education credentials alone due to the high potential for fraud and the difficulty in determining their value:

CNA believes that recognition of foreign-educated workers' qualifications should include recognition of competencies and experience and not just educational credentials. Canada is a very attractive country, and immigrants will often utilize various measures to gain access, including purchasing educational credentials through the Internet. Also, the constant

⁶¹ The Ontario Regulators for Access Consortium began in the late 1990s as a small group of regulators assembled by the Maytree Foundation. Their objective was to encourage the collaboration of regulators to support and assist them in improving access for internationally educated professionals. In 2001, with funding from the Access to Professions and Trades Unit of the Ministry of Colleges and Universities, these regulators formed the Ontario Regulators for Access Consortium. As of 2023, their website is only accessible via the Internet Archive Wayback Machine which I assume to mean the network disbanded.

proliferation of nursing educational institutions around the world makes it increasingly difficult for regulatory bodies to validate transcripts and curriculum content (Little, *CIMM 05* - March, 2004)

Regarding Filipino nurses in particular, the International Council of Nurses has noted that the proliferation of private and public nursing programs in the Philippines in the early 2000s raises suspicions over the capacity of the Filipino government to regulate the quality of these programs properly (Kingma, 2006). In their 2008 policy brief regarding recruiting IENs, the RNAO noted that the concern with the “downward harmonization of nursing credentials,” along with pressures to facilitate the integration, jeopardized the four-year university nursing program requirement. The organization also expressed concern that professional standards were “already being diluted” in certain jurisdictions in the US. New Mexico and California, particularly, permitted Filipino nurses to take the US licensing exam without passing the Philippine national board exam, a “lower standard” than the one American nurses were subject to in those states (RNAO, 2008, p. 9).

As nursing regulators across Canada established the baccalaureate degree and diploma requirements for licensed nurses and licensed practical nurses, respectively, the concern with the authenticity and quality of foreign credentials heavily and disproportionately impacted IEN integration. For instance, after the CNO introduced these requirements in 2005, the clearance rates of international applications dropped from 80% to 20% (compared to a drop from 100% to 90% clearance rate for Ontario-based applicants). Subsequently, the proportion of IENs relative to the total provincial nursing workforce dropped from around 13.3% in 2006 to 10.6% in 2007 (CIHI, 2008; OFC, 2007a; RNAO, 2008).⁶²

In addition to concerns about the dubious quality of IEN credentials and the impact of their integration on professional standards, there is also a concern with the quality and appropriateness of other skills related to their nursing practice. When I asked representatives from nursing governance bodies about the particular difficulties Filipino nurses faced in integration, there was a common perception that, in the Philippines, nurses are not expected to utilize their critical thinking skills, assert themselves, seek consent from patients, conduct patient assessments, become specialists, and work with modern technologies, all of which are requisites of safe practice in

⁶² See Appendix F CNO Applicant Data for full data set.

Canadian settings. For instance, a representative from the RPNAO who had previously worked at the CARE Centre of Internationally Educated Nurses said the following:

They certainly have theoretical knowledge; the challenge in my experience with IENs is the systems in which they've practiced are very much physician-driven systems. Here, in health care, everybody gets their critical thinking input in their application, whereas they work in a system where the doctor gives the order, and they do the order. They did not apply their nursing knowledge, and they struggled when they got into practice here with their accountability and their standards of practice with respect to being able to critically apply and implement nursing care, so that's a struggle depending on where they come from...those coming from physician-driven systems needed a lot of direction... Part of our work at the CARE Centre was to help develop [IENs'] confidence to assert their knowledge and find their voice. IENs tend to feel like they've been knocked down, so they're not assertive in their knowledge because they feel significantly intimidated and undermined by our regulated professionals here. I feel that nursing in Canada is held in such a high regard across the world that umm, you know I counsel both RNs and RPNs as an RPN [myself], and they couldn't quite understand how I could do that at my level. They don't understand that nursing here is one profession, two categories, both equally important. (Interview 12, 2020)

A representative from the CARE Centre for Internationally Educated Nurses representative also stated, although more cautiously, that she “did not want to stereotype or generalize” but that Filipino nurses struggle to assert themselves in Canadian nursing settings because they are used to a hierarchical medical system. Therefore, the centre offers support, such as mentorship programs, to help them build confidence (Interview 13, 2020).

Similarly, in a 2021 recruitment video for an IEN bridging program out of British Columbia entitled *What is the difference between a Registered Nurse (RN) in the Philippines and Canada?* the featured faculty nurse also claimed that compared to nursing practice in Canada, in the Philippines, she was not expected to talk back to the doctor, conduct patient assessments beyond examining their chart, become specialized in a particular field, work with modern technologies such as central venous pressure measuring kits or high-fidelity mannequins, or to communicate with patients to explain treatment or seek consent. The bridging program is designed to help Filipino nurses assimilate into the Canadian nursing system by addressing these deficiencies and incompatibilities.

As I elaborate on *Chapter Four*, concerns with the dubious quality and the incompatibility of IEN skills are not new. However, these concerns became increasingly couched in the race-neutral sounding language of “appropriateness of care,” “language,” and “cultural competence.” In a standing committee concerning FCR policy, a representative from a healthcare professional association warned against policy changes that did not take these concerns into account:

In considering possible changes to the recognition of foreign credentials, one thing is paramount: we cannot compromise safety or Canadian standards of care. In fact, it goes way beyond standards of care. It includes appropriateness of care, with cultural and language components. This by no means suggests that we are unwilling to look at ways to make the process more understandable, smoother, and if appropriate, less time-consuming. However, this must be achieved in a way that maintains the appropriate care that our patients deserve and expect (Dubé, *CIMM 07*, 2004).

Note in the quote above that the concern with prioritizing patient safety is not seen as necessarily incompatible with adjustments that make the assessment process “more understandable” (read: transparent), “smoother” (read: consistent), and “less time-consuming” (read: timely). Similarly, in the 2009 Framework, the objectives of “public protection and a fair, transparent and timely [FCR] system” are represented as “fully compatible” (p. 9). At the same time, this framing delimits FCR policy efforts; for instance, making the process “less time-consuming” is only possible “if appropriate,” meaning as long as it does not compromise public safety as defined by regulators as per occupational standards. Despite asserting that integration and protecting public safety are compatible objectives, by subjecting IENs to additional scrutiny that “goes way beyond” considerations of standards of care, the effect is, therefore, to treat these as conflicting objectives.

Beyond existing in the minds of those assessing and recognizing IEN skills, this dichotomization—depicting, on the one hand, IENs as undesirable and potential risks to public safety and, on the other hand, Canadian nursing standards as the desired norm and synonymous with public safety—informs the types of supports demanded by IENs and those offered; meaning, it forms the basis under which assessment approaches became nationally standardized.

First, despite its racial implications, by legitimizing this dichotomization as necessary and reasonable, it neutralizes criticisms that regulators are engaging in racist forms of protectionism. Subsequently, it reaffirms the regulators’ position as the definitive authority to further scrutinize

IENs' skills as part of their mandate to protect the public. The following statement made by a representative from a healthcare care professional association during the 2004 standing committee on FCR illustrates this point:

With regard to the whole issue of protectionism and whatnot, I'm obviously from a visible minority. I'm a child of an immigrant family that came here from India many years ago. I was fortunate to be able to pursue the career that I chose, because my father was able to work and whatnot. I don't really feel this is an issue of the medical establishment being protectionist or putting up artificial barriers. I think it's a matter of maintaining standards, recognizing that things change very rapidly in medicine today. The drugs, for example, that we use in cardiovascular disease and the way we treat cardiovascular disease are completely different from the case seven or eight years ago. A lot of the medications we use today weren't even around seven or eight years ago. So it's a matter of continuing medical education, assessing credentials, and whatnot (Zaidi, *CIMM 09*, 2004).

Although the above statement concerns integrating internationally educated physicians rather than IENs, it exemplifies the dominant assumption that maintaining occupational standards is necessary and reasonable to ensure public safety, especially in the context of rapid technological changes, and the assumption that those with 'foreign' credentials practice in less 'developed' or technologically advanced conditions.

While not necessarily subscribing to the idea that IENs' skills are inferior, IENs and their advocates also uphold this dichotomization by defending the idea their integration should not come at the expense of lowering occupational standards. For instance, a founding member of the Kababayan Multicultural Centre, a Toronto-based group advocating for the rights of Filipinos, stated, "We are not asking that the standards of health care be lowered. We strongly believe they should be maintained and even strengthened" (Hernandez, *CIMM 44*, 2005, p. 32). During a separate standing committee hearing, a project coordinator for the National Organization of Immigrant and Visible Minority Women of Canada similarly stated that,

From a new Canadian's perspective, both personal and in terms of many of my immigrant friends, we don't want to lower any standards. We appreciate this country for what it is. That's why we have chosen this country. But some barriers today often are of the "either my way or no way" kind (Pobric, *HUMA 65*, 2007, p. 27).

By demanding more support and flexibility to approximate Canadian nursing standards, they acquiesce to the dominant view that these standards should be maintained and that IENs should work towards assimilation.

In addition to reaffirming the authority of regulators to maintain or even strengthen standards and making it the responsibility of IENs to conform to those standards, the dichotomization of nursing skills also makes assessments stricter and more demanding. As Guo and Shan (2013, p. 475) note in their analysis of the 2009 Framework, there was a “shift in language:” “[q]ualifications now are not assessed against the Canadian educational standards, but occupational standards.” In particular, this means a shift from considering not only credentials when evaluating IENs’ skills but also their competencies and experience. If you recall, in the 2005 study *Navigating to Become a Nurse*, the recommendation to establish a national assessment service was similarly premised on assessing competencies beyond credentials:

[C]reating a standard evidence-based approach to the assessment of IENs that includes educational preparation, Prior Learning and Assessment Recognition, clinical competency through supervised practice or an Objective Structured Clinical Examination, and a standard language test such as Canadian English Language Benchmarks Assessment for Nurses (Jeans et al., 2005, p. 6).

Consequently, whereas nine of 25 regulators conducted competency assessments on IENs in the early 2000s⁶³ (Jeans et al., 2005), as NNAS standardized competency assessments across all regulators, it introduced a growing list of requirements for IENs, resulting in additional time, effort, and cost. In short, assessments may have become more consistent but more consistently assimilative, strict, and demanding.

5. Managed Integration to Reduce Reliance on IENs

The bifurcation of swift integration and protecting public safety as conflicting objectives is further compounded by another assumption: that relying on integrating IENs as a means to address labour shortages discourages the development of the workforce in the recipient country and exacerbates nursing shortages in sending countries, thus, contributing to a worsening of conditions of care in both contexts. Following this assumption, FCR policy is coordinated and harmonized within an

⁶³ The CNO began considering nursing experience when assessing educational equivalence in 2006 (OFC, 2007a).

“ethical” framework, discouraging swift integration of IENs to meet domestic labour demands in favour of managed integration that prioritizes domestic supply.

In terms of the impact on recipient countries, RNAO, for instance, has spoken against “normalizing and expanding recruitment of IENs” due to the “potential implications for public safety, the viability of nursing as a self-regulating profession, and the sustainability of the nursing workforce” (RNAO, 2008, p. 2, 2014). To illustrate its concerns, RNAO has pointed to examples of professional standards in some American jurisdictions being “diluted” as a means to facilitate entry of IENs into the profession, as well the deterioration of wages and working conditions in places such as Texas driven by “an influx of IENs who are in a more vulnerable position and consequently less prone to agitate” (p. 10). The CNA has also highlighted the negative implications of the “resource-intensive” integration of IENs on domestic nurses, remarkably increasing the burden on regulators and slowing down the speed of assessments:

Many provincial regulatory bodies in nursing are reporting double the number of applicants in less than one year. This increased volume has resulted in an extended timeframe for delivery of assessment. Currently applications can take up to 18 months to process. There is a component of user-pay for this service, but the bulk of the costs are borne by the regulatory body, which is funded by nurses licensed to practice in Canada. The increased focus on internationally educated nurse applicants is resource-intensive and competes with other equally important priorities (Little, *CIMM 05 - March*, 2004).

In terms of the impact on sending countries, the Romanow Commission recommended all governments eliminate the recruitment of and dependence on internationally educated health professionals as a matter of “ethical responsibility” to “ensure that [Canada] does not attempt to solve its shortages of health care professionals on the backs of less powerful, less wealthy and less developed nations” (Romanow, 2002, p. 244). The RNAO also opposes the “active recruitment” of IENs on the basis that it is “unconscionable for affluent jurisdictions that have the capacity to grow their own workforce of health professionals to deprive those that are living in low income and precarious health of their precious few health-care providers” (RNAO, 2014, p. 2). Other nursing associations such as CNA, the International Council of Nurses, and the Canadian Network of Agencies of Regulation also support policies that discourage the “active” and “unethical” recruitment of IENs from countries experiencing shortages (*CIMM 05 - March*, 2004; ICN, 2019).

While nursing regulators and associations express that IENs have a right to migrate and that governments should facilitate the integration of IENs who are already in the country, these claims tenuously co-exist with conflicting policies aimed at discouraging their swift integration. The CARE Centre for Internationally Educated Nurses, for example, does not offer its services to IENs who do not have permanent residence or citizenship status in accordance with international treaty obligations that discourage the recruitment of IENs (Interview 13, 2020). In a 2015 study comparing the employment match rates⁶⁴ of internationally educated individuals, the relative decline in the employment match rates of IENs is partly attributed to employment policies that “may have displaced immigrant nurses” by prioritizing the hiring of domestically educated nurses, such as the Nursing Graduate Guarantee initiative (Augustine, 2015, p. 41). Herein too, the move towards a more consistent FCR policy in accordance with an “ethical” framework results in the deprioritization and vilification of IEN integration.

6. Conclusion

In this chapter, I argued that the lack of a coordinated and harmonized approach to FCR is primarily framed as a procedural problem rooted in jurisdictional complexity. In other words, from the perspective of federal-level policy, assessing and recognizing IEN credentials is confusing, inconsistent, fragmented, and time-consuming due to the vast and growing number of governance bodies involved in FCR policy, often acting independently and in contravention of one another. Within this problem framing, federal policy must contend with the jurisdictionally complex task of balancing the conflicting goals of facilitating swift integration and protecting public safety. These goals are represented as conflicting based on the assumptions that (1) IENs’ skills are inferior (lower quality), deficient (lacking in some way), or fraudulent, and (2) relying on their integration to meet labour demands, as opposed to developing the domestic workforce, has adverse implications for the nursing workforce here and abroad. This racialized dichotomization, which depicts IENs as undesirable and threatening and Canadian nursing standards as the desired norm and synonymous with public safety, heightens the scrutiny and assimilation of IENs’ skills and legitimizes resistance to their integration.

⁶⁴ Employment match rate is defined as the “total number of people working in the regulated profession divided by the total number of employed people who have completed education that would normally lead to licensure in that profession” (Augustine, 2015, p. s30).

Rather than eliminating the complexity of the process, complexity itself—in the form of a more selective and assimilative assessment process that overly scrutinizes IENs and limits access to only those who can spend the necessary time, effort, and money to approximate Canadian nursing standards—came to be legitimized as inevitable and necessary to protect public safety. The policy goal became managing complexity in a way that does not disturb the power of regulators by setting up new bureaucracies and industries around them to help IENs navigate their processes. As IENs increasingly bear the burden of navigating this complexity in terms of added time, effort, and cost, the vast majority of them thus remain unable to access the nursing profession, relegating them to the lowest tiers of care provision.

As I underlined at the outset, my intention at this point is not yet to challenge the deep-seated assumptions in this representation of the problem but rather to flesh out how they set limits on what can be said and done about the problem and how they produce IENs as particular kinds of subjects. Developing an alternative representation of the problem of FCR that does not replicate these adverse effects will require challenging these assumptions. In particular, it will require that we bring attention to what is missing and obfuscated in the following assumptions: that jurisdictional complexity is inevitable and necessary on the basis that the swift integration of IENs and protecting public safety are conflicting goals and that the heightened scrutiny and assimilation of IENs' skills and resistance to their integration are necessary and reasonable; both of which rest on the dichotomous understanding of IENs and their skills as undesirable and threatening, and Canadian nursing standards as desirable and synonymous with public safety. For this, we will need to consider the historical role nursing regulators and associations have played in developing the current protectionist regulatory regime, one which rests on the continuous reassertion of racialized and feminized hierarchies of skill and labour as a means to elevate the relative power and privilege of white nurses. We will also need to consider factors that pose more substantial risks to public safety than the swift integration of IENs, such as the neoliberal privatization of health care provision. I am, however, leaving my attempt to challenge these assumptions to *Chapter Four* and *Chapter Five* because, as *Chapter Three* shall show, these are also assumptions that underlie provincial-level FCR policy.

CHAPTER THREE

“We Are Presumed and Treated Like Incompetents, Cheaters and Dummies Unless We Can Prove Otherwise”: The Problem of Foreign Credential Recognition as Lack Of Fair Access

Introduction

In this chapter, I focus on how the problem of FCR is represented in immigration and labour market policies at the provincial level. As discussed in the previous chapter, in policy discussions regarding the problem of FCR, the greater scrutiny and management of IENs’ skills is justified on the basis that educational programs, curriculum content, and work experience from other countries are difficult to authenticate and equate to national entry-to-practice standards or competencies.⁶⁵ Within this understanding, the authority and expertise of regulatory bodies to determine and maintain entry-to-practice standards are upheld as part of their obligation to protect the public. In fulfilling this obligation, regulators are expected to follow a principle-based approach that respects the applicant’s right to a fair assessment—one that is transparent, timely, applied consistently using objective criteria, and without regard to the applicant’s particularities (e.g., their race, country of origin, or country of education and training)—and is appealable. However, the problem was that existing mechanisms and principles provided inconsistent and insufficient procedural protection to applicants holding foreign credentials, resulting in undue discrimination.

Although a pervasive lack of fairness in how regulators conduct assessments of international applicants has long been identified as one of the primary reasons why many internationally educated immigrants are disproportionately excluded from practicing in their professions,⁶⁶ it was not until the 2000s that a more robust legislative response was provided. This chapter focuses on the response devised by the government of Ontario. In 2006, the Ontario

⁶⁵ Entry-to-practice standards or competencies describe the “required knowledge, skills, and judgment expected of new graduates entering practice to provide safe, ethical care in various settings [and] are used as a guide for curriculum development in nursing education programs” (Shaffer et al., 2016, p. 53).

⁶⁶ Lack of fair access was identified back in the 1984 *Report on the Commission on Equality in Employment*. The report recommended reviewing the criteria used by regulatory bodies to assess foreign credentials to ensure that requirements were “bias-free,” “objective,” and “fair” (Abella, 1984, pp. 47, 265). However, beyond suggesting regulators remove the requirement of citizenship to practice a profession in Canada, the report left undetermined how fair access would be achieved in practice.

government became the first province to pass fair access legislation known as the *Fair Access to Regulated Professions and Compulsory Trades Act* (FARPCTA, hereafter fair access legislation).⁶⁷ This statute establishes procedural criteria for regulators and third-party assessment agencies to ensure their registration practices⁶⁸ are “transparent, objective, impartial, and fair.” It also establishes the Office of the Fairness Commissioner (OFC) to oversee compliance. As an oversight body, the OFC conducts studies and assessments of provincial regulators and offers recommendations to ensure compliance with fair access legislation.

Despite some initial resistance from regulators, fair access interventions are generally considered necessary for holding regulators accountable and increasing access to the professions. Concerning IENs specifically, the OFC highlights dozens of changes made to the CNO registration practices, an ideological shift in how regulators prioritize fair access, and an increase in the total number of licenses offered to IENs since the legislation was adopted as evidence of their success. In 2016, the OFC classified the CNO as fully compliant with legislation. Under the OFC’s current monitoring framework, which considers potential risks to fair access, the CNO is classified as moderately low risk, resulting in fewer monitoring and reporting requirements. This commendation, however, contrasts sharply with the lived experiences of IENs who continue to face a strict, lengthy, and expensive assessment process. Rather than characterizing fair access interventions as an empty promise or poorly implemented initiative, the WPR approach instead calls for analyzing the deep-seated, unquestioned assumptions underlying the framing of the problem.

This chapter is concerned with how the lack of fair access to registration/licensing is framed primarily as a procedural problem, specifically a lack of oversight over regulators’ entry criteria (or assessment methods) as opposed to a problem located in entry-to-practice standards (or competencies); that is, as a problem in how regulators apply their standards rather than a problem with the standards themselves. Within this problem framing, fair access interventions are reduced to procedural minutiae and unenforceable recommendations. At the same time, the determination of occupational standards is left up to the discretion of regulators as part of their mandate to protect

⁶⁷ The Act was originally known as the Fair Access to Regulated Professions Act when passed in 2006, but was amended in 2009 to include compulsory trades hence the name change.

⁶⁸ The OFC defines registration practices as an “action, procedure, or policy used by regulators to assess applicants for the purpose of registration” (OFC, 2022a, p. 6).

public safety. I argue that this framing of the problem legitimizes Canadian nursing standards as universal and objective measures of skill and patient safety, as well as regulators' power and position as the best arbiters of competence. Consequently, fair access interventions not only fail to improve integration substantially but, by painting the process with a veneer of fairness, also further obfuscate an increasingly selective and assimilative process; that is, one that heightens scrutiny of IENs by reproducing racialized dichotomies of skill and limiting access to those IENs who can spend the necessary time, effort, and money to approximate Canadian nursing standards; thus further entrenching their downward occupational mobility.

This chapter's analysis applies questions one through four of my modified version of Bacchi's (1999, 2009; Bacchi & Goodwin, 2016) WPR approach to federal-level FCR policy: (1) What is the problem of FCR represented to be in provincial policies, specifically Ontario, related to the immigration and labour market integration of IENs? (2) How and where has this representation been produced, disseminated, and defended? (3) What are the deep-seated assumptions about this representation? (4) What are the effects (discursive, subjectification, lived) of this representation? Specifically, how has this representation framed or imposed limits on what can be said about the issue? How are IENs and their skills constituted in relation to domestically educated nurses? How has this representation impacted the lived reality of IENs?

This chapter begins by tracing how the problem of FCR became represented in provincial-level policies, particularly in Ontario, as a problem of lack of fair access leading to the adoption of fair access legislation. To motivate and ground the subsequent deconstructive analysis, this section concludes by considering some of the lived effects of fair access interventions on IENs via an analysis of applicant data. In the second part of the analysis, I explore the deep-seated assumptions underlying the representation of the problem and their discursive and subjectification effects. I conclude by discussing some of the silences and unquestioned assumptions in this problem representation, corresponding to question four of the WPR approach. However, I tackle these silences or unquestioned assumptions more substantially until *Chapter Four* and *Chapter Five*.

PART ONE

1. The Problem of FCR as Lack of Fair Access

In his 2004 analysis of systemic barriers faced by internationally educated immigrants written for the Ontario Human Rights Commission, Samuel points out that while there are no explicit references to race and other markers of social identity in regulators' entry requirements, there was a recognition, as early as the late 1980s, that these had "a disproportionately negative impact on members of minority ethnic groups." However, throughout the 1990s, there was a more significant concern with limiting the immigration and emigration of professionals, resulting in minimal funding and effort dedicated to evaluating regulators' policies and practices. This emphasis on restricting immigration among professionals changed in the early 2000s when there was a resurging interest in facilitating the integration of highly educated immigrants. Indeed, upon examining many provincial policy documents related to the labour market integration of internationally educated immigrants, the lack of fairness in regulators' registration practices due to inadequate oversight is consistently cited as one of the main reasons why so many IENs fail to become integrated into the Canadian nursing market. While this chapter focuses solely on fair access legislation passed in 2006, it is essential to note the broader policy context that led to its development.

The 1989 *Access Report* by the Ontario Task Force on Access to Professions and Trades is the first comprehensive assessment highlighting the need for more robust fair access accountability mechanisms in FCR. This report is an in-depth analysis of occupational statutes, the *Canadian Charter of Rights and Freedoms*, and the 1981 *Ontario Human Rights Code*. It defines fairness in registration as follows:

[A] decision be based on an unbiased and accurate assessment of the applicant's qualifications, that the applicant be aware of the required standards against which his or her qualifications are to be measured, that the applicant be provided with an opportunity to state his or her case, and that the person reviewing the qualifications properly interpret the entry standards (Cumming et al., 1989, pp. 305–306).

The Taskforce concluded that existing mechanisms and principles provided inconsistent and insufficient procedural protection to applicants holding foreign credentials. It recommended

amendments to occupational statutes to help improve the flow of information to applicants, enable applicants to provide evidence of equivalency, and grant appeal bodies full powers of review.⁶⁹ It also recommended that ‘place of education or training’ be added as a protected ground under the *Ontario Human Rights Code* to place the onus on regulators to make the registration process more accessible to internationally educated applicants.⁷⁰ Finally, it recommended the development of a Previous Learning Assessment Network⁷¹ to increase fairness in the assessment of equivalency, which they considered to be the “most problematic [stage], the most difficult, the least standardized, and the most open to abuse” (p. 142). This body was envisioned as a government-funded body that would assess foreign applicants' prior academic and experiential learning to determine equivalency.

In 1990, following the release of this report, the Ontario Ministry of Citizenship established the Access to Professions and Trades Unit⁷² to “promote fair and merit-based registration and employment practices.” The subsequent decade was marked by a few other studies and partnership projects, such as the 1998 report by the Foreign Academic Credentials Assessment Services Business Assessment and the launch of a credential assessment service in partnership with World Education Services (Samuel, 2004). However, as mentioned, the government did not dedicate much resources or attention to the problem of FCR until the early 2000s, when the concern for integrating internationally educated immigrants grew.

In 2003, the Steering Committee of Ontario Regulators for Access⁷³ commissioned a series of studies to “learn more about the practices, challenges, and needs of Ontario regulators” with the goal of “improv[ing] access to Ontario’s self-regulated professions by international candidates while maintaining standards for public safety” (Ontario Regulators for Access, 2003b, p. 1). The

⁶⁹ For a list of full recommendations see: (Cumming et al., 1989, pp. 318–325).

⁷⁰ As part of their duty to accommodate, the task force suggested that regulators could investigate the standard of training in other countries; establish a testing mechanism that fairly assesses individual applicants; provide access to remedial programs; provide financial assistance to those seeking upgrading; and, establish a mentorship system (Cumming et al., 1989, p. 341).

⁷¹ Recall that in Chapter Two of this analysis, the use of Prior Learning Assessment Recognition to assess IENs’ skills was also one of the recommendations in the 2005 *Navigating to Become a Nurse* report, and adopted in the development of the National Nurses Assessment Service agency.

⁷² The unit moved in 1995 to the Ministry of Citizenship, Culture and Recreation, to the Ministry of Training, Universities and Colleges in 2000, and then back to the Ministry of Citizenship in 2006 where it was dissolved with the passing of the Fair Access Act (Ministry of Government and Consumer Services, 2015).

⁷³ The Committee was part of the Access Solutions project, funded by the Access to Professions and Trades Unit, which also produced a how-to-guide and provided resources to regulators who wished to assess and revise their procedures and policies.

Steering Committee subsequently developed the following guiding principles for regulators: 1) fairness, 2) objectivity, 3) transparency, 4) accountability, and 5) collaboration.⁷⁴ It also offered resources such as tool kits to help regulators conduct reviews of governing legislations, by-laws, and rules to ensure that standards and practices for candidates were “relevant, fair, and comparable to Canadian-trained” and compliant with overriding legal requirements (pp. 78-9).

On the heels of this work, in 2005, the Ontario Ministry of Citizenship and Immigration⁷⁵ released the *Review of Appeal Processes from Registration Decisions in Ontario’s Regulated Professions* (hereafter the Thomson Report). The Thomson Report identified the following ten elements of fair access: (1) accessible information about the registration, decision, and appeal processes; (2) support for applicants through the process; (3) reasonable fees and timelines; (4) alternative evidence of unobtainable documents; (5) access to documents on file, with some exceptions; (6) training for council members and staff with a focus on understanding diversity; (7) procedural protections with third-party assessments; (8) arm’s-length internal appeal or review processes; (9) opportunity to present one’s case; and, (10) clear registration decisions and reasons.

It also offered two key recommendations: (1) the institution in statute or regulation of a Fair Registration Practices Code along with an oversight body, and (2) the establishment of a new, independent appeals tribunal under the authority of the Ministry of the Attorney General.⁷⁶ Although the second recommendation would not come to fruition, the first recommendation forms the basis for fair access legislation passed in 2006, also known as Bill 124.

⁷⁴ Fairness is defined in the report as access to the profession to all qualified candidates, processes and entry decisions free of personal and systemic discrimination, an arms-length appeal process, and reasonable fees commensurate with the services provided. Objectivity is defined in the report as the objective and consistent application of standards of competence for entry. Transparency is defined as the ready availability of requirements overseas and in Canada and the identification of gaps in requirements along with suggestions as to “possible ways to fill them through courses, skills training, and work placements.” Accountability is defined as regulators including statistics and information about initiatives on access for international applicants in their annual reports. Collaboration is defined as regulators collaborating with other bodies to improve access for international applicants while “respecting each other’s unique roles and mandates.” (Ontario Regulators for Access, 2003b, p. 77).

⁷⁵ The review of appeal processes was first commissioned by the Minister of Training, Colleges and Universities in 2004, but the responsibility for this area was passed on to the Ministry of Citizenship and Immigration by the time the report was set to be released (Thomson, 2005, p. ii).

⁷⁶ This tribunal would also abide by the principles of accessibility, fairness, and accountability, not unlike the *Health Professions Appeal and Review Board* (HPARB). However, it would address its shortcomings related to the inadequate level of training and support for adjudicators, timeliness, and the “general lack of support to applicants.” It would also expand its scope to cover all professions (Thomson, 2005, p. xii).

Although other guideline documents⁷⁷ and provincial occupational regulations⁷⁸ already established similar principles of fair access concerning the assessment of international credentials, FARPCTA is the first statute to target regulatory bodies across the province and to establish an arm's-length oversight body to ensure compliance with the Act. It also serves as the legislative model that other provinces subsequently adopted.⁷⁹

2. The Role and Mandate of the OFC

Fair access legislation consists of five main elements. First, it contains what is known as the Fair Registration Practices Code, comprising a set of *general duties*,⁸⁰ of which all regulators⁸¹ are

⁷⁷ In 1990, the Council of Ministers of Education Canada established the Canadian Information Centre for International Credentials to help Canada fulfill its international treaty obligations, specifically the United Nations Educational, Scientific and Cultural Organization's 1979 *Convention on the Recognition of Studies, Diplomas and Degrees concerning Higher Education in the States belonging on the European Region*, which was subsequently replaced by the 1997 *Convention on the Recognition of Qualifications concerning Higher Education in the European Region*, also known as the Lisbon Recognition Convention. In collaboration with the Alliance of Credential Evaluation Services of Canada and the Canadian Information Centre for International Credentials released the *General Guiding Principles for Good Practice in the Assessment of Foreign Credentials* in 1998, which was revised in 2012 to become the *Pan-Canadian Quality Assurance Framework for the Assessment of International Academic Credentials* with funding from the Foreign Credential Recognition Program. This document outlines fundamental principles and general procedural guidelines for the non-discriminatory evaluation of foreign credentials. For instance, they recommend "situat[ing] the academic credential within the framework of the education system of origin" and considering past practices to ensure consistency. It also sets out criteria around processing times, information requirements, fees, translation, document requirements, the status of institutions and programs, the purpose of assessment, level of study, assessment criteria such as contents of the program and duration, and an appeals process (CICIC, 2012). World Education Services, a third-party assessment agency which provided assessment services for the CNO before the NNAS took over this role in 2014, abides by the principles and recommendations in this document.

⁷⁸ The *Regulated Health Professions Act, 1991* mandated independent oversight of the CNO's registration decisions by the Health Professions Appeal and Review Board and reporting of registration committee activity.

⁷⁹ Three provinces other than Ontario have passed similar legislation. Manitoba in 2007, Nova Scotia in 2008, and Alberta in 2020.

⁸⁰ General duties refer to the provision of registration practices that are transparent, objective, impartial and fair (FARPCTA, 2006 II s.6).

⁸¹ As of 2022, 62 regulators are covered by the FARPCTA. This includes 13 non-health professions, 23 compulsory trades, and 26 health professions (OFC, 2022b).

required to comply with, and two⁸² distinct sets of *specific duties* for health⁸³ and non-health regulators.⁸⁴ Second, it establishes the OFC,⁸⁵ headed by an appointed Fairness Commissioner (FC), to assess, monitor, and publicize regulators' compliance with legislation.⁸⁶ Third, it establishes the Access Centre for Internationally Trained Individuals, a centralized information hub for internationally educated health professionals, an element I did not analyze.⁸⁷ Fourth, it establishes reporting and auditing requirements. Fifth, it outlines sanctions for lack of compliance.

Since 2007, the OFC has received over \$21 million in funding to fulfill its mandate.⁸⁸ How the OFC has fulfilled its mandate has changed over time, increasingly narrowing its focus on regulators considered more at risk of non-compliance. From 2007 to 2010, the OFC undertook the “start-up and research phase” (OFC, 2010, p. 43). During this phase, it established a conceptual framework for the *general duties*⁸⁹ listed in the Act and, on this basis, determined the nature and scope of its four assessment mechanisms: Fair Registration Practice Reports,⁹⁰ assessments of

⁸² Health professions must comply with the same *general duties* and are subject to the same assessment mechanisms (although under different guidelines) as all other regulators, such as Fair Access Registration Reports and reviews of registration practices (described later in this chapter). However, they are not required to comply with the same set of *specific duties* regarding timeliness, access to records, and public reporting. More specifically, health regulators are only required to provide information about the amount of time the registration process usually takes rather than ensure that the process occurs within a reasonable time. Health regulators are also not required to let applicants access their registration records or to make the reviews of their entry-to-practice review reports publicly available. The Fairness Commissioner (FC) can only issue compliance orders to non-health regulators, not health regulators (OFC, 2014a). It is not clear what factors led to the distinction between health and non-health regulators.

⁸³ Health regulators are required to meet specific duties in the following areas, as found in the RHPA, Schedule 2: a) information for applicants (s.22.3); b) internal review or referral to registration committee (s.15, s.18, s.19); c) information on appeal rights (s.20, s.21, s.22); d) documentation of qualifications (s. 22.4(1)); e) assessment of qualifications (s.22.4(2)); f) training (s.22.4(3)); and, g) access to records (s.16).

⁸⁴ Non-health regulators are required to meet specific duties in the following areas: a) information for applicants; b) timely decisions, responses, and reasons; c) internal review or appeal; d) qualifications; e) language proficiency; f) Canadian experience; g) training; and, h) access to records (FARPCTA, 2006 III s.7-12).

⁸⁵ The Access to Professions and Trades unit was dissolved with the establishment of the OFC.

⁸⁶ To see the complete list of functions see: Schedule 2 Section 22.5 of the RHPA.

⁸⁷ See Appendix D: Overview of Other Federally-Funded FCR Initiatives to read the summary of the Access Centre.

⁸⁸ This amount was calculated by using data from OFC's annual reports from 2008 until 2021.

⁸⁹ The OFC defines *transparency* as a process that is open, accessible, and clear, wherein it is “easy to see what actions are being taken to complete the process, why these actions are taken, and what results from these actions” (OFC, 2022a, p. 7). *Objectivity* as a process based on “formal systems, such as criteria, tools, and procedures that have been repeatedly tested during their development, administration and review and have been found to be valid and reliable” (OFC, 2022a, p. 5). *Impartiality* as neutral decision-making process encompassing identification and strategies to help ensure that “all sources of bias are identified and that steps are taken to address those biases” (OFC, 2022a, p. 4). And, *fairness* as a process or decision that demonstrates substantive, procedural, and relational fairness (OFC, 2022a, p. 3).

⁹⁰ Fair Registration Practice Reports, submitted by regulatory bodies every year, describe any improvement/changes to registration practices implemented and the impact on applicants. According to the *Guidelines for Fair Registration Practices Reports* (first released in 2008 and revised in 2015), regulatory bodies are required to report

registration practices,⁹¹ entry-to-practice reviews,⁹² and audits.⁹³ Through these mechanisms and additional baseline studies,⁹⁴ the OFC gathered information on registration practices to identify issues and commendable practices,⁹⁵ and developed and monitored the progress of recommendations.⁹⁶ It also gathered quantitative data on the number of applicants and members

on the following twelve areas: 1) requirements for registration, including alternatives; 2) assessment of qualifications; 3) provision of timely decisions, responses and reasons; 4) fees; 5) timelines, deadlines, or time limits; 6) policies, procedures and/or processes including by-laws; 7) resources for applicants; 8) review or appeal processes; 9) access to applicants records; 10) training and resources for registration staff, council and committee members; 11) mutual recognition agreements; and 12) any other registration related changes. The regulatory bodies must also submit quantitative data to observe “statistical changes and trends related to application, licensure, appeals and staffing year over year” (OFC, 2015d, pp. 5–7).

⁹¹ Assessments of Registration Practices consist of an assessment by OFC staff of the regulatory body’s practices against the duties set out in legislation to determine compliance, identify gaps and make recommendations, and, if necessary, “engage the regulatory body in action” (OFC, 2015e, p. 3). The *Registration Practices Assessment Guide For Health Regulatory Colleges* (first released in 2011 and revised in 2016) translates the general and specific duties of the Act into 69 practice-based expectations. Each practice describes a specific action(s) that regulatory bodies must take to fulfill the expectation. For instance, for the specific duty of Information for Applicants, the regulatory body must demonstrate the following five practices: describe the requirements for registration on the website, describe all the steps, provide information on how long the process usually takes, the fee scale, and ensure that the information required by practices one to four is “clear, accurate, complete, and easy to find” (OFC, 2016b, pp. 4–5).

⁹² The document *Conducting Entry-to-Practice Reviews: Guide for Ontario’s Regulatory Bodies* (first released in 2009 and revised in 2015) uses the name Entry-to-Practice Reviews for what fair access legislation refers to as “reviews of registration practices.” In these reviews, regulators must self-analyze their registration practices and requirements, particularly the efficiency and timeliness of decisions, the reasonableness of fees, and the need and relevance of each entry-to-practice requirement (OFC, 2015c).

⁹³ Audits are assessments of registration practices conducted by an external auditor. In the document *Audits of Registration Practices: Guidelines for Ontario’s Regulatory Bodies* (first released in 2008 and revised in 2015), the OFC specifies the scope of and standards for audits, eligibility criteria for the roster of auditors, and provides guidance on the evaluation of registration practices and information about audit timelines. While auditors retain complete discretion to determine the nature of the inspection, the 2008 guide offers a series of questions to assist auditors in their inspection of the following areas: how information was provided to applications, the timeliness of decisions, responses, and reasons given; on internal reviews or appeals; on documentation required and alternatives offered; on how qualifications were assessed; on training to registration staff; and, on access to records (OFC, 2009). The 2009 baseline audit of the CNO’s registration practices examined for “trends, compliance, discrepancies and best practices” by reviewing relevant documentation (specifically, the website, by-laws, policies, committee terms of reference, committee minutes, registration related application forms, guides, information sheets and checklists), information gathered in discussion and meetings with CNO staff, by performing testing of sampled applications, and by surveying recently registered members regarding their registration experience (OFC, 2009, pp. 5–6).

⁹⁴ The studies produced the following basic information about each regulated profession: its requirements for registration, licensure, and/or certification; components of its registration practices; recent developments in the profession; job prospects; staff handling registration; handling of complaints; the role of third parties; fees; and statistics for 2005, 2006, and 2007 on the number of members, applicants, and the jurisdiction of their initial training. The OFC compiled a study for each profession and also released an analysis of their findings for all professions (OFC, 2007a, 2008).

⁹⁵ A commendable practice is defined as “program, activity or strategy related to a regulator’s registration practices that go beyond the minimum standards set by the OFC” (OFC, 2022a, p. 2). The purpose of identifying commendable practices is two-fold: “to recognize and encourage regulators for practices that exemplified fair-access principles and to identify practices that could be useful to other regulators in their continuous-improvement efforts” (OFC, 2013, p. 42).

⁹⁶ In the cases where OFC made recommendations, regulators were expected to “develop and implement action plans with support, monitoring and follow-up from the OFC” (OFC, 2013, p. 45).

by the jurisdiction of initial training,⁹⁷ the status of applications,⁹⁸ internal reviews and appeals process,⁹⁹ and on staff and their specific roles.¹⁰⁰

From 2010 to 2015, the OFC transitioned into a Strategy for Continuous Improvement of Registration Practices to “facilitate the improvement of registration practices, foster a culture of continuous improvement, and monitor the implementation of the fair-access legislation” (OFC, 2015e, p. 2). As part of this strategy, the OFC revised its four assessment mechanisms. In particular, it revised the Fair Registration Practices Reports¹⁰¹ to “streamline the reporting process, ease the reporting burden, and make the content more relevant to the OFC’s oversight role” (OFC, 2016a, p. 12). It revised the guidelines of assessments of registration practices¹⁰² and reduced their frequency to provide regulators “greater flexibility in implementing recommendations” (OFC, 2016a, p. 5). It also limited the conditions under which regulators would be subject to entry-to-

⁹⁷ The jurisdictional categories for all these data sets are: Ontario, Canadian, US, and non-US internationally educated applicants. Only the data set which tracks the number of applicants and members is further broken down by specific country of origin e.g. Philippines, India, etcetera (OFC, 2015d).

⁹⁸ The number of new applications; applicants “actively pursuing licensing,” defined as those who have had some contact with the organization within the reporting year, “inactive applicants,” who had no contact; who met the requirements but did not become members; who became fully registered; who were authorized an alternative class of license but were not issued one; and, applicants who were issued an alternative class of license (OFC, 2015d).

⁹⁹ Data on reviews and appeals processed is categorized as applicants subject to internal review or referred to a statutory committee such as a Registration Committee; applicants who initiated an appeal of a registration decision; appeals heard; registration decisions changed following an appeal (OFC, 2015d).

¹⁰⁰ Staff data is categorized as total staff employed, staff involved in appeals, and staff involved in the registration process (OFC, 2015d).

¹⁰¹ Under previous guidelines, regulators had to describe all their registration practices. Under revised guidelines, they only had to report on what had changed in the current reporting year. The OFC also developed an online reporting platform with detailed instructions and other features to make submission easier. This new system also expanded on the type of quantitative data collected, including information by jurisdiction (by country) and gender of applicants and members.

¹⁰² When Assessments of Registration Practices were first conducted in 2011, the FC determined that they would occur in cycles every two years, alternating between comprehensive and targeted assessments. In 2015, the cycle was expanded to every three years (OFC, 2015e). Since the shift to a risk-based approach to compliance is fully in place as of 2021, these assessments are to be done only on a case-by-case basis and for regulators designated as moderate to high-risk Fields (OFC, 2021c).

practice reviews¹⁰³ and audits¹⁰⁴. During this period, it also continued to publish research and conduct educational activities related to its mandate.¹⁰⁵

From 2015 to date, the OFC transitioned to a Risk-Informed Compliance Framework (OFC, 2021a). This targeted approach categorizes each regulator’s risk profile as low, moderately low, moderate to high based on its historical performance¹⁰⁶ and forward-looking risk factors¹⁰⁷ and allocates resources accordingly. The OFC also revised its ten compliance tools to be applied in an escalating manner.¹⁰⁸ These range from providing advice and promoting best practices to publicizing non-compliance issues to issuing compliance orders against a regulator, which “ may contain any actions that the Fairness Commissioner deems appropriate for the regulator to do, or to refrain from doing, in order to comply with the legislation” (OFC, 2021c, p. 18).

As of 2022, the CNO has been subject to one baseline study in 2007, an audit in 2009, one entry-to-practice review in 2011, three assessments of registration practices (two full assessments in 2012 and 2016, and one targeted in 2014) and has completed fourteen Fair Registration Practice Reports. These assessment mechanisms produced a total of 43 recommendations¹⁰⁹ and a series of commendable registration practices by the CNO, such as clarifying the information provided on

¹⁰³ While regulatory bodies are encouraged to conduct voluntary entry-to-practice reviews, the OFC indicated that it would only conduct mandatory reviews when they identified a “concerning,” “persistent” issue with a registration practice or requirement needing a more “systematic analysis” to “eliminate or mitigate negative impacts on applicants” (OFC, 2015c, p. 13). During a mandatory review, regulatory bodies must follow the guidelines; whereas, during a voluntary review, regulators are only advised to consult the guidelines.

¹⁰⁴ After 2015, audits would only focus on particular issue(s) identified by the OFC and conducted only in situations determined as high-risk (OFC, 2015b).

¹⁰⁵ Some seminal reports produced by the OFC include the 2009 *Study of Qualification Assessment Agencies*, the 2010 *Getting Your Professional Licence in Ontario: the Experiences of International and Canadian Applicants* study, and the 2013 *Academic Requirements and Acceptable Alternatives: Challenges and Opportunities for the Regulated Professions in Ontario*. An example of an educational activity includes the 2015 conference hosted by the OFC called Learning Day. This event was held in Toronto and attended by nearly 100 participants from Ontario’s 42 regulators. Its purpose was to increase collaboration among regulators by allowing them to share resources, best practices, and concerns and issues (OFC, 2016a).

¹⁰⁶ Historical performance determines a regulator’s degree of compliance by considering the implementation of past recommendations, their level of motivation to comply, any court and/or tribunal decisions discussing their practices, and the extent to which the regulator has adopted fair registration fair practices (OFC, 2021a, p. 21).

¹⁰⁷ Forward-looking risk factors consider the regulator’s organizational capacity, the control they exert over assessment and registration processes, particularly over third parties, the impact of emergency situations such as the COVID pandemic, over-reliance on Canadian experience requirements, and public policy considerations, particularly the need to address critical labour shortages and the application of an inclusion and anti-racism lens to registration decisions (OFC, 2021a, p. 21).

¹⁰⁸ For the complete list of compliance tools and circumstances under which each may be used see the OFC’s *Risk-informed Compliance Framework and Policy* (OFC, 2021c, pp. 16–18).

¹⁰⁹ The CNO received eight recommendations in 2012, 34 in 2014, and one in 2016 (OFC, 2012b, 2014b, 2016c). See Appendix E: List of OFC’s Recommendations to the CNO from 2012 to 2016.

the College’s website,¹¹⁰ developing an online application portal,¹¹¹ implementing staff-training requirements,¹¹² utilizing applicant satisfaction surveys,¹¹³ developing registration tools such as worksheets to help measure applications against objective criteria, developing an international nursing program database to reduce duplication, and transitioning into more broadly accessible, computer-based entrance exams (OFC, 2012b, 2014b, 2016c).

Since 2016, following the implementation of all recommendations, the CNO has been classified as fully compliant with legislation. It currently has a moderately low-risk rating, subject to minimal monitoring outside the submission of the yearly Fair Registration Practice Reports (J. Mendel, personal communication, June 7, 2022).

In sum, fair access legislation sets forth criteria and accountability measures, including an oversight body, reporting requirements, and penalties for non-compliance. The OFC serves as the oversight body tasked with assessing the registration practices of regulators and ensuring adherence to the principles established in the Act. This role is deemed fulfilled concerning the CNO, which is now under limited monitoring and reporting obligations.

3. How are Fair Access Interventions Evaluated and Defended Relative to their Effects on IENs?

Although the initial reaction to fair access legislation, or Bill 124, was mixed, fair access interventions are broadly understood to have successfully improved access to regulated professions.

¹¹⁰ In the 2012 assessment, the CNO’s website was praised for “clearly informing applicants” about acceptable alternatives to requirements, accommodations of special needs, available resources (e.g. study guides), steps of the registration process, workshops offered by HealthForceOntario, and fees including those not under CNO’s control. In the 2014 assessment, for providing comprehensive and thorough information tailored for applicants trained in Ontario, elsewhere in Canada, and abroad. And, in 2016, for revising, in consultation with applicants, the information available on the website and in correspondence.

¹¹¹ This online portal was fully implemented in 2018 to replace most paper application processes. This was introduced as part of a broader initiative to “upgrade our technology and business processes so we can offer more efficient services and reduce paper” (CNO, 2018b).

¹¹² In 2012, CNO was commended for requiring staff who deal with applications to complete the Accessibility for Ontarians with Disabilities Act online education module, a self-administered cultural knowledge test, and training on applying assessment criteria in a way that ensures that they “do not undervalue applicants from certain jurisdictions or give undue preference to applicants from other jurisdictions,” and, for making sure that customer service representatives stayed current with information (OFC, 2012b). In 2016, the CNO Council was commended for participating in an OHRC workshop on applying the Code to regulatory decision-making (OFC, 2016c).

¹¹³ The CNO drew feedback from a monthly survey conducted with applicants, including IENs, on their experiences with registration as well as from the Nurses Newly Registered advisory group, which was formed in 2016 and was comprised of nurses within their first two years of registration (OFC, 2016c, p. 3).

However, the experiences of IENs, as reflected in an analysis of application and appeal data, complicate this narrative.

Starting with initial reactions to Bill 124, they can be generally divided into three major camps: staunch supporters, skeptics, and opponents. Starting with staunch supporters—specifically, some immigrant-serving organizations, business associations, and professional associations such as the RNAO—argued that even if imperfect, fair access legislation was a long-needed step towards addressing the issues of FCR.

For instance, a representative of the Fair Access Coalition, one of the leading groups responsible for the drafting of Bill 124, said that it represented “a bold step forward in correcting inequities and unfair practices faced by internationally trained professionals,” called the Bill “balanced and effective,” and urged its passing as presented (Calla, *Hansard T-15*, 2006, p. 178). Meanwhile, a representative from the Consortium of Agencies Serving Internationally Trained Persons, a consortium of eight organizations that provide employment and training services to immigrants in the Greater Toronto Area, similarly praised it for setting a “new standard of accountability that will not only have an impact economically but also in the arena of human rights,” and for creating an “equity framework that protects and promotes the human rights of internationally educated” (Cullingworth, *Hansard T-15*, 2006, p. 193).

Skeptics—specifically some immigrant-serving organizations such as the Ontario Council of Agencies Serving Immigrants, the CARE Centre for Internationally Educated Nurses, community groups such as the Chinese Canadian National Council, the Ontario Federation of Labour, opposition parties, and individual witnesses such as current Mayor of Toronto Olivia Chow—supported the premise of the Bill and considered it an important step towards improving integration of immigrations in the province. However, they criticized the legislation’s vague language, the bifurcation between regulators and third-party agencies, the OFC’s limited enforcement powers, the absence of an independent appeal body, and the lack of additional funding for programs to help immigrants upgrade their skills and navigate the system.

In response to these concerns, the opposition parties (the New Democratic Party and the Progressive Conservatives) jointly proposed amendments to the Bill to clarify the Act's language and increase its enforceability and scope. For instance, they tried to include detailed time-frames

for regulators to decide on applications (*Hansard T-19*, 2006, p. 297); specify the training provided by regulators to focus on anti-discrimination, anti-racism, cultural competency and human rights (p. 303); provide more enforcement powers to the OFC to ensure that third-party assessments agencies comply with the Act, rather than relying on regulatory bodies to “take reasonable measures” for compliance (p. 302), and to enable it to rule on removing requirements such as exorbitant fees that violate the Act rather than simply reporting about it (p. 293); and, to expand the role of the OFC by making its report directly to the legislature rather than the Minister and assess the comparability of Ontario registration practices to those other jurisdictions to facilitate reciprocal agreements (pp. 306-8). However, they were unsuccessful, and the Bill was passed virtually unamended.

On the other side of the spectrum, opponents to the Bill—primarily regulators—supported its premise but opposed it on the grounds that it was redundant and a possible infringement on their authority to determine standards of practice. Specifically, they argued that since their registration practices already abided by the principles of fairness espoused in the legislation, additional reporting requirements would become burdensome and strain their already limited resources. The CNO specifically argued that the Bill would “begin to erode the college’s legislated privilege and demonstrated expertise in setting entry-to-practice requirements for Ontario’s nurses.” As such, it recommended that the OFC’s authority be “limited to reviewing procedural matters that relate to an applicant’s right to administrative fairness.” It also highlighted that it had already invested considerably in “ensuring the success of [IENs] applying for registration in Ontario” and pointed to its collaboration with the CARE Centre, the Ministry of Training, Colleges, and Universities, and other groups in the creation of guides and self-assessment tools as evidence. If the Bill was to pass, as was foreseeable, the CNO recommended that, at the very least, its enforcement be staggered and that its initial focus be on regulators without an independent appeal body (Coghlan, *Hansard T-15*, 2006, p. 199). Notwithstanding these disagreements, there was a shared belief that fair access would help more international applicants access the professions. In other words, despite disagreements on implementation, there is an overwhelming belief that fair access can address issues related to FCR.

Several years into the implementation of Bill 124, the OFC maintained that while changes to registration practices may seem minute, lasting systemic change had occurred through

continuous, incremental improvement and encouraging regulators to go beyond legalistic compliance (Augustine, 2012, p. 12). For instance, in a 2015 study,¹¹⁴ the OFC pointed to an increase in the employment match rates¹¹⁵ of internationally educated individuals as well as an increase in the percentage of internationally educated individuals who held a licence to practice in Ontario relative to total licence holders¹¹⁶ as evidence of this incremental progress. Indeed, CNO data from 2007 to 2020 submitted for the Fair Access Registration Reports shows a similar increase in the percentage of IENs who became licensed (49%) compared to Ontario-educated applicants (22%).¹¹⁷ The OFC called these increases “encouraging” because they suggest that internationally educated individuals were “better placed to compete for jobs in 2011 than in 2006, despite challenging labour market conditions” (Augustine, 2015, p. s35).

Reflecting ten years since the passing of legislation, the OFC maintains that changes to licensing practices have “cumulatively reduce[d] and eliminate[d] undue burdens, resulting in a fairer process” (OFC, 2017, p. 6). In the case of the CNO, it points to changes such as the implementation of the online application portal, the expansion of alternatives to meeting language proficiency requirements,¹¹⁸ and the removal of the limit on the number of attempts for the

¹¹⁴ This study used data from the 2006 Census, the 2011 National Household Survey, and data collected from regulators over five years after passing of fair access legislation (Augustine, 2015).

¹¹⁵ Employment match rate is defined as the “total number of people working in the regulated profession divided by the total number of employed people who have completed education that would normally lead to licensure in that profession” (Augustine, 2015, p. s30). The OFC found that Ontario and Quebec applicants who studied abroad (both Canadian-born and immigrants) had experienced a statistically significant 1% increase in employment match rate (compared to Canadian-educated workers who experienced no change) over the five years after the passing of fair access legislation (Augustine, 2015, p. s35).

¹¹⁶ The OFC noted a 22.7% increase in the number of internationally educated individuals who held a license to practice in Ontario (compared to 13.7% growth in total license holders) (Augustine, 2015, p. s35)

¹¹⁷ The percentage of non-US international applicants registered to practice in Ontario increased by 49% from 14,272 in 2007 to 21,362 in 2020. In comparison, the number of Ontario-educated applicants registered to practice in Ontario increased by 22% from 127,794 in 2007 to 156,925 in 2020. See Appendix F: CNO Membership and Applicant Data for complete data sets.

¹¹⁸ Before 2015, IEN applicants had to meet the language proficiency requirement via an officially recognized language test. After 2015, the CNO permitted IEN applicants to meet their language proficiency in other ways including additional education, completion of a non-nursing program, or teaching experience in either English or French (CNO, 2015). A year later, the registration committee was empowered to decide on language proficiency based on evidence such as letters from an employer. In January 2020, the CNO introduced new forms to collect information about language proficiency, which includes letters of reference from employers or other organizations (CNO, 2020a).

entrance examinations¹¹⁹ as evidence of the College going beyond compliance to make their registration practices and processes fairer.

The OFC highlights that regulators have undergone a significant ideological change, moving beyond mere compliance with the law to actively prioritizing fair access. Additionally, regulators “routinely seek the [OFC’s] advice before implementing new licensing requirements and policies” (OFC, 2017, p. 6). I witnessed an example of this proactive prioritization of fair access during the September 2021 council meeting. When a public member of the Council suggested that the new Supervised Practice Experience Partnership program¹²⁰ be made a mandatory requirement for all IENs, the entry-to-practice manager declined this suggestion because it would constitute an unfair registration practice:

One of the components that we talk a lot about is fairness for applicants and for applicants, we cannot require in our circumstances to have Canadian experience and that would be deemed to be Canadian experience. So, we see this as an additional opportunity for applicants to gain this experience [...] as one of the pathways that they will have [...] that’s one of the reasons why we cannot make it mandatory (Vogler, 2021).

Despite providing these improvements to the integration process, the OFC notes persistent issues related to the lengthiness of registration timelines in health care professions,¹²¹ regulators’ use and monitoring of third-party assessment agencies,¹²² the inaccessibility of alternative pathways,¹²³ and issues of hiring and retention which negatively affected the employment match

¹¹⁹ The NCLEX-RN and the Regulatory Exam – Practical Nurse (REx-PN), the current entrance exams for Registered Nurses and Registered Practical Nurses in Ontario, can be taken unlimited times, compared to a three-time maximum in previous practice Fields (CNO, 2015, 2019b).

¹²⁰ The Supervised Practice Experience Partnership is a program which provides eligible candidates an alternative opportunity to meet their evidence of practice and language proficiency requirements by working as an extern under the supervision of a preceptor in a variety of health care settings.

¹²¹ In 2013, the OFC noted that international applicants in health professions had not experienced similar improvements in timeliness as applicants in non-health professions; on the contrary, some health professions had actually experienced longer timelines (OFC, 2013).

¹²² In the OFC’s 2015 report of trends in progress and problems identified through 34 targeted assessments of registration practices, the OFC noted that while regulators are required to ensure third-party assessment agencies are compliant, it claims that they “may not be sure how to monitor this or how to go about developing a good accountability mechanism” (OFC, 2015a, p. 29). In the 2016 assessment of the CNO’s registration practices, the OFC attributed, at least in part, the drop in the number of IEN applications (from over five thousand in 2012 to over one thousand in 2015) to the introduction of the NNAS and recommended that the CNO work with the NNAS to “clarify for applicants the purpose of collecting practice and employment information” (OFC, 2016c, p. 13).

¹²³ In 2015, the OFC panned the York University IEN bridging program for being too long and costly, not being flexible to address specific competency gaps, being open only to applicants pre-evaluated by the CNO, and for only helping applicants meet one of the several requirements for registration (OFC, 2015a, p. 22).

rates of IENs.¹²⁴ The OFC does not attribute these issues to failures of fair access interventions or as indications that they are ineffective or inappropriate. Rather, as indications that (a) more work is required to ensure compliance with legislation, such as providing further education to regulators, continuing to monitor their practices, encouraging them to seek public and applicant feedback when making changes to registration practices, and demanding legislative changes so that all regulators are subject to the same requirements; and, (b) fair access interventions need to be implemented in conjunction with policies that provide appropriate levels of funding to support regulators in making changes, increase access to bridging programs and loan programs, and incentivize the hiring and retention of immigrants (Augustine, 2015; OFC, 2013, 2014a, 2015a).

To summarize, despite some initial resistance from regulators, fair access interventions are represented as necessary accountability mechanisms and successful in increasing access to the professions by pointing to hundreds of changes made to registration practices, an overall increase in the number of internationally educated individuals who have been able to get their licence, improvements in their employment match rates, and a shift in how regulators prioritize fair access beyond legal compliance. Meanwhile, persistent issues with integration are represented as manageable through additional education and consultation, better legislative oversight, sustainable government funding, and additional hiring and retention interventions.

This representation as a successful initiative starkly contrasts with the lived experiences of IENs, which show that integration has become stricter, lengthier, and more expensive since the passing of fair access legislation. Because these experiences starkly contrast with the aforementioned representation of fair access interventions as largely successful, I direct attention to the lived experiences of IENs before analyzing the deep-seated assumptions underlying this initiative. Whereas in the analysis of NNAS in the previous chapter, I was able to examine IENs' direct experience with the organization, fair access interventions do not interact directly with applicants. This means one can only infer their lived effects by analyzing aggregate data.

As I mentioned, the OFC points to the relatively higher increase in IENs who have become licensed since the passing of legislation (a 49% increase relative to a 22% increase for domestic

¹²⁴ Despite indications that the employment match rates among all internationally educated individuals had improved after the implementation of legislation, the OFC found that there had been a decline in the employment match rates of IENs, which it partly attributes to employment policies that “may have displaced immigrant nurses” such as the Nursing Graduate Guarantee initiative (Augustine, 2015, p. 41).

applicants) as evidence of the success of fair access interventions. However, a closer look at applicant data from the same period reveals that the more likely causes of this increase are not fair access interventions but rather (a) a disproportionate admission of IENs into the lower tier of nursing as licensed practical nurses and (b) a massive increase in the number of applicants. The data also reveal that the relatively higher increase in IENs who became licensed since the passing of legislation has not significantly affected the composition of the nursing workforce.

Regarding the first point, although I could not locate IEN data disaggregated by province, nationwide data from Statistics Canada indicates that from 2006 to 2016, the proportion of IENs in licensed practical nursing positions grew from 12.3% to 21.2%. In comparison, their proportion in RN positions only grew from 14.4% to 16.1% (Cornelissen, 2021). This is congruent with data from the Canadian Institute for Health Information, which indicates that from 2006 to 2015, the supply of licensed practical nurses grew by more than 50% compared to 10% for RNs (CIHI, 2016). Although this latter figure includes both international and domestic graduates, based on the fact that during roughly the same period, the domestic supply of graduates from both classes of nurses grew at a similar rate,¹²⁵ one can deduce that the relative expansion of licensed practical nursing positions was driven primarily by international graduates. In basic terms, there has been a significant surge in licensed practical nursing positions despite Canadian nursing programs not producing more licensed practical nurses compared to RNs. This strongly suggests that the rise in licensed practical nurses is largely driven by international applicants.

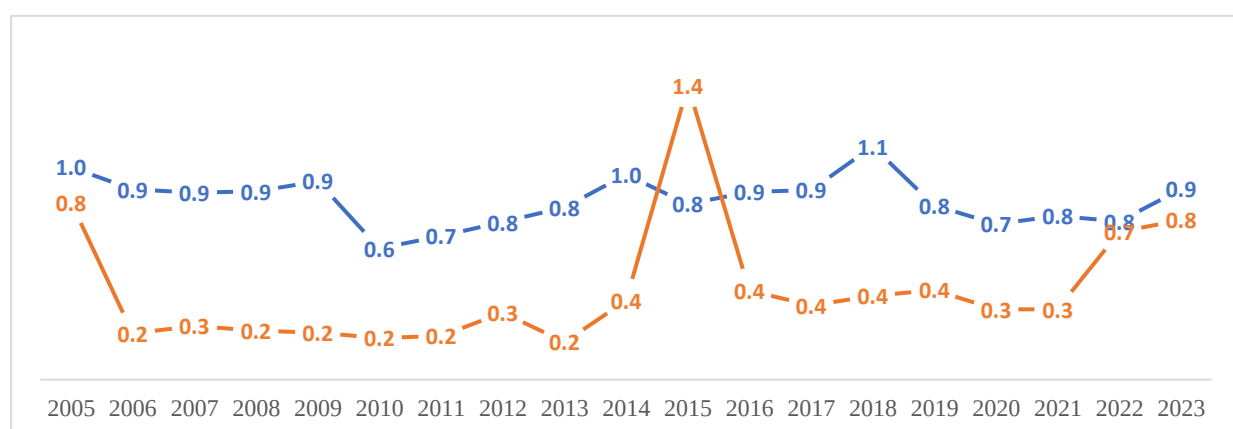
As it relates to the second point, CNO data¹²⁶ show that from 2007 to 2020, the number of IEN applicants increased by over 300% (from 2,114 to 6,315) compared to an increase of 18% (from 8,688 to 10,319) of Ontario-educated applicants (CNO, 2007, 2021). This indicates that although the licensing rate for IENs compared to Ontario-educated applicants was higher (49% versus 22%), this does not imply that obtaining a license as an international applicant has become easier. Instead, it suggests that there are significantly more international applicants. In fact, as *Figure 1* illustrates, following the passing of legislation in 2006, there is neither a discernable increase in the clearance rate of IEN applications nor a significant narrowing of the gap between

¹²⁵ According to CIHI (2016), from 2007 to 2013, the number of graduates from Canadian licensed practical programs increased at an average annual growth rate of 4.7% compared to 4.6% among graduates from Canadian registered nursing programs.

¹²⁶ See Appendix F: CNO Membership and Applicant Data for the whole data set.

the licensing rate of international relative to domestic applications (that is, until 2022, the reasons for which I outline in *Chapter 6*). In particular, between 2006 and 2014, an average of 20% of non-US IEN applications were approved per year compared to 80% of those made by domestically educated applicants.¹²⁷ In other words, eight years after the passing of legislation, domestic applicants were four times more likely to get their licence than their international counterparts.

Figure 1. Clearance Rate of Applications Domestic (Blue) vs. Non-US IENs (Red)



Clearance rate is the number of applications approved relative to the number submitted per year. Data are from CNO's Fair Registration Practice Reports (2007, 2008, 2009, 2010, 2011, 2012, 2013b, 2014, 2015, 2016a, 2017, 2018b, 2019b, 2020a, 2021, 2022, 2023a).

Although there was an improvement in the clearance rate of international applications and a narrowing of the gap between the licensing rate of international and domestic applications after 2014, this coincides more with the introduction of NNAS than with fair access interventions.¹²⁸ By acting as a pre-screening mechanism, NNAS massively reduced the number of international applications made to the CNO, thereby increasing the likelihood of success for those applicants who reached this stage. Consequently, from 2016 to 2020, roughly 40% of international applications were approved per year compared to 90% of Ontario-based applications. As I discussed in *Chapter Two*, this improved rate does not mean that NNAS has necessarily translated

¹²⁷ Similarly, using CNO data from January 1, 2012, to December 31, 2012, Walton-Roberts (2021, p. 2331) calculated that out of the 5517 new applications from non-US IENs received by the CNO, 1761 or 32% completed their registration within 1 year. In comparison, 7736 (or 74%) of the 10,458 Ontario-trained nurses who applied achieved full licensure by the end of the year.

¹²⁸ The OFC attributed, at least in part, the drop in the number of IEN applications (from over five thousand in 2012 to over one thousand in 2015) to the introduction of the NNAS (OFC, 2016c, p. 13).

into an overall reduction in the time, effort, and cost of the licensing process but, rather, that it has shifted the burden of the first four steps of the assessment process away from the regulator towards the IEN. In other words, the demonstrable improvement in the acceptance rate has less to do with the process becoming less onerous and more with the fact those who make it further in the process have been more effectively selected. In contrast, those who do not pass the NNAS assessment stage are not captured by data collected by the CNO.

Meanwhile, regarding the composition of the nursing workforce, an analysis of the data¹²⁹ reveals that the proportion of non-US IENs registered relative to the total membership remained fairly stagnant after the passing of legislation, growing only from 9.7% in 2007 to 11.3% in 2020 (OFC, 2021b). In comparison, other professions that experienced similar increases in the relative percentage of international applicants becoming licensed witnessed a more significant shift in their workforce composition. For example, from 2007 to 2020, the number of non-US internationally educated physicians who became licensed increased by 47% (from 8,634 to 12,666) relative to 25% (from 18,079 to 22,580) of Ontario-educated physicians. Subsequently, the proportion of internationally educated physicians relative to the total membership grew from 26% to 29% (College of Physicians and Surgeons of Ontario (CPSO), 2020; OFC, 2007b). Even though both occupations were licensing international and domestic applicants at similar rates, the percentage of non-US internationally educated physicians relative to the total membership grew at twice the rate (3%) of non-US IENs (1.6%). One likely explanation for why the proportion of IENs has remained fairly stagnant is that attrition among IENs is higher than among domestic applicants. If IENs leave nursing at a higher rate, it also clarifies the previously mentioned findings showing that employment match rates for IENs have dropped since fair access legislation was enacted, while those for all internationally educated immigrants have risen (Augustine, 2015).

The previous higher proportion of IENs in the nursing workforce and the significantly better clearance rate of international applications before the introduction of fair access legislation cast doubt on the notion that this legislation has succeeded and supports the idea that the integration of IENs has become more difficult over time. From 1999 to 2003, IENs made up an average of 34% of new registrants in Ontario and, at their peak in 2006, IENs made up around 13.3% of the

¹²⁹ See Appendix F: CNO Membership and Applicant Data for the whole data set.

provincial nursing workforce¹³⁰ (Bourgeault, 2006b; CIHI, 2005, 2008). In 2005, the clearance rate of non-US international applications was around 80% compared to 100% of Ontario-based applications. The introduction of the baccalaureate and diploma requirements for registered nurses and registered practical nurses after 2005, however, has made it more challenging for those with international degrees and diplomas for their education to be deemed equivalent. As a result, in 2007, the clearance rates of international applications dropped to 20% (compared to 90% of Ontario-based applicants), and the proportion of IENs relative to the total provincial nursing workforce dropped to 10.6% (CIHI, 2008; OFC, 2007a). In other words, fair access interventions have proved insufficient in the face of moving goal lines in the form of increasing requirements.

4. Summary

The representation of fair access legislation as a successful initiative is not reflected in the clearance rate or workforce composition data. Instead, the data show that most applicants still fail to become licensed, and those who get their licenses tend to do so as licensed practical nurses. To understand why fair access interventions not only fail to substantially improve access to the nursing profession but, on the contrary, enable integration to become “managed” or constrained through selectivity and assimilation, we need to examine the unquestioned assumptions and silences underlying the representation of the problem of FCR as a lack of fair access. I attribute these effects to an understanding of the lack of fair access as primarily a procedural problem, particularly a lack of oversight in how regulators assess IENs rather than in the standards themselves. The following section identifies the deep-seated assumptions in this framing and their discursive and subjectification effects.

¹³⁰ According to the Canadian Institute for Health Information, the total number of RNs and RPNs in Ontario in 2006 was 115,002. Of these, approximately 15,256 or 13.3% were internationally educated. This data combines international applicants from all jurisdictions, including the US (CIHI, 2008). This data does not differentiate between non-US and US-based international applications.

PART 2

1. A Procedural Problem Rooted in Entry Criteria

To summarize the previous section, fair access legislation forms part of a broader ‘principle-based’ approach that seeks to balance protecting public safety from potentially incompetent practitioners with protecting international applicants’ right to a fair assessment, i.e., one that is transparent, timely, applied consistently using objective criteria, and without regard to their particularities (race, country of origin, or country of education and training), and appealable. It is a response to the criticism that the regulatory regime provided insufficient and inadequate oversight or accountability mechanisms to ensure regulators abide by these principles. The assumption is that ensuring regulators abide by these principles can help improve access to the professions by reducing delays, avoiding biases in assessments, and remedying errors. It can also enhance public confidence in the registration process by demonstrating it is not unduly discriminatory.

Despite leading dozens of procedural changes to the CNO’s registration processes and practices, encouraging more prominent consideration of fair access when making changes to registration requirements, and ensuring the CNO complies with legislation, there is little empirical evidence that fair access interventions substantially improve integration for IENs. Instead, the licensing process has become more constrained while simultaneously being labelled as fairer. That is, the upper tiers of the nursing profession have become increasingly out of reach for many as the assessment process has become stricter, lengthier, and more expensive, resulting in many IENs being channelled into the lower tiers of nursing and healthcare work.

In this section, I investigate the deep-seated assumptions underlying this framing of the problem of lack of fair access as a procedural problem located in regulators’ entry criteria or assessment methods, as opposed to being located in their entry standards or competencies; that is, as a problem in how regulators apply their standards rather than a problem with the standards themselves. Within this problem framing, regulators, in their legitimate pursuit to protect public safety, are not seen as intentionally discriminating against IENs but rather as unwittingly setting up assessment methods that disproportionately impact them. This

framing created a need for regulatory reform, specifically the establishment of an independent oversight body tasked with evaluating regulators' registration processes according to the legislation's principles, providing recommendations, and ensuring ongoing compliance while maintaining respect for the principle of self-regulation.

As fair access interventions became singularly focused on ensuring entry criteria abided by the principles set out in fair access legislation, they legitimized regulators' power to limit access according to the objectives of selectivity and assimilation. Consequently, these interventions not only fall short in significantly improving integration but also cloak regulators' actions in a guise of neutrality. This obscures an already strict, drawn-out, and costly process that perpetuates racialized skill dichotomies, imposing additional burdens on individual IENs and their families while offering them little recourse.

2. Fair Access in the Context of Self-Regulation

In the policy documents I analyzed, discussions of fair access clearly distinguish between entry standards and criteria. In the case of nurses, entry standards or competencies refer to the knowledge, skills, judgement, and attitudes expected of graduate nurses to provide safe, ethical care across various settings. RNs are expected to meet 101 competencies, which are organized thematically under nine roles: (1) clinician, (2) professional, (3) communicator, (4) collaborator, (5) coordinator, (6) leader, (7) advocate, (8) educator, and (9) scholar (CNO, 2018a). RPNs are expected to meet a total of 79 competencies organized into five categories: (1) professional practice, (2) legal practice, (3) ethical practice, (4) foundations of practice, and (5) collaborative practice (CNO, 2019a).

Entry criteria refer to the methods or procedures of assessment (i.e., registration practices and processes) used to determine whether applicants meet these competencies, such as assessments of nursing education and work experience and the use of examinations. Fair access interventions are meant to improve the quality and speed of assessments by ensuring that entry criteria and decisions rendered through the use of these criteria are *transparent* in terms of being clearly and accessibly communicated, *consistent* both in terms of being justifiably and reliably linked to competencies and in terms of being impartially

applied, *timely* in terms of rendering decisions swiftly, and *accountable* in terms providing the opportunity for review to remedy errors.

This distinction between standards and criteria aligns with how other accountability mechanisms also function. The Health Professions Appeal and Review Board,¹³¹ in particular, distinguishes between standards and criteria when it conducts reviews of registration decisions made by health regulators. In carrying out its role, the Board is not mandated to tell the regulator “how to exercise its professional judgment but rather to exercise it free of an identified error.” Specifically, this means that reasonable grounds for appeal are based on an “error of law, an error of fact, or an error of mixed fact and law...[including] procedural error that resulted in prejudice to the applicant, and reasonable apprehension of bias” (Thomson, 2005, p. 67).

Two assumptions underlie this delineation of standards and criteria: that facilitating swift integration and protecting public safety are conflicting objectives and the belief in the self-regulation model. As I discussed in more detail in *Chapter 2*, the bifurcation of facilitating swift integration and protecting public safety is based on the assumptions that (1) the skills of IENs are potentially inferior or lower in quality, lacking or deficient in some way, or fraudulent; and, (2) prioritizing IEN integration will come at the expense of developing the domestic nursing workforce (here and abroad) with implications for healthy public policy. Fair access interventions purposefully steer clear of assessing entry standards to ease concerns that facilitating the integration of international applicants will come at the expense of public safety by lowering these standards. This approach is exemplified in the following statement by the Commissioner of the Office of Manitoba Fairness Commissioner, which is built on the same principles and approach as the Ontario OFC:

¹³¹ In Ontario, under section 21 of Schedule 2 of the *Regulated Health Professions Act*, health regulators are required to have internal review processes in place that can reconsider the registrar’s first-level decision as well as provide the applicant with the additional opportunity to appeal this decision to the Health Professions Appeal and Review Board (HPARB). The HPARB is a quasi-judicial body established by the *Ministry of Health Appeal and Review Boards Act, 1998*. It is responsible for, among other things, conducting reviews and appeal hearings. It can either confirm the registration committee’s decision, refer the matter back for further consideration, or require the college to issue a conditional license or certificate. Registration appeals are handled by adjudicators who are members of the public, none of whom are members of regulated health professions, to “enhance HPARB’s independence and impartiality [and] also help to discourage panels from substituting their opinions for those of regulators for decisions requiring the exercise of professional expertise” (Thomson, 2005, p. 25).

The focus of our work is not the professional standards of each profession but rather how regulators assess people against those standards. That's where we think a lot of the issues are, and I think we've been proven pretty right. They're not being asked to lower their standards and let immigrants in through the back door. They're being asked to make sure that the way in which they assess them is fair (Munoz, *HUMA 10*, 2011, p. 10).

Fair access interventions also avoid assessing entry standards to ease regulators' concerns that oversight would encroach on their self-regulating authority. Regulators are granted the power of self-regulation on the basis that practitioners are "best qualified to ensure that proper standards of competence and ethics are maintained in order to protect public health, safety, and welfare" (Thomson, 2005, p. 13). For instance, the CNO described the value of their expertise in determining standards as follows:

"When considering changes to entry-to-practice requirements, the College assesses the constantly changing role of the nurse in the current health care environment. The competencies embodied in educational programs have been developed in collaboration with nurses in practice, nurse educators and health care administrators and reflect the needs of today's complex practice environment" (Coghlan, *Hansard T-15*, 2006, p. 199).

By leaving the determination of standards up to the discretion of regulators and focusing solely on assessment criteria, fair access interventions aim to strike the right balance between respecting regulators' independence and protecting applicants' right to a fair assessment. This sentiment is reflected in the following statement by a representative of the Fair Access Coalition, one of the main groups responsible for the drafting of Bill 124:

There is, I guess, an issue around balance that one needs to strike between the independence that, obviously, a regulatory body needs to have to protect the public and an intervention that will ensure that the internationally trained have fair access to that profession. When we look at this bill, the kinds of principles the bill espouses are really about the entry criteria. It has nothing, of course, to do with the kinds of standards the profession itself sets for its members. It has to do with the entry criteria. This bill sets out principles. The biggest problem that internationally trained professionals have had has been in understanding how to make an application, what the process is, how the decision is made, what rights they have, and this bill sets those principles out (Calla, *Hansard T-15*, 2006, p. 178).

In the foregoing quote, occupational standards are not cast as barriers to integration. Instead, the “biggest” barrier to integration is assumed to be processual, such as international applicants not knowing how to meet these standards, how decisions are made, and their rights regarding how they can remedy errors in judgment or find alternative ways to meet requirements.

Framing the issue as a procedural one linked to entry criteria influences both the perception of nursing standards and the experience of IENs in various interconnected ways. It objectifies Canadian nursing standards as universal and objective skill and patient safety measures. Meanwhile, while the CNO is sometimes chastised for not fulfilling, even if unwittingly, its obligation to provide fair access, it is nonetheless positioned as the best arbiter of competence. Consequently, despite the OFC’s (2013, p. 2) expressed commitment to a model of “substantive fairness”—that goes “beyond procedural minutiae” and encourages regulators to adopt the “right mindset” that immigrants are “vital economic contributors, rather than assuming that their training is inherently inferior”—in practice, fair access interventions cannot deliver on this commitment. Instead, the OFC portrays the CNO’s registration practices as *fair* even as access has become increasingly selective and assimilative, i.e., scrutinizing and limited to those IENs who can spend the necessary time, effort, and money to approximate Canadian nursing standards.

Guo and Shan’s (2013, p. 474) discourse analysis of fair access legislation and the 2009 Framework similarly criticize the procedural fairness paradigm underpinning these initiatives. Specifically, they argue that,

The government comes through as a culturally neutral institution that could introduce distributive justice or specific to the case of qualification recognition, bias-free intervention mechanism. In effect, however, while countering possible protectionism that is being practised by some regulatory bodies, these documents are devoted to liberalise the labour market. In other words, they are neoliberal in nature and they serve to reinforce market-driven individualism and labour market competitiveness...with their focus on procedural fairness, they have left unattended the systemic devaluation of difference, which is a paradigmatic issue that needs to be challenged.

In other words, bound by their ideological commitment to procedural fairness, these initiatives provide little recourse to IENs because they obfuscate historical and structural inequalities when determining procedural impropriety, and because they reinforce market-driven individualism and

labour market competitiveness by treating differences as deficiencies and assimilationist assessment methods as universal and objective.

To illustrate these effects, I examine three examples of changes made to the CNO's registration practices and processes: reducing the timeframe to provide evidence of practice from five years to three years, the introduction of the Internationally Educated Nurses Competency Assessment Program (IENCAP), and the launch of NNAS. Observe that, although the OFC recognizes problems associated with these changes—issues that either hinder or complicate access for IENs—it refrains from taking substantial action to address these effects. Instead, the OFC considers the CNO's registration practices and processes to be fair, despite the fact that access has been increasingly restricted.

2.1. Reduced Timeframe for Providing Evidence of Practice

At the start of 2013, the CNO reduced the time window for new applicants and those renewing their membership to show evidence of nursing practice from five years to three years. This was part of the newly implemented Declaration of Practice requirement, which aimed at “assur[ing] the public that any nurse providing care has recent practice” (CNO, 2013a, p. 7). Since settling into the country and starting the licensing process often takes longer than three years, during which IENs cannot practice as licensed nurses, this change makes it more challenging to meet their evidence of practice requirement. Filipino nurses immigrating through the former Live-in-Caregiver program, for instance, could not meet this requirement as transitioning out of the program and into permanent residence took longer than three years (Walton-Roberts et al., 2014).

In its 2014 annual report, the OFC recognized that this change “disproportionately affect[ed]” IENs and delayed the CNO's processing times. In particular, the OFC criticized these changes as being “poorly implemented” because applicants were not given sufficient time to transition to the new rules, for insufficiently grandparenting of applications already in progress, and a general lack of transparency (OFC, 2014a, p. 14). However, aside from critiquing how this change was implemented, the OFC lacks the authority to contest it or lessen its effects on IENs. The OFC only recommended that the College gather input from applicants before pursuing future changes and ensure that these changes are communicated more transparently.

2.2. The Internationally Educated Nurses Competency Assessment Program (IENCAP)

In 2013, the Touchstone Institute¹³² launched the IENCAP as an alternative way for IEN applicants for RN status to meet the nursing education requirement. It is described as a “standardized evaluation of IENs’ knowledge, skill and judgment applying to become RNs in Ontario.” It consists of a multiple-choice exam and an OSCE of 12 stations that simulate real-life clinical scenarios (CNO, 2020b). IENs who successfully complete the program are deemed to have the education equivalent to a domestically educated nurse. Meanwhile, those who fail are given a more detailed overview of missing gaps in their competencies. In its 2014 assessment of the CNO’s registration practices, the OFC identified a series of issues with the new alternative assessment method. Still, following minor procedural adjustments, it was deemed compliant with fairness legislation in 2016. It quickly became one of the most popular routes for IENs to meet the educational equivalence requirement (OFC, 2015a, 2016b).

One of the issues identified by the OFC was that the IENCAP failed to meet the “substantive fairness”¹³³ criteria because it did not establish a “clear connection between this assessment method, the CNO’s registration requirements, and the necessary competencies.” As a result of this “missing” or “unclear connection,” the OFC found it “difficult to defend the quality of the CNO’s assessment decisions as a valid and reliable measure of testing competencies necessary to practise the profession, or even whether certain elements of the assessment [were] necessary” (OFC, 2015a, p. 24). To address this, the College was told to clarify and make accessible information about how the program was developed, what it assessed, and how the College planned on evaluating its continued relevance. In other words, the OFC would consider issues of “substantive fairness” to be resolved if the CNO addressed issues related to transparency, specifically, if it simply *told* applicants and the members of the public more information about the methodology, administration, and a proposed plan for evaluation of the program. The CNO acted accordingly by providing a fuller program description on its website and a proposed plan for its

¹³² Prior to 2014, the Touchstone Institute was known as the Centre for the Evaluation of Health Professionals Educated Abroad.

¹³³ The OFC defined substantive fairness as ensuring the registration decision met “pre-determined and defensible criteria.” A decision meets the criteria for substantive fairness when it is “reasonable and the reasoning behind the decision [is] understandable to the people affected (OFC, 2022a, p. 3).

evaluation. Beyond this, however, there is no evidence that the OFC *ensured* that the assessment method measured what it purported to; this determination is left up to the discretion of the CNO.

In the 2014 assessment, the OFC also raised concerns about potential duplication between the IENCAP's assessment of self-regulation and the jurisprudence exam. More specifically, the OFC noted that it was "unclear why the IENCAP includes an assessment of self-regulation and ethics, when all applicants are required to complete a separate jurisprudence exam" (OFC, 2015a, p. 24). Without this clarification, the OFC argued that it could lead IEN applicants and the public to "believe that the assessment process is unnecessarily repetitive for certain groups of applicants" (OFC, 2015a, p. 24). Thus, in the "interest of eliminating or reducing duplication," the OFC recommended that the CNO "clarify why," meaning that it be more transparent as to why applicants must take both (OFC, 2014b).

Shortly after, the CNO added the following section to the *Frequently Asked Questions* section of the program's webpage:

I passed my jurisprudence exam. Can I use that to show I have met some of the competencies that the IENCAP will assess?

No. The purpose of the jurisprudence exam, which all applicants must pass, is to assess your knowledge of the laws and regulations that govern the nursing profession in Ontario. It is not designed to be an evaluation tool, and it cannot be used to show how you have addressed the identified gaps in your RN entry-to-practice competencies.

Nursing education is a separate requirement that you meet by showing us you have nursing knowledge, skill and judgment equivalent to a current graduate of a Canadian university baccalaureate degree nursing program. If we can't determine this based on a review of your nursing education alone, then you must complete Touchstone's evaluation.

The evaluation will help us determine if your combined education and nursing experience has provided you with the nursing knowledge, skill and judgment required of Ontario nurses. This is done through both a written multiple-choice test and an OSCE, which allows us to observe your application of nursing knowledge, skill and judgment. A written jurisprudence exam does

not allow you the opportunity to demonstrate your nursing knowledge, skill and judgment in a comprehensive evaluation that includes application in a clinical setting.¹³⁴

This text states that the jurisprudence exam differs from the IENCAP in that the former is a narrow assessment of knowledge of laws and regulations, while the latter is a broader assessment of all competencies.

With this addition, the OFC determined that potential duplication issues had been addressed (OFC, 2014b). However, aside from an observational visit to Touchstone's test site,¹³⁵ the OFC cannot *ensure* there is no duplication as this assessor operates outside its direct oversight. Again, this is left up to the discretion of the CNO. To this day, the newly revised IENCAP, now called the Registered Nurses Canadian Competency Assessment Program, continues to assess IENs' knowledge of their legal obligations but has abandoned the multiple-choice exam component (Touchstone Institute, 2023).

Another set of issues that the OFC has raised about the IENCAP is its inaccessibility, particularly its high cost and long waiting lists. When first launched, this program was offered free of charge, aside from a \$200 refundable administration fee (Lourdes, 2014). However, as government funding for the program declined, its cost has grown exponentially.¹³⁶ In November 2015, the fee was doubled from \$200 to \$400. In 2023, the in-person fee was raised to \$1500, and the newly introduced virtual OSCE fee is \$1750.

Regarding the waitlist to take the exams, in 2020, the CNO estimated that since the program's introduction, approximately 15 thousand IENs had been "working their way through" the assessment (Santa Mina et al., 2023). A couple of IENs I interviewed declared that it was not easy

¹³⁴ This answer slightly differs from the current one on the website, but it essentially communicates the same information. I was able to access this original answer via the Wayback Machine's internet archives (CNO, 2016b).

¹³⁵ In its 2013-2014 annual report, the Touchstone Institute reported that it had welcomed representatives from the OFC to observe the IENCAP and help them "gain an understanding of the assessment process, the candidate's experience and the logistics involved" (CEHPEA, 2014).

¹³⁶ In November 2015, the fee was doubled to \$400 and was no longer refundable (CNCAP, 2015). In 2018, it was increased to \$750, in 2019 to \$1000, and in 2020 to \$1500. Government funding comprised over 81% of the Touchstone Institute's total revenue in 2014 and decreased to around 64% in 2020, with only a slight increase to around 67% in 2022. In the meantime, fees have increased their share as a revenue source from around 12% in 2014 to around 33% in 2020, only slightly decreasing to around 28% in 2022 (Touchstone Institute, 2018, 2019, 2020, 2022).

to book the exam and that the earliest possible date to take it was over six months away. The pandemic significantly extended these wait times.

Finally, the OFC has criticized the IENCAP, especially given its high failure rates, for not offering a clear pathway for IENs to address identified competency gaps (Augustine, 2015; OFC, 2015a). IENs are not informed about which courses or bridging programs would fill particular gaps. In fact, the CNO cannot assure that completing certain programs will resolve these gaps, requiring IENs to independently determine how to address them. One of my participants, Mike, discusses this issue and how this forced his downward trajectory in the profession:

[The CNO] did not give me recommendations of what courses I need to take. It will depend on the college or university you're applying to actually see what courses can address those gaps. But there is a note that says that even if you take those courses, it is not guaranteed that you will cover all the gaps. So it's your responsibility as an applicant to do your own research. You are on your own... I am looking at university in Alberta and Nova Scotia because I cannot afford to change provinces and those institutions are offering online courses. But my plan B right now is actually to apply for the [Registered Practical Nurse] assessment because even though if I secured a slot in the IENCAP, it would still take me one to two years in order to close those gaps. Working as a [Registered Practical Nurse] will allow me to orient to the health care system (Interview 7, 2019).

IENs also encounter long waiting lists to enroll in bridging programs, which they are required to complete and pay for in their entirety, as these do not offer à la carte options (Da Silva et al., 2022; Santa Mina et al., 2023; Walton-Roberts, 2021). For instance, one of my participants who took the IENCAP in 2017 told me she had to wait two years to get into a bridging program. During our conversation, she mentioned that these delays, coupled with her pregnancy, prompted her to abandon her own licensing efforts in favour of supporting her husband's licensing process (Interview 5, 2019; Interview 6, 2019). Although the OFC recognizes the program's inaccessibility as a major barrier to integration, it considers these issues to fall outside the realm of fair access legislation. As such, its only solution is to advocate for more sustainable government funding (Augustine, 2015; OFC, 2015a).

2.3. Introduction of NNAS

As discussed in *Chapter Two*, since 2014, NNAS has acted as the primary entry point for all¹³⁷ IENs seeking licensure in Canada. In particular, it harmonizes the first four steps of the assessment process, including collecting, validating, and authenticating documents and assessing language and educational comparability to Canadian entry-to-practice standards. In 2016, the OFC attributed the decline of IEN applications from a peak of over five thousand in 2012 to just over one thousand in 2015 to the launch of NNAS two years earlier (OFC, 2016c, p. 13). Notwithstanding a short claim that it would monitor NNAS' outcome and one minor recommendation to "clarify for applicants the purpose of collecting practice and employment information," the OFC issued no further analysis or recommendations on how to hold this third-party assessment service accountable (OFC, 2016a, p. 11; OFC, 2016b, p. 9). Instead, the responsibility falls on the regulator to ensure that NNAS practices adhere to legislation (OFC, 2015a). To date, there has been no additional evaluation of NNAS practices or recommendations issued.

While the OFC and federal evaluators of NNAS have expressed frustration with the OFC's lack of direct legislative authority over third-party assessors,¹³⁸ it is not clear that direct oversight would yield substantial improvements in how NNAS conducts assessments, their length, or their cost. This is because NNAS outsources the bulk of assessments to its US-based vendor, the Commission on Graduates of Foreign Nursing Schools International, which shields NNAS from direct accountability. Therefore, even if OFC could require NNAS to provide a rationale for the fees it oversees or ensure their assessments are fair, NNAS could claim that it has no influence over the assessment costs or their execution. Consequently, the processes of NNAS would still be deemed compliant with legislation.

¹³⁷ With exception of Québec, Yukon, Nunavut, and the Northwest Territories.

¹³⁸ For instance, in the 2020 Evaluation of the Foreign Credential Recognition Program, evaluators lamented the OFC's lack of power to monitor NNAS to address issues of transparency, redundancy, consistency, fairness, cost, and timeliness related to the assessments completed by NNAS (ESDC - Evaluation Division, 2020). Meanwhile, in the 2015 assessment of recognition practices, the OFC lamented that "without effective strategies in place to ensure that third parties are complying with province-specific laws, Ontario regulators may subject applicants to unnecessary hurdles in parts of the licensing process" (OFC, 2015a, p. 26).

This is why the OFC challenges regulatory bodies to develop effective measures to ensure that third parties practices comply with fair-access principles.

3. Conclusion

In the preceding discussion, I argued that lack of fair access is primarily framed as a procedural problem solely rooted in entry criteria, specifically a lack of oversight in how regulators assess internationally educated applicants to ensure that they meet the requirements to practice, rather than a problem in the entry standards themselves, which exist to uphold public safety. The prevailing assumption in this framing of the problem is that international applicants encounter integration challenges because regulators do not, perhaps unwittingly, fulfill their duty to ensure a fair assessment. However, in helping regulators fulfill this responsibility, fair access measures must refrain from undermining their authority to set occupational standards, as the experts within these institutions are considered the best arbiters of competence.

Within this framing, as fair access interventions are reduced to procedural minutiae and unenforceable recommendations, occupational standards are legitimized as universal and objective measures of skill and public safety. Standards are thus maintained and even strengthened, upholding the CNO's authority and expertise to determine them. As a result, I demonstrated that efforts to ensure fair access do not significantly enhance integration but instead complicate an already selective and assimilative process by masking regulators' actions with a superficial layer of fairness.

To develop alternative representations of the problem, we must examine the assumptions regarding nursing standards, public safety, the role of regulators, their silences, and their effects. We specifically need to examine the historical and structural forces involved in establishing the self-regulation model, which positioned regulators as the best arbiters of competence, intensified the scrutiny and assimilation of IENs' skills, and legitimized resistance to their integration as fair and reasonable while asserting that Canadian nursing standards represent universal and objective criteria for skill and public safety. Since these assumptions, silences, and effects also inform federal-level policy, I will address these aspects together in the following chapter.

CHAPTER FOUR

Reconceptualizing the Problem of FCR: Challenging the Racialized Dichotomization of Nursing Skills

Introduction

In the previous chapters, I argue that federal initiatives such as NNAS and provincial initiatives such as fair access legislation fail to substantially improve the FCR process for IENs. On the contrary, over the last two decades, the licensing process has only become increasingly selective and assimilative, meaning there is (a) heightened scrutiny of IENs through a reproduction of racialized dichotomies of skill, which depicts, on the one hand, IENs as undesirable and threatening, and on the other hand, Canadian nursing standards as the desired norm and synonymous with public safety; and (b) limited access to those IENs who could meet the increasing demands for time, effort, and money to approximate Canadian nursing standards. As a result, IENs' downward occupational mobility intensifies as most remain unable to access the upper tiers of the profession (i.e., RNs) and, as such, are relegated disproportionately to the lower tier of practical nursing or other subsidiary occupations such as personal support work. Meanwhile, those few IENs who do become RNs are also more likely to be employed in more precarious nursing settings and experience differential treatment in the workplace.

Building on Bacchi's (1999, 2009; Bacchi & Goodwin, 2016) WPR approach to critical policy analysis, I demonstrate that the downward occupational mobility of IENs into the healthcare workforce is not a failure but rather a feature of these initiatives. It is a consequence of how these initiatives understand the problem of FCR in the first place: that is, as a problem of procedural fairness (i.e., a lack of a transparent, consistent, timely, and accountable assessment and recognition process) rooted in, at the federal level, a lack of coordination and harmonization of policy and, at the provincial level, a lack of regulatory oversight of assessment processes to ensure IENs meet entry-to-practice standards. The problem is located in how IENs are being assessed against occupational standards rather than in the standards, which are upheld as indispensable and objective means to protect public safety.

In framing the problem this way, governments and regulators understand themselves as balancing two inherently competing policy objectives: facilitating the swift integration of IENs and protecting public safety. As I demonstrate in the previous two chapters, the bifurcation of these two objectives is imbued by a racialized dichotomous understanding of nursing skills, which depicts, on the one hand, IENs and their skills as undesirable and threatening and, on the other hand, Canadian nursing standards as the desired norm and synonymous with public safety. Based on this dichotomous depiction, policies aimed at IENs consider it necessary and reasonable for regulators, positioned as the best arbiters of competence within the current system of self-regulation, to “manage” IEN integration per the goals of selectivity and assimilation. As regulators demand more from IENs by tightening requirements for entry, the complex bureaucracy of public and private actors that has developed to meet these goals of selectivity and assimilation further shifts the additional cost, time, and administrative burdens of navigating this complex bureaucracy onto IENs and their families. As a result, while the various initiatives and regulatory reforms offer procedural improvements, mainly in transparency, by maintaining and even strengthening occupational standards, they often fail to address or even exacerbate many systemic issues identified by IENs. In other words, I argue that the dominant understanding of the problem contributes to the downward occupational mobility of IENs by reifying this largely racialized, feminized, and precarious group of workers as undeserving of access to the upper tiers of the nursing profession, thereby channelling them into more precarious and disabling occupations.

As a first step in developing an alternative representation of the problem, this chapter examines what is left unproblematicized and silenced in the dominant understanding of the problem. In particular, I am interested in unpacking the racialized dichotomization of nursing skills and the regulatory regime that underpins it by examining where these understandings of skill come from and what they obfuscate, particularly what ideological and socioeconomic interests are supported through these depictions. I accomplish this by building on Armstrong’s (2013) feminist political economy analysis of the social construction of skill, which rejects the dominant understanding that skill constitutes an independently acquired capacity (i.e., through individualized formal education and training) with inherent and objectively measurable value (e.g., through credentials) and, instead, considers how broader historical, discursive, and structural forces shape how skill is understood, organized, and valued (Armstrong, 2013). In the context of Canada’s “racialized regime of skill,” treating skill as a social construct does not mean rendering it meaningless or an

“empty signifier” but, rather, considering how skill acts as “floating signifier” by “obscur[ing] context, inequities, and the social nature of the learning process itself” (Guo, 2015, p. 238).

Building on this framing of skill, with insights from anti-racist feminist political economy scholars and nurse historians, I argue that the dichotomous rendering of IEN skills as undesirable and threatening, and Canadian nursing skills as the desired norm and synonymous with public safety, is not simply the result of ‘unfair’ skill recognition systems, which can be improved through procedural fixes. Rather, it is the result of the ideological and material subordination of labour historically associated with poor and racialized women, and the continuous reassertion of masculinist and colonial norms and beliefs about skill. In particular, I contend that the racialized dichotomization of nursing skills is a reconfiguration of long-standing ideologies, norms, policies, and practices related to the gendered and racial segmentation of nursing and care provision more broadly. Through a brief historical overview of the development of nursing as a racially segmented occupation, I seek to show how white nurses have consistently elevated their relative power and privilege (e.g., better pay, benefits and protections, and social status) through the law (e.g., entry-to-practice standards, scopes of practice) and institutions (e.g., regulators and professional associations), in part, to contend with the gendered subordination of their skills.

In this sense, the construction of IENs’ skills as undesirable and threatening represents a continuation of the vigorous promotion of racial and cultural exclusivity by nursing leaders, associations and regulating bodies, healthcare administrators, and immigration policies. Rather than outright exclusion, however, the goal within the current regulatory regime is “managed” integration through selectivity and assimilation, mystified through race-neutral discourses such as the appeals to protecting public safety and respecting applicants’ right to a fair assessment. This policy approach to labour market integration is aligned with what Galabuzi (2004, p. 178) identified as the three goals of immigration policy, which are responsible for deepening racial stratification in Canada: “managed growth” to prevent hardship to the existing workforce, “selectivity” by maintaining administrative categories of (un)desirability, and “assimilation” by heightening demand for specific skills in determining eligibility. Although racial segmentation may not afford nurses socioeconomic advancements akin to male-dominated professions, it enables white nurses to play an essential role in the colonial project of nation-building as reproducers of settlers, racial distinctions, and colonial beliefs and practices. Racial segmentation also enables the widespread availability of cheaper and more easily exploitable sets of subsidiary

workers to meet the nation's growing social reproductive needs. As such, I argue that the downward occupational mobility of IENs is not simply an unfortunate remnant of prejudice but rather foundational to developing, expanding, and maintaining the settler-colonial capitalist state.

This chapter's analysis mainly corresponds to the fifth question and the first part of the sixth question of my modified WPR approach: (5) What is left unproblematic in dominant representations of the problem of FCR, and what are the silences? (6) How can the problem of FCR be reconceptualized, disrupted, or replaced? By examining the history of the racialized segmentation of nursing and care provision, I challenge the deep-seated assumptions about IENs and their skills as inherently undesirable and threatening, as well as about Canadian nursing standards and the role of regulators as inherently universal and neutral measures of skill and patient safety. Opting for an alternative framing, I present this dichotomous depiction as a continuation of long-standing mechanisms of control mobilized against racialized women. I end this historical overview by discussing how current racialized depictions of IENs and their skills map onto these historical and structural inequities, and how some of my IEN participants responded to these depictions. This analysis lays the groundwork for an alternative understanding of the FCR problem, which I flesh out in the following chapter: one that reconceptualizes the integration of IENs and protecting public safety as inherently competing goals, and instead considers their downward occupational mobility a more significant threat to public safety.

1. A Brief History of the Racial Segmentation of Nursing and Care Provision

As women, nurses have historically struggled to achieve similar compensation levels and the educational and legal control afforded to physicians. The traditional justification for this disparity is that caring and domestic skills (e.g. cleaning, changing diapers, feeding, bathing, providing emotional support) are usually devalued or not recognized because they are “considered to be ‘natural’ to women rather than acquired” (Bacchi, 1999, p. 81). As the following historical overview shows, rather than challenging the devaluation and naturalization of caring and domestic skills, nurses have usually sought to raise the occupation’s profile by increasingly distancing themselves from these framings (Armstrong et al., 2008; Armstrong & Day, 2017; McPherson, 2003a).

One way in which nurses created distance was by introducing a new division of labour. This process sought the gradual elimination¹³⁹ of “ancillary” duties from nurses’ scope of practice—by “carving pieces out of nursing work to be done by those who had less formal training and less power,” that is, poor and racialized women—to allow them to focus on the “clinical” aspects of care (Armstrong et al., 2008, p. 85). This new skill-based division of labour was subsequently institutionalized through professionalization, which involves nurses claiming their education and training as legitimate, exercising jurisdictional monopolistic control over their expertise, and embarking on a “collective process of upward social mobility” (Bourgeault, 2006a, pp. 3–4). As nursing evolved into a ‘skilled,’ self-regulating profession, its elite, especially leaders of regulatory bodies and associations, acquired significant power and privileges for white, middle-class women, often at the expense of poorer and racialized women who worked in lower tiers of nursing and care provision.

Over time, this racialized division of labour has led to expanding subsidiary work to meet demands for cheaper, more flexible forms of labour. Although the adversarial relationship that inevitably emerged between the occupation’s elite and less privileged groups of workers renders the relative power of all nurses fragile and makes it more difficult to organize against the deterioration of working conditions, the response has been repeatedly to reinforce the racial boundaries of the profession rather than foment solidarity.

¹³⁹ As Armstrong et al. (2008, p. 85-6) note, this process was not wholly successful: “While the new division of labour was intended to define boundaries and leave nurses free to focus on the clinical aspects of care, the boundaries remain blurred... not only because the nurses are always there, but also because the work must be done.”

1.1. Early Settler-Colonialism—1600s to the late 1800s

Akin to the history of other occupations,¹⁴⁰ the history of the development of nursing as a regulated profession does not start with the outright exclusion of racialized people; rather, it is one of initial usurpation successively sustained through exclusion and differential inclusion. In other words, before nursing emerged as a regulated profession that white women subsequently gatekept racialized women out of, it was initially Black and Indigenous women's nursing work that kept settler populations healthy and growing. For instance, writing on the origins of the Black hospital and nurse training, Hine (1989, p. 4) indicated that “[s]ince their arrival in the Americas, Black women had always provided health care. They were nurturers of the sick, both Black and white, on slave plantations [...] they helped to deliver most of the babies born during slavery and in the early years of freedom, especially in the rural South.” In fact, this notion that Black women were “natural nurses” is what helped substantiate the ubiquitous image of the ‘Black mammy.’

Writing on the history of Indigenous women's productive and reproductive work in the context of settler-colonialism (from the 1830s forward), Williams (2012, pp. 9–10) similarly notes that while the colonial myth of “self-sufficiency” sought to erase Indigenous women's contributions, their work provided the “essential infrastructure upon which the non-Indigenous settler population depended, experienced elevated self-worth, and economically thrived.” The survival of early traders especially depended on intermarriage. Intermarriage, however, provoked numerous anxieties concerning racial identity and was thus followed by a general obsession with asserting and controlling racial differences and upholding whiteness (Lawrence, 2003; McCallum, 2014).

One of the ways whiteness was upheld was by elevating the identities of white women as “reproducers of the race” and, through the usurpation of nursing duties,¹⁴¹ they increasingly took over the role of keeping settler populations healthy and growing at the expense of Indigenous populations whose health rapidly deteriorated as a result of colonial disruption (McCallum, 2014;

¹⁴⁰ Sakai (1983) argues that the history of unionization and collective organizing in the United States did not start with the exclusion of Black, Indigenous, and other racialized workers by the white proletariat. Instead, after non-white workers and slaves were used to develop the nation, subsequent white settlers usurped the positions of these workers and monopolized them through unions and associations. Roediger (1999) similarly notes that Irish people “elbowed out” Black people from ‘unskilled’ jobs with “relative ease” by embracing whiteness (p. 148-9).

¹⁴¹ Rendering all work done by Indigenous women as invisible, the first European woman to settle in Quebec, Marie Rollet Hébert, is credited as being “the first person in present-day Canada to provide nursing care to the sick” (Masters, 2023 p.24).

McPherson, 2003b; Sinha, 2004). Armed with allopathic medical knowledge¹⁴² and embodying the white, feminine values of respectability,¹⁴³ these public health nurses also functioned as “agents of imperial hygiene,” ensuring the bodies of colonizers and colonized peoples alike remained “clean” and that their cultures remained “distinct” (Howell et al., 2013 p. 340). Through their perceived feminine ability to more easily forge relationships with and serve as role models for ‘social inferiors,’ they were also able to colonize communities unreachable by other means (Kelm, 2010; McPherson, 2003a, 2003b). By serving as the first point of contact in ‘isolated’ Indigenous communities, they helped to overcome the “difficulties of transportation and communication [which were] intimately tied to a broader project of assimilation” (McCallum, 2014 p.104).

To summarize, in the early period of settler-colonialism, the initial development of nursing as a distinct occupation for white women involved seizing nursing and reproductive roles from Black and Indigenous women. As nurses, white women could insinuate themselves into racialized communities and assert their position within the broader nation-building project as reproducers of settlers and colonial values. As the following sections will show, these racialized dynamics are foundational to the eventual development of nursing as a self-regulated profession.

1.2. Early Nineteenth and Twentieth Centuries

In the 1880s, as hospitals moved away from using women with informally acquired skills providing rudimentary bedside care towards a formal education and apprenticeship system, access to the occupation became increasingly limited to women who could train and work in these new conditions. As part of this shift, nurses were expected to conduct themselves in accordance with

¹⁴² The allopathic approach to health care is grounded on a Western model of science, which is “informed by positivism and is characterized by the preference for objectivity, causality, replication, standardization, generalizability, precision, and measurement” (Campbell, 2016, p. 72). Allopathy emphasizes individual treatment rather than prevention and diagnosis rather than care, and it is based on “an engineering model of the body, which views the body like a machine made up of interconnected parts that can, to a large extent, be separately treated.” Although allopathy has permitted a “refinement of techniques,” Armstrong et al. (1993) argue that its “emphasis on body parts downplays the importance of care of the whole person” and works to “primarily to isolate the patients’ problems from their social environments” (Armstrong et al., 1993, pp. 23–24). Despite its adverse impact on care, Armstrong et al. (2008, p. 62) attribute the bifurcation of care into clinical care and ancillary care to the continued dominance of allopathy: clinical care is provided by physicians and nurses “who have acquired formal, advanced training and who are focused primarily on interventions, treatment, and cure, or on carrying out the directions of those who have such a focus;” whereas ancillary care is provided by “low-skilled” workers who are deemed to lack this formal, advanced training.

¹⁴³ “Whiteness laid the groundwork for respectability, but maintaining gendered norms ensured it” (Kelm, 2010 p. 135)

bourgeois, white standards of morality and identity, such as sexual restraint, deference, temperance, tenderness, and propriety. Not surprisingly, Black, Indigenous, and Asian women did not meet these standards, which virtually barred them from becoming nurses (Flynn, 2009; Hine, 1989; McPherson, 2003a; Toman, 2010).

Racialized women were also disallowed from training programs, budding associations, and hospitals because of the belief that they could not be entrusted with white patients' care due to their "allegedly inferior training, lack of executive skills, limited intelligence, weak character, and inability to withstand pressure" (Hine, 1989 p. 101). Administrators and leaders of nursing associations such as the CNA, established in 1908 as the national voice of provincial associations governing the education and registration of nurses, claimed that racialized women "could not be relied on to reflect the morality of health at the bedside, to meet the standard of gentility demanded by elite patients, or to negotiate the tricky sexual terrain of patient care" (McPherson, 1996 p. 17). In fact, their very presence as "dirty" and "contaminated" subjects was believed to exacerbate white patients' health problems (Flynn, 2009; Hine, 1989; McPherson, 2003a).

During this period, few racialized women became nurses, and those who did were only admitted on the basis that they exclusively served "their own" communities in segregated settings. This was because, as a "vocational calling," nursing was "embedded in nationalist ideals" (McPherson, 1996 p. 17). For instance, Chinese hospitals founded in Montreal in 1918 and in Vancouver in 1921 "intended for chronically-ill aged men who could not return to China and who had no families in Canada to care for them" employed a few Chinese nurses (H. Turcotte, 2004, p. 132). Similarly, between 1917 and 1930, a small number of "exceptional" Indigenous women were trained as nurses to serve the Indigenous communities deeply affected by the tuberculosis and influenza epidemics (Toman, 2010).

Also, in this timeframe and the decades to follow, the formalization of education and training for nurses, especially following the adoption of germ theory towards the end of the nineteenth century, and the development of nursing organizations across Canada may not have translated to economic advancements and status akin to that of physicians. However, their position as "skilled workers subordinate to the medical profession but privileged compared to lesser-trained nurses or domestic servants" helped to "forge a distinctive occupational identity." Although there were contestations, McPherson (2003a, pp. 72–73) notes they were not "powerful enough to rupture the common occupational identity" as this identity was further strengthened by the

“common bond of gender,” which legitimated the standards of bourgeois femininity and nursing as “naturally” women’s work, as well as by racial homogeneity, which “underscored their superiority” over their patients and lesser-trained workers.

1.3. Post World War II to the Late 1960s

The post-war period was marked by the development of new technologies such as antibiotics, new approaches to care such as the medicalization of childbirth, and the massive expansion of hospitals. The subsequent shortage of nurses, combined with amplified political struggles and rhetoric against discrimination, put pressure on eliminating race-based exclusion from nursing programs, which, up until the 1960s, were predominantly located in hospitals. For instance, in 1944, the CNA passed a resolution “reaffirm[ing] its policy to support the principle that there be no discrimination in the selection of students for enrollment into schools of nursing” (McPherson, 1996 p. 211). Systemic barriers and discrimination in admission, recruitment, hiring, on-the-job practices, and immigration policies, however, continued to ensure that nursing was overwhelmingly composed of white women. Moreover, although the shortage of nurses and the assumption of new technical responsibilities invigorated nurses’ organizing power, these also resulted in increased specialization within the occupation and new divisions of labour, which encouraged the channelling of racialized workers into the lower tiers of care provision as the occupation’s status improved (Armstrong et al., 2008; McPherson, 2003a). Let us look at these developments in turn.

Regarding admission and recruitment, McPherson (2003, p. 211) notes that despite the official rhetoric and position of the CNA, “nursing programs and provincial associations were slow to open their doors to non-white women.” In 1943, the Registered Nurses Association of Nova Scotia reminded the national office that “only white Canadian nurses were eligible for postgraduate training in the United States since there were no programs for training ‘coloured girls’ in Canada.” In 1944, a young woman from Owen Sound was redirected by Ontario’s Council of Nurse Education to apply to a program in the US since training was not available for Black Canadians. Black women were not admitted into nursing programs in Quebec until the 1960s (McPherson, 2003a). In regard to Indigenous women, while the intention of many was to work in their own communities, they were forced to relocate far from their communities to study and work as nurses. Far away from home, Indigenous nurses struggled to overcome discouragement, isolation, and

poverty. What little funding was available to them in the form of loans was severely monitored¹⁴⁴ under the pretence that it would encourage self-sufficiency (McCallum, 2014). Meanwhile, in their work as nurses, especially due to their small numbers, they faced constant harsh criticism and prejudice. In particular, Indigenous and Black nurses' abilities to teach and to provide care were rendered simultaneously invisible and scrutinized regardless of their qualifications (Flynn, 2009; McCallum, 2014; McPherson, 2003a).

While admission restrictions and discrimination kept the number of Canadian-born racialized nurses low, this trend was also supported by immigration policies that, until the late 1960s, virtually banned or severely restricted immigrants from non-European nations or the British colonies, as well as by labour market policies that actively encouraged the recruitment and swift integration of nurses from "desirable" sources to help meet high demand. For instance, McPherson (2003, p. 213) notes that while nursing leaders agreed that graduates from European nursing programs needed some evaluation and to "not fail to make use of trained minds and hands," in contrast, when assessing the skills of the few nurses who immigrated from non-European nations, "immigration officials and nursing leaders were less ready to value immigrant nurses' credentials." Calliste's (1993) analysis of Black Caribbean nurses and student nurses immigrating between 1950 and 1962 illustrates this approach.

Although Black Caribbean nurses were British subjects, Calliste (1993) demonstrates that they were admitted only in exceptional circumstances or as "cases of exceptional merit." To be eligible for landed immigrant status, these nurses were required to produce job offers from employers "aware of their racial origin," work as nursing assistants until they completed additional training, and have qualifications exceeding those of white nurses (Calliste, 1993, p. 94). Their immigration was limited because Black people were considered "inferior" and to constitute a "permanent social problem in Canada" (p. 89). They were also considered biologically and culturally incapable of assimilating into the Canadian climate and society. However, the desire for cheap labour and a need to facilitate trade and investments in the British Caribbean motivated a

¹⁴⁴ In *Indigenous Women, work, and History, 1940-1980*, McCallum (2014, p. 212) noted that before the 1970s, when funding for post-secondary education became available for Indigenous peoples, when the Department of Indian Affairs chose to support nursing students, it "maintained close control over funding throughout the course of study and monitored the progress of students through contact with nursing school matrons." While non-indigenous students only had to contend with school matrons, Indigenous nursing students "in addition had to deal with Indian agents, the superintendent of welfare and training of Indian Affairs, and their former principals, all of whom were informed by the matrons of students' progress."

limited arrangement where few were granted exemptions. Many of these nurses were subsequently trapped in nursing assistant work because they were discouraged or prevented from pursuing additional training.¹⁴⁵ Some were granted landed immigrant status, but most continued working with temporary permits. As a result of these policies, of the approximately 35,000 nurses who were admitted as landed immigrants between 1953 and 1968, only 982 of those were Caribbean nurses.

While the small number of racialized nurses meant they could not be relied upon to meet shortages, policy turned towards other means to meet the growing demand for nursing services, such as the employment of married women and, more importantly to our discussion of segmentation, the development of new categories of subsidiary or auxiliary workers (Armstrong et al., 2008; McPherson, 2003a). After nurse training was moved out of hospitals in the 1960s, along with the unpaid labour of nursing students, and as the trend towards specialization exacerbated the pressures on overworked and understaffed nurses, hospitals turned to employing subsidiary workers such as practical nurses, nursing assistants, ward aides, and ward clerks. The intention of employing these subsidiary workers was to “relieve graduate nurses of ‘routine’ personal care patient services and elementary ward administration” so they could focus on “highly skilled functions” by “delegate[ing] all non-nursing tasks to other members of the healthcare team” (McPherson, 2003a, pp. 222, 228). Although these subsidiary positions were not new, their use was “dramatically expanded” in the post-war period and became “a regular feature of institutional staffing” (p. 222).

Despite the potential for job displacement, nursing leaders and administrators “applauded” these new categories to reduce nurses’ workload and because “personal care tasks, traditionally part of nurses’ repertoire of skills, were being defined as inappropriate of highly trained ‘professionals’” (McPherson, 2003a, p. 223). As McPherson (2003a, p. 223) states, the “ideological and formal divestment of those tasks that had bordered on the domestic and personal constituted a crucial line of demarcation between ‘professional’ graduate nurses and ‘non-professional’ subsidiary workers.” Professional associations and unions subsequently mobilized this divestment as part of their strategy to gain greater levels of compensation, better working conditions, and social status:

¹⁴⁵ Calliste (1993) found that the obstetrics training that Caribbean nurses were required to take only allowed two foreign students in each course. Meanwhile, student nurses enrolled in nursing assistant programs were given temporary entry to help staff in less attractive sectors such as psychiatric hospitals.

[F]ormally educated nurses had been forming professional associations and unions that became increasingly successful in demanding not only decent wages and working conditions but also the right to leave some of those domestic tasks to others...in part, [as] an attempt to distance themselves from the association with women's household work and to gain status by means of that distance (Armstrong et al., 2008, p. 85)

Differences and rankings in terms of pay and status among these categories of healthcare workers were signified by class, gender, and race-based constructions of skill not only in terms of the kinds of duties assigned but also in differential access to training programs and jobs (Armstrong et al., 2008; McPherson, 2003a). Since racialized women continued to face difficulties in accessing the nursing workforce, it became much easier and was indeed considered to be more suitable for them to be part of the growing workforce of subsidiary workers. These divisions of labour were also accompanied by the development of standardized management strategies, wherein a formal distribution of duties and fragmentation of tasks was established. Altogether, these factors further solidified the position of privilege and authority of nurses over subsidiary workers. However, as the next section will show, this relative power and privilege would not render nurses immune to neoliberal restructuring and budgetary cuts. Instead, it would eventually render them more vulnerable.

1.4. The Late 1960s to the Late 1990s

In the late 1960s, declining European emigration, a falling birthrate, the introduction of publicly funded hospitals, and the desire for economic expansion led to the removal of race-based exclusions from immigration policy in favour of a points-based system legitimized through the discourse of multiculturalism (Arat-Koç, 1999; Galabuzi, 2004; Thobani, 2007). While balancing the need to meet labour market needs with the desire to keep 'undesirables' out has always been a feature of immigration and labour market integration policies, the points-based system prompted a shift in the way these goals would be carried out. Rather than outright exclusion, the focus became (a) "managed" immigration growth through pre-determined quotas or targets, (b) "selectivity" through the administration of (un)desirability by deprioritizing 'non-economic' immigrants and using specific filtering and ranking criteria in the selection of 'economic' immigrants, and (c) "assimilation" by prioritizing particular sets of skills and traits (Galabuzi, 2004, p. 178). Accordingly, the following decades were marked by a massive increase in immigrant

nurses, mainly from the Caribbean and the Philippines (Choy, 2003; McPherson, 2003a). By 1989, Filipinos comprised Canada's second-largest group of immigrant nurses (12%) (Choy, 2003).

The widescale immigration of racialized people ignited significant racial anxieties and outright hostility. Compared to white immigrant women of the past who occupied a special place as future “mothers of the nation” and “transmitters of (British) culture,” racialized immigrant women were only admitted for their labour, that is, as mere commodities (Arat-Koç, 1999, p. 229). Popularly, immigrants from “non-desirable” sources were depicted as “strangers,” “devoid of the qualities and values of the nation,” and as “making unreasonable claims upon the nation and its precious finite resources” (Thobani, 2007 p. 4). In a context of economic uncertainty brought on by stagflation and geopolitical conflict, white citizens responded by “flexing their political muscle to maintain their legally and socially exalted status” (p. 26). In particular, they subjected racialized immigrants to unequal access to the labour market and social entitlements, thus granting them limited or qualified entry not only into the country but also into citizenship (Arat-Koç, 1999; Galabuzi, 2004; Thobani, 2007).

Migrant nurses, in particular, were granted admission based on their qualifications but faced greater scrutiny and surveillance, had to be exceptional at their jobs, and were relegated to the more precarious, lower tiers of care provision (Calliste, 1996; Choy, 2003; Galabuzi, 2004; Ronquillo, 2012; Stasiulis & Bakan, 2003). Their downward occupational mobility thus mirrored that of Caribbean and other racialized nurses in the previous decades. However, they faced unique circumstances as they tended to be older,¹⁴⁶ and were subject to increasing requirements for registration, such as language tests.¹⁴⁷ In the face of an arduous licensing process, many prioritized their family and the steady income from working in the lower tiers of care provision. As such, they either delayed or abandoned accessing the upper tiers of nursing (Choy, 2003; Ronquillo, 2012; Stasiulis & Bakan, 2003).

¹⁴⁶ For instance, unlike domestically educated nurses who tend to be young and single when they become nurses, Filipino nurses tend to be older and their integration into the Canadian nursing workforce often coincides with the time they begin to have children (Ronquillo, 2012).

¹⁴⁷ According to Stasiulis & Bakan (2003), in the 1960s and 1970s, Filipino nurses were not required to take English language tests. However, by the 1980s, migrant nurses from non-English-speaking countries had to pass language tests such as the Test of Spoken English (TSE) or the Test of English Fluency (TOEFL) to register. These tests were challenging, eventually leading immigrant advocate groups to lobby against them in the early 1990s: “Even though many of the Filipino applicants spoke English, they would commonly fail these language tests, leading advocates to charge that the tests reflected cultural biases and were unnecessary impediments to the accreditation of nurses from the Philippines” (p. 117).

In the 1970s, the challenges faced by migrant nurses were compounded by the push for national self-sufficiency in health care policy. In 1975, nurses were removed from the list of targeted occupations receiving additional points, and they would not be included again until 2008 under the Federal Skilled Workers Program (Bourgeault et al., 2010; Gabriel, 2011). One of the motivations for national self-sufficiency was the nursing associations' concern for the effects of poaching on countries "facing their own shortages" (Kergin, 1969, p. 33). However, it seemed there was a greater concern with protecting the domestic nursing profession, which is why the CNA presented the expansion of subsidiary work as a more suitable policy choice over recruiting immigrants:

Instead of recruiting nurses, why cannot this nation recruit individuals who lack the educational prerequisites to enter nursing but who would qualify to enter a nursing assistant program? These individuals would thereby enter a useful occupation and share the pleasures of life in our democratic society [...] Let us not try to eliminate a category of personnel, but, rather, let us reign in the criteria with which a professional nurse can judge what level of skill is required to provide therapeutic nursing care? (Kergin, 1969, p. 33)

This push for self-sufficiency deeply affected the migration patterns of IENs and their integration into the workforce. While the number of immigrants between 1986 and 1993 doubled, permanent residents claiming nursing as their intended occupation dropped to about half (Bourgeault et al., 2010; Gabriel, 2011; Valiani, 2012). This decline, however, did not mean that fewer IENs were entering Canada; rather, they were entering through different routes as dependents¹⁴⁸ or via temporary schemes such as temporary employment authorizations or the Live-in-Caregiver program. Each of these routes had adverse impacts on IENs and presented its challenges. For instance, sponsored immigrants were not able to access social services such as language training and were legally and economically dependent on their partners, which made them vulnerable to abuse (Arat-Koç, 1999; Stasiulis & Bakan, 2003). Temporary employment authorizations restricted immigrant nurses' ability to demand better wages or more desirable positions (Stasiulis & Bakan, 2003). Meanwhile, nurses who entered via temporary schemes such as the Live-in-Caregiver program had to work as domestic caregivers for two years before being eligible for permanent residency, which often meant they could not meet the practice requirement for licensure

¹⁴⁸ From 1986 until 2008, 23% of immigrants indicating nursing as an intended occupation, entered as dependents or sponsored immigrants (Gabriel, 2011).

(Dumont et al., 2008; Gabriel, 2011; Higginbottom, 2011; Salami & Nelson, 2014; Stasiulis & Bakan, 2003).

Although the push for self-sufficiency slightly increased the number of employed, domestically educated graduate nurses (from 73% in 1973 to 81% in 1983), as neoliberal restructuring ramped up in the following decades, nursing jobs disproportionately bore the brunt. Budgetary cuts and the introduction of rationalization techniques such as patient classification systems deteriorated nurses' working conditions by intensifying their workload and increasing surveillance, fragmentation of care, and interpersonal conflicts.¹⁴⁹ Unpaid overtime and part-time work became more common, and there was a cutback on the number of positions (McPherson, 2003a; Stasiulis & Bakan, 2003). As hiring and retaining nurses became more difficult, many domestically educated nurses emigrated to the US, a trend only exacerbated by NAFTA's streamlining of temporary work authorizations (Gabriel, 2011; Little, 2007; Valiani, 2012). For these reasons, Doris Grinspun, Executive Director of the RNAO, describes this period as "the largest employment displacement of nurses in recent Canadian history" (Grinspun 2003, cited in Gabriel, 2011, p. 46).

In this "atmosphere of a general assault on the recognition of the skills and abilities of nurses in Canada," Stasiulis and Bakan (2003, p. 108) argue that "management strategies augmented the salience of racial, ethnic and citizenship differences among nurses." Nurses on temporary work permits, who were disproportionately Filipino and Caribbean, experienced massive job losses as they were the first to have their contracts terminated. Racialized nurses were "compelled to endure working conditions, including those injurious to their health and dignity, assigned by management and rejected by Canadian-born and white nurses" (p. 108). They also faced tightened hiring and registration requirements,¹⁵⁰ which affected their recruitment and retention. Moreover, their

¹⁴⁹ Patient classification systems served to standardize time spent on particular tasks and types of patients. McPherson (1996) notes that instead of relying on experienced workers to adjust staffing to patient demand, the new documentary system "produced knowledge away from the ward." By standardizing times for specific tasks, the extra time nurses needed to complete the 'indeterminate work' or 'untimed background work' – such as communicating with physicians, patients, and families or organizing the work of subsidiary personnel – was not adequately factored into staffing formula; meaning these systems intensified the amount of work that nurses were expected to complete (p. 251-2). According to Stasiulis and Bakan (2003, p. 108), these new management strategies and philosophies "fundamentally altered the nature of nursing, reducing the time available for patient care, speeding up work and increasing surveillance, rendering nursing more fragmented and stressful, and leading to a rise in staff conflicts."

¹⁵⁰ In Mount Sinai in Toronto, the simultaneous layoff of Registered Nursing Assistants and the shift to hiring only those with baccalaureate degrees rather than college diplomas adversely affected racialized nurses, who comprised

working conditions became more precarious as they tended to be disproportionately targeted for discipline, surveillance, and infantilization and were less likely to receive wage increases and promotions (Calliste, 1996; Das Gupta, 2009; Gabriel, 2011; McPherson, 2003a; Stasiulis & Bakan, 2003; Valiani, 2012).

By the turn of the century, the combination of these factors resulted in a significant decrease in the percentage of IENs working as nurses. In 1961, IENs comprised approximately 17% of the nursing workforce; by 2000, their numbers had dwindled to 6.2% (Bourgeault et al., 2010; McPherson, 2003a; Valiani, 2012). Faced with mounting discontent regarding the state of the healthcare system and the looming healthcare demands from ageing baby boomers, the Canadian state finally acknowledged the CNA's position that the nursing sector was in crisis in 1997 (Gabriel, 2011). It is at this point in time that my analysis, which is contained in the previous two chapters, begins, with immigration and labour market policies once again turning to integrating IENs as a way to meet labour demands.

1.5. The 2000s to Today – Continuities and Contestations

Despite policymakers' expressed intentions to address systemic barriers and historical biases to improve the integration of IENs, the last twenty or so years of immigration and labour market integration policies represent a continuation of racialized dynamics that limit access to the nursing profession and channel them into the lower tiers of care provision and more precarious settings. Unlike white nurses, who are treated as producers of the nation, IENs are treated as mere commodities, valuable insofar as they support Canada's global competitiveness. Meanwhile, IENs' skills are treated with suspicion and condescension, subjecting them to greater scrutiny and assimilation. Although mobilized through the discourse of protecting public safety, the depictions of IENs and their skills as undesirable and threatening are devoid of any reference to aggregate empirical data indicating that these are accurate depictions or that the swift integration of IENs has led to worse patient health outcomes. Yet, they form the basis of integration policy at all levels, from how their skills are assessed to the kinds of employment and working conditions they are subject to.

35% of these workers. Meanwhile, the CNO's decision to not grandfather the registration of nurses who were already working but did not have a baccalaureate degree, the most affected group was Filipino nurses, who made up 30% of those workers and nurses from the Caribbean (Stasiulis & Bakan, 2003 p. 118-9)

For instance, the contemporary perception of Filipino IENs as struggling with critical thinking and asserting themselves, which casts doubt on their ability to deliver culturally competent or appropriate care, lead subsidiary workers, and act as ‘professionals,’ is a reproduction of long-standing colonial tropes of Asian submissive femininity that justify their exclusion from the profession and continued surveillance within it. It is also a manipulation of their marginalized social location:

Having come from precarious and very poor conditions, some migrant nurses may find the substandard pay and working conditions offered in the destination country a whole lot better than what was offered in their homeland. When they recognize that they are being exploited, migrant nurses are understandably fearful of complaining, since they are on temporary visas and dependent on recruitment agencies or employers. Challenging their employer and facing the possibility of deportation or unemployment may not be an acceptable option (Kingma, 2006, p. 118).

Similarly, the characterization of Filipinos as inherently nurturing and family-oriented also contributes to their relegation to certain roles or settings where domestically educated nurses are less likely to work (Choy, 2003). In particular, Filipinos tend to be seen as better suited for working in long-term and home care settings, where there is ongoing contact with care recipients and their families (Neiterman & Bourgeault, 2015b, 2015a).

Although I cannot dedicate adequate time and space within the scope of this dissertation to discussing how racialized nurses respond to and resist these depictions, I would be remiss if I did not mention a few examples. For instance, the recruitment video I mentioned in *Chapter Two*, entitled *What is the difference between a Registered Nurse (RN) in the Philippines and Canada?* which characterizes Filipino nursing practice as hierarchical, outdated, and incompatible with Canadian nursing practice, received a lot of backlash from the Filipino nursing community online, leading to its subsequent removal and the issuing of an apology by Stenberg College and the faculty nurse featured in the video for its “condescending and offensive” content (Stenberg College, 2020). A Filipino IEN licensed as an RN in Canada thoroughly debunks all of the video’s claims and argues that they are “not applicable to the current setting in the Philippines” but rather based on “outdated information” going back to “somewhere around 20 to 30 years ago.” He further repudiates its depiction of Filipino nurses as “weak,” “timid,” “unprofessional,” “incompetent,”

and “uncaring” about their patients, calling it “condescending” and “insulting” for presenting the information as if it were a documentary rather than an advertisement for a school (Raxus Online, 2021).

Moreover, when I asked some of my IEN participants what they thought about the depiction of Filipinos as subservient and docile, they challenged this conception as constituting a fundamental misrecognition of (a) their marginalized social location, such as their fear of losing their jobs, which thwarted their ability to assert themselves, and (b) the cultural tendency to speak respectfully to those who hold a specific status in society, such as elders, physicians, or managers. Others, like Arnold, a Filipino nurse who arrived in Canada in 2008 and graduated from the York University IEN bridging program in 2012, scoffed at the insinuation that Filipinos were submissive and lacked critical skills. I include his complete response as it strongly connects this way of thinking to colonialism, asserting that Canadians are better suited for this depiction:

Look, nurses don't just follow the physicians. In the Philippines, they have the right to tell the doctor whether they have the right assessment or not. The same here in Canada. In Canada, most physicians also think they are always right. Most of the time, [physicians'] assessment depends on the assessment of the RN. So you see? I don't know what they're saying about critical thinking because I have a different view of critical thinking. Critical thinking, for me, is looking at the underlying mechanisms of why something is happening. Why is it that physicians, especially white, middle-age physicians, why are they controlling all the power? To critically think about how to improve the health of the residents, you have to address social determinants of health; you have to address education, labour, income, and all the interlinking social determinants of health to improve people's health. That, for me, is critical thinking, not this kind of thing that nurses don't have the power to tell physicians whether they are right and that this is all happening in the Global South. That point of view is the view of the colonizers that they think they're better than the people they've colonized. Even here, nurses of all races submit to the power of physicians, but that does not mean you're submissive. The term submissive is quite questionable. You may look at Filipinos as submissive people, but they are not. They are not. We've had a series of revolutions in our country to effect transformative social change. Many Filipinos are being killed fighting for systemic change. You won't find that here in Canada, in contemporary times, where activists are being killed. You go back to the Philippines and see a lot of activism and social movements. How many doctors and nurses in the barrios are being killed because they are suspected of being activists? They are not

submissive, this is a dangerous way of thinking. I find Canadians nice and submissive. They are not able to effect deep transformational change. Even during the pandemic, where's the change? I don't believe we will have change after this. We are living under neo-colonialism suffered by Indigenous and racialized groups of people, and we will always be under the policies of neoliberalism. So, people here are submissive because they are not able to affect change. That's submission. That's an old view that we submit to physicians, we have lots of nurse activists. Here, physicians are the ones who make policy and control the power and wealth (Interview 11, 2020).

His rejection of the racialized dichotomization between Filipino and Canadian nurses is significant as it underscores the stakes involved: these portrayals are harmful not only because they validate the downward occupational mobility of IENs but also because they hinder healthcare workers' ability to bring about meaningful, systemic change. Establishing Canadian nursing standards as the default and viewing 'foreign' nursing skills as automatically substandard rather than different in kind—rooted in colonial mindsets—results in integration policies that set many IENs up for failure, overlook the essential knowledge and contributions these nurses offer, and undermine the sense of unity and solidarity among nurses needed to advocate for collective progress.

2. Conclusion

This chapter traced contemporary configurations of the FCR process to explicitly gendered and racialized governance strategies of the past, not as unfortunate remnants of prejudice but as prominent features of settler-colonial capitalist structures by enabling (a) white nurses to play an essential role in the colonial project of nation-building and (b) the widespread availability of more easily exploitable sets of subsidiary workers to meet the nation's growing social reproductive needs. By locating the current downward occupational mobility of IENs within the broader history of racial segmentation of nursing, my goal is to challenge the assumption that facilitating IEN integration and protecting public safety are necessarily at odds. Instead, and perhaps more importantly, I aim to reveal how the downward occupational mobility of IENs constitutes a far more significant risk for public safety as it allows the expansion of precarious employment among this group of highly educated and trained professionals, the growing fragmentation and privatization of care, and the weakening of the collective bargaining power among nurses, among other disabling effects. Yet, these risks are excluded from the dominant conceptualization of 'public safety,' which focuses narrowly on the need to uphold or even strengthen occupational

standards to prevent IENs from integrating into the nursing workforce. In the next chapter, I elaborate further on this point, which reconceptualizes the downward occupational mobility of IENs using Gorman's (2016) disablement framework.

CHAPTER FIVE

“I don’t want to call it a depression. But I had a bad experience when I worked there. I was thinking, ‘Why am I doing this?’ I am licensed and trained to be a nurse, but you need a survival job” (Interview 2, 2019).

The Downward Occupational Mobility of IENs: Through the Lens of Disablement

Introduction

This chapter continues to develop an alternative understanding of the problem of FCR. In *Chapter Four*, I demonstrated how the racialized dichotomization of nursing skills, which underpins the current integration approach, represents a reconfiguration of long-standing ideologies, norms, policies, and practices related to the gendered and racialized segmentation of nursing and care provision. In particular, it is a continuation of a gatekeeping process through which white nurses have elevated their relative power and privilege over and at the expense of subordinating a growing cadre of subsidiary workers¹⁵¹ primarily composed of poor and racialized women. Compared to the outright, racially explicit exclusion of the past, I argue the current approach is “managed” or constrained integration through selectivity and assimilation, mystified through race-neutral policy discourses about protecting public safety by maintaining occupational standards while safeguarding international applicants’ right to procedural fairness.

By unpacking the racialized dichotomization of nursing skills and locating it within a broader history of the gendered racialized segmentation of nursing and care provision, the previous chapter laid the groundwork to reconceptualize another related assumption underlying the current approach, specifically that facilitating IEN integration and protecting public safety are conflicting objectives. In this chapter, I am interested in exploring how, contrary to this assumption, the downward occupational mobility of IENs constitutes a far greater risk to public safety than

¹⁵¹. ‘Subsidiary workers’ refer to all those in the lower tiers of care provision relative to RNs, including licensed practical nurses, PSWs, and ancillary workers.

facilitating their integration because it reproduces the exploitative and oppressive conditions that render disability¹⁵² as abject, i.e., as a lack, a burden, undesirable, and unliveable.

I conduct this analysis by building on Gorman's (2016) framework of disablement. This framework examines how governance strategies (particularly in settler-colonial contexts) disproportionately constitute racialized women as a 'reserve army of labour' and disable them by exposing them to greater levels of injury, violence, etc., while also effectively complicating or outright barring them from accessing disability identity or status (and the benefits and protections conferred by this status). The result is an "ongoing re-constitution of the disabled subject as a white subject" (Gorman, 2016, pp. 254–256). In other words, through the lens of disablement, racialized people, especially women, are not only more likely to experience disability, they are less *able* to claim this identity so they can access compensation, protection, and care. As a result, disability becomes an identity that effectively only white people can claim.

The disablement framework also integrates Mbembe's (2003) necropolitics notion of the "uneven biopolitical incorporation" of disabled subjects, Thobani's (2007) conceptualization of "exalted subjects," and feminist political economy analyses of global care chains and care drain in its understanding of disability. Within this framework, disability is thus not simply defined as a condition of social and economic exclusion, specifically exclusion from the labour force. Instead, disablement understands disability as being in a dialectical relationship with class, gender, and race-based oppression and exploitation insofar as these social relations mutually generate the prosperity of capitalists and affirm settler-colonial subjectivities. In other words, rather than an unfortunate epiphenomenal effect of oppression and exploitation, disablement understands disability as an essential source of profitability and the reproduction of settler-colonial subjectivities.

Building on this framework, I demonstrate how policies promoting IEN integration produce the disablement of IENs by constructing them, a primarily racialized and feminized group of workers, as undeserving of the benefits and protections allotted to the upper tiers of the nursing profession, thereby channelling them into subsidiary healthcare occupations with low levels of

¹⁵² Disability here is broadly understood to include injuries, illness, violence, and other types of physical and psychological distress and harm. When I talk about 'disabled people,' I include all those who identify as disabled as well as those who may not identify as disabled but are experiencing disability in some way.

socially recognized skill. As these subsidiary occupations tend to be more precarious, IENs are exposed to greater levels of risk as this risk is rendered invisible and unmanageable. Preventing IENs from being able to mitigate the risk of disability and access care by relegating them to subsidiary occupations thus readily makes available a reserve army of highly educated, flexible, cheap workers who facilitate disabled citizen-subjects' access to care.

In addition to producing the disablement of IENs, I argue that integration policy, in conjunction with the Philippines' labour market strategy of underfunding healthcare and overproducing nurses for export, produces the disablement of poor communities in the sending state by displacing and transforming care (broadly defined) to prioritize the healthcare needs of Canadians, while also effectively barring poor and disabled people from ever immigrating. More specifically, I examine how mass nurse emigration compromises poor communities' access to care and constitutes them as raw training material for honing IENs' skills to provide better care abroad. In this sense, the disablement of IENs and poor communities back home is a persistent feature of Canadian integration policy because it supports the conditions for citizen-subjects to make disability claims at their expense.

Notwithstanding the relative privilege that integration policy provides to citizen-subjects, I argue further that the disablement of IENs is intimately tied to the deterioration of care conditions in Canada. Integration policies facilitate the neoliberal privatization of healthcare along with its disabling implications by (a) enabling the expanded use of subsidiary healthcare workers to act as a reserve army of labour, thereby displacing RN employment and weakening the collective bargaining power of healthcare workers, and (b) placing IENs in positions where they are compelled to use their nursing skills without authorization,¹⁵³ thereby increasing their exploitation and further obscuring care deficits. By considering how integration policy affects not only IENs and their communities back home but also how it contributes to the deterioration of care conditions in Canada, I make a case for why all of us, except those interested in profiting from care, have a vested interest in radically changing it.

This chapter's analysis mainly corresponds to the fifth question and the first part of the sixth question of my modified WPR approach: (5) What is left unproblematic in dominant

¹⁵³ When I refer to 'nursing skills,' I refer to the authorized acts outlined in the *Nursing Act, 1991*, S.O. 1991, c. 32 that are within nurses' scope of practice.

representations of the FCR problem, and what are the silences? (6) How can the problem of FCR be reconceptualized, disrupted, or replaced? This chapter is divided into two main parts. Part one focuses on how disablement is produced in IENs and poor communities back in the Philippines. Part two explores the disabling implications of IENs' downward occupational mobility for care conditions in Canada. The analysis in this chapter lays the groundwork for an alternative approach to integration policy, which I outline in the next and final chapter, premised on challenging skill-based hierarchies and profitability as organizing principles in the provision of care.

PART ONE

1. Integration Policy and the Production of Disablement Among IENs

Healthcare work is highly disabling. Accordingly, workers in healthcare occupations rank among the highest of all occupations at risk of exposure to injuries, illness, violence, and mental health distress. These conditions have only worsened since the start of the pandemic.¹⁵⁴ Those at the lower levels in the occupational hierarchy tend to fare much worse as they experience higher levels of risk and incidence of disability. Recent Ontario Workplace Safety and Insurance Board data, for instance, show that those working in “assisting occupations in support of health services” led the claim count of work-related injuries annually, accounting for over 66 thousand claims between January 2012 and June 2024 (compared to just over 20 thousand claims made by nurse supervisors and RNs, and 256 made by physicians, dentists, and veterinarians) (WSIB, 2024). Although these data do not disaggregate PSWs, mainly due to the methodological difficulties of identifying these workers, several studies indicate they are particularly affected.

For instance, Zagrodney and Saks (2017, p. 36) note that PSWs in Canada “generally have low health scores across all types of health measures...reporting musculoskeletal injuries as the most common health issue.” In a comparative study of Canadian and Nordic long-term care workplaces, where PSWs provide the majority of direct care, Banerjee et al. (2008, p. 8) similarly found that Canadian workers are nearly seven times more likely to experience daily physical and verbal violence compared to their Nordic counterparts, with almost half (43%) of PSWs experiencing violence daily. A 2017 province-wide poll found that the prevalence of violence perpetrated against hospital staff by patients is very high: 68% of RPNs and PSWs have experienced physical violence at least once in the past year, while 83% have experienced non-

¹⁵⁴ According to a 2018 Statistics Canada study, healthcare occupations had the highest rate of workplace harassment, which includes verbal abuse, humiliation, threats, physical violence, and unwanted sexual attention or harassment (Hango & Moyser, 2018). In a 2019 study of leading indicators for occupational health and safety management systems in healthcare, since 2009, the healthcare sector was ranked second highest for lost time from work injury rates among all sectors in Ontario, with women healthcare workers ranked the highest among all occupations (Almost et al., 2018). Looking at all available statistics on workplace violence, Keith and Brophy (2021, p. 13) noted that out of all occupational groups, “healthcare workers bear the greatest risk.” A 2023 Statistics Canada report found that healthcare and social assistance workers reported the highest levels of work-related stress than any other occupation. They also were “more likely than the average worker to cite a heavy workload (32.3%, compared with 23.7% on average) and the emotional load (21.4%, compared with 11.7% on average) as causes of work-related stress” (Statistics Canada, 2023, p. 2). The latest Canadian Institute of Health Information report on the state of the health workforce in Canada indicated that sick time and the number of workplace mental health and violence reports were on the rise, especially since the start of the pandemic (CIHI, 2024).

physical violence. A similar poll conducted in 2019 in long-term care settings produced even more alarming results: 89% of PSWs and 88% of RPNs experience physical violence, with 62% and 51%, respectively, at least once a week, while 72% of PSWs and 67% of RPNs experience non-physical violence (Keith & Brophy, 2021, p. 17). Moreover, out of the over 30 thousand recorded cases of COVID-19 in healthcare workers in Ontario, of which approximately 17 died, most cases and deaths are PSWs (CIHI, 2021; Marani et al., 2021). As most IENs are relegated to subsidiary healthcare occupations, their risk of experiencing disability is, therefore, higher than for domestically educated nurses.

Understanding what makes subsidiary occupations risky is essential to understanding how disablement is produced among IENs. Some risk exposure is inherent to front-line healthcare work. PSWs, for instance, perform physically and emotionally demanding tasks and provide care in challenging circumstances, specifically to people who tend to be older and present with chronic, more complex, and less predictable health problems and, in the case of those with dementia, are more likely to react violently when receiving care (D'Hondt et al., 2012; Keith & Brophy, 2021; Nuernberger et al., 2018; RNAO, 2017, 2020; RPNAO, 2018). However, the relatively higher risk of this type of work is more often shaped by what Vosko (2010, p. 2) calls “dimensions of labour market insecurity”¹⁵⁵ and the “social locations and contexts (e.g., occupation, industry and geography)” that workers occupy, which increases exposure to risk while simultaneously rendering this risk invisible and limiting workers’ power to address it, thereby making it unmanageable.

PSWs are overwhelmingly located in the long-term and home and community care sectors, where the pay tends to be lower, they experience high job insecurity, have limited access to benefits and statutory entitlements, and, more so in the context of home and community care, have low unionization rates (Armstrong et al., 2008; Armstrong & Day, 2017; Banerjee et al., 2008, 2015; Church et al., 2004; Day, 2014; Galabuzi, 2004; Hapsari et al., 2022; Lewchuck et al., 2006; Lilly, 2008; Long-Term Care Staffing Study Advisory Group, 2020; Lum et al., 2010; Marani et al.,

¹⁵⁵ According to Vosko (2010, p. 2), “dimensions of labour market insecurity” include (a) the degree of certainty of continuing employment (e.g. whether a position is permanent or temporary or exists outside a legal employment relationship); (b) the degree of regulatory effectiveness (e.g. the existence, design, application and enforcement of formal protections); (c) the degree of control over the labour process (e.g. working conditions, wages, work intensity, unionization rates); and, (d) the adequacy of the income package (e.g. wages, direct and indirect government transfers, statutory, employer-sponsored benefits).

2021; Rossiter & Godderis, 2020; Sethna, 2013; Stasiulis & Bakan, 2003; Vosko, 2006; Zagrodney et al., 2023; Zagrodney & Saks, 2017; Zeytinoglu et al., 2009). These precarious employment and working conditions produce PSWs' disablement because they expose workers to disabling conditions, such as the mental stress of having no certainty of continued employment. At the same time, they also complicate their access to respite and redress. PSWs are not sufficiently compensated to afford quality living conditions; they are not provided adequate health benefits to access proper care; and because they lack regulatory protections such as paid sick days, workers' compensation programs, and collective bargaining rights, these workers are more likely to work while ill and less likely to file complaints or demand better working conditions. For instance, although the incidence of violence against women working in healthcare is greater than for men, a study of gendered differences in injuries attributed to workplace violence in Ontario found that between 2002 and 2015, men in the healthcare sector were almost twice as likely as women to have lost-time workers' compensation claims due to assaults (Chen et al., 2019). Among surveyed home care workers in the US, as many as 80% do not report incidents for fear of losing their jobs (Keith & Brophy, 2021, pp. 44–45).

In long-term care settings, these disabling conditions are further compounded by abysmal staffing levels, heavy workloads, limited control over the work process, inadequate access to training and proper equipment, low upward mobility, and a high degree of unpaid labour, which lead to burnout, high stress, lower job satisfaction, violence, musculoskeletal disorders, and other adverse health outcomes (Armstrong et al., 2008; Banerjee et al., 2015; D'Hondt et al., 2012; Rossiter & Godderis, 2020; Syed et al., 2016; Zagrodney & Saks, 2017). For instance, in a study of the experiences of PSWs bathing long-term care residents with dementia, D'Hondt (2012, p. 254) found that while PSWs provide the majority of care they "receive the least amount of training to manage responsive/protective behaviours" such as hitting, spitting, name-calling, and other verbal and physical behaviours. In addition to inadequate training, PSWs in this study identify "working with limited resources," such as time, training, and proper equipment and being "faced with competing demands and pressures" as the key barriers to managing these behaviours, leading to greater exposure. The marginal and precarious social location of those who tend to do this work and the structure and conditions of this work simultaneously increase exposure to risk while rendering this risk invisible and limiting workers' power to address it, thereby making it unmanageable.

In addition to the structure and conditions of employment and work, the risk of disability is also shaped by how the tasks in this line of work are perceived, how these tasks are divided or allocated among the different occupational categories (as per perceived skill levels), and the types of tasks expected from workers in relation to psychosocial factors in the workplace environment.¹⁵⁶ In subsidiary work, providing personal care, homemaking, and other manual, routine, or ‘dirty’ tasks requires skills that are typically devalued and taken for granted. As a result, these tasks carry varying levels of risk that are correspondingly rendered unavoidable, unimportant, and invisible. In Armstrong et al.’s (2008, p. 121) analysis of ancillary healthcare work, they found that the “segregation of women into jobs defined as requiring little effort helps render many of the hazards invisible [and] [s]o does the focus on male work and the tendency to use male-dominated work as the standard for safe practices.” Similarly, writing on the “paradox of invisibility and essentiality” of PSWs during the COVID-19 pandemic, Rossiter and Godderis (2020, pp. 27–28) note that while the work PSWs perform “remains physical, exhausting and may be considered some of the most risky in terms of the spread of infection because of its intimate nature that demands very close contact between healthcare worker and patient,” PSWs are not “accounted for in the infection control procedures and thus in the organization’s calculus of risk.” During the lockdowns, PSWs in long-term care were not allowed to move in and out of the facility and between suites, rendering the risk posed to themselves and others invisible. In contrast, nurses and doctors “almost always only work in a single facility, and their health status is carefully monitored.” This invisibility intersects with PSWs’ precarious employment conditions and racialization, hence further “limit[ing] the ability to self-advocate or create safer boundaries to mitigate against workplace risk” (p. 28).

Syed et al.’s (2016, p. 42) study of the impact of work hierarchies and divisions of labour on health and safety identifies strict and hierarchical divisions of labour and task orientation, compounded by heavy workloads and low staffing in long-term care settings, as playing a role in “an intensifying effect in reducing workers’ occupational health through psychosocial factors in the organization.” In particular, they characterize the work done in these settings, especially by racialized women at the bottom of the occupational hierarchy, as “boundaried, highly regulated,

¹⁵⁶ In Syed et al. (2016, p. 42), psychosocial factors include: “job demand, job control, social support, time pressure, degree of monotonous work, the extent of social reciprocity (or effort-reward balance), autonomy, fairness, job security, as well as social contact between co-workers and supervisors.”

and formalized” (p. 41). Regarding task orientation, they find their “assembly-line” style work to be “highly focused and prioritized on the completion of tasks, without adequately considering the outcomes of the tasks completed” (p. 41). These two factors combined — strict and hierarchical division of labour and task orientation — intensify job demand and reduce control, inducing feelings of “under-appreciation among staff, job stress, surrender, tension, guilt, anger, resentment and resignation, and even incidences of bullying in the workplace,” and, in turn, this increases occupational morbidity and high-risk behaviours that compromise workers’ well-being and safety (p. 46). In contrast to task orientation, relational work, which is more typical of care provision in Nordic settings and involves “cooperative task sharing, more flexible regulations, limited restrictions on work, and increased work autonomy,” is “beneficial to workers through stress reduction, and beneficial to residents through improvements in their care needs” (p. 41).

Although PSWs working in home and community care settings may have more task autonomy than long-term care workers, as they often work alone and unsupervised, they do not fare much better regarding risk exposure (Neysmith & Aronson, 1996). On the contrary, longitudinal data from 1996 to 2010 showed that compared to PSWs in hospital and long-term care sectors, home and community care workers had significantly lower wages, labour participation levels, permanent positions, job duration, and unionization rates (Zagrodney et al., 2023). A 2015 US study that surveyed 1,200 home care workers found that the majority experience violence, leading to high rates of stress, depression, sleep problems, and burnout (Keith & Brophy, 2021, pp. 44–45). Working alone in unsupervised and non-institutional environments also presents unique challenges, such as hazards in the home, encounters with vicious animals, and other forms of violence. For instance, Maria, one of my interviewees who had worked as a PSW providing home care, experienced these risks firsthand when she injured her knee after slipping and falling outside a client’s home. Because the impact of the fall on her knee did not present itself immediately, but rather a few weeks later, she did not file a report promptly and was subsequently ineligible for workplace compensation (Interview 1, 2019). In spite of these barriers to reporting, in Ontario, home and community care organizations reported a higher frequency of lost time injuries related to musculoskeletal disorders, twice the rate of slips/fall-related injuries, and 20 times the rate for driving-related lost time injuries compared to other healthcare workers (Denton et al., 2018, p. 2).

These analyses demonstrate that rather than being inherently or inevitably risky, the precarious, inflexible, and demanding structure and conditions, along with the expected tasks of these jobs, more closely dictate the high-risk level of subsidiary healthcare occupations. These factors coalesce to make disability likely because they make it challenging to identify, prevent, and mitigate. The disproportionate relegation of IENs and other racialized workers into these subsidiary occupations is, therefore, a process of disablement, as it exposes them to high levels of risk while simultaneously shutting them out of access to workplace assurances granted to those in the upper tiers.

Compared to subsidiary workers without a nursing background, IENs' nursing background only compounds these workplace risks due to the added stresses of navigating the licensing process and the stresses associated with working in jobs that do not match their perceived skill level. In my conversations with IENs, participants express feelings of frustration, depression, discouragement, and despair related to the difficulties they face in getting their skills recognized to become licensed, the inability to utilize their nursing skills, and the associated fear of losing these skills as well as their previous social status, or even the expectation that they put their skills to use without commensurate compensation. For instance, Oscar, an IEN who worked as a dietary aid at a hospital while obtaining his nursing licence, expressed frustration at not being able to practice as a nurse despite feeling that he had more experience than the nurses in Canada. In conversation with one of his friends, he found that this was a common experience for Filipino nurses:

Working as a nurse [in the Philippines], you are more exposed, so you tend to gain lots of experience; you are really hands-on over there. You're allowed to do more. Here, [nurses'] scope of practice is really narrow. Back home, maybe because of the lack of nurses, we tend to practice more jobs and are filled with knowledge and experience. So when you come here, you feel like you know more than the nurses here, yet it's so difficult to get into nursing. One of my co-workers is in Edmonton right now; she got a dietary job working for four to five years. She also shared the same experience of feeling discouraged and depressed because she was working in the Philippines to gain more experience, thinking it would be easier for her, yet the process was hard for her. (Interview 2, 2019)

These disabling conditions only worsen the longer IENs are kept out of the nursing profession. Although family members, friends, and co-workers still come to her for medical advice, Maria, who had 18 years of nursing experience before coming to Canada as a refugee in 2004, mourned the loss of some of her knowledge and status as a result of her downward occupational mobility:

Yes, I have started to forget things, which greatly hurts me and my son. My son used to be so proud of me back home, where they would see me coming and say, 'Oh, here comes the nurse,' 'You're the son of the nurse,' or 'She brought my child to the world,' when I used to work in the birthing unit. My son would see that I was everyone's boss. And here I would come home exhausted, with no energy to do anything and with lousy pay. My status went down." (Interview 1, 2019)

She also voiced her frustration about the inadequate acknowledgment of her nursing expertise, which ultimately resulted in her becoming more indifferent toward her clients:

One time, I was talking to my supervisor, and I told her that one client had schizophrenia and that the medication she was taking was inappropriate. They told me to be quiet because I was not allowed to diagnose. I tried to talk to my client's son about it to get him to at least talk to her doctor. But he didn't do anything. I told them to switch me out of that client because it was too much for me because she was not properly medicated. While my nursing background helps me, I've since chosen to keep my mouth shut because they don't value you here." (Interview 01, 2019)

Others, like Joanna, who had 17 years of nursing experience prior to coming to Canada and worked as a PSW at a retirement home for two years before obtaining her RPN licence in 2010, recalled feeling frustrated not with the inability to employ her nursing skills but rather with the expectation to do so despite the lack of proper compensation or protections:

It's so frustrating, having been an RN for so long back home, to come here and have a lot of experience working as a PSW. But also, when I was a PSW, there was one RN who knew I was an RN back home, and he asked me, 'Hey, I know you're an RN back home. Can you do the catheter for my resident?' I said absolutely no because I don't have a licence, I am not an RN, I am a PSW; catheterization is not part of my job description. (Interview 3, 2019).

These testimonials indicate that IENs in subsidiary roles encounter the same disabling conditions as their non-nursing, personal support work peers. However, their nursing background

often exacerbates these conditions, particularly when they work alongside domestically educated nurses.

IENs are not the only highly educated immigrants who experience adverse health outcomes as a result of not working in their intended occupation. Several qualitative and quantitative studies, particularly in the context of the so-called “healthy immigrant effect,”¹⁵⁷ found that being under/unemployed negatively affects the physical and mental health of immigrants with high education levels more so than immigrants with lower education levels (see for instance: Chen et al., 2010; Dean & Wilson, 2009; Frank & Hou, 2018; George et al., 2012; Lu & Ng, 2019; Premji & Shakya, 2017; Robert & Wilkinson, 2012). This is due to the associated loss in income and status, concerns about losing their skills, family pressures, social isolation, and the risks of working in highly precarious jobs. These studies also found that the negative health impacts of not working in their intended occupation extend to their family members, that they more acutely affect racialized women and those who work in feminized and racialized jobs, and persist over several years after arrival.

Although policymakers consider the adverse impacts of not working in their intended occupation a key motivator for improving IENs’ access to the upper tiers of the nursing profession, as I demonstrated in the previous chapters, policy initiatives have been inadequate in substantially improving integration. Furthermore, these initiatives reinforce skill-based hierarchies in healthcare and promote the idea that jobs viewed as ‘low-skilled’ inherently carry risks. Conversely, only roles deemed ‘high-skilled’ (those that align with the preferred skill standard) are afforded safety through workplace protections. Consequently, integration policy not only leaves the vast majority of IENs who remain outside the upper tiers of the profession but also fail to tackle how integration processes in Canada lead to increased disablement in sending countries and worsen care conditions in recipient countries.

¹⁵⁷ The “healthy immigrant effect” refers to the phenomenon that economic immigrants are generally healthier than Canadian-born people at the time of arrival but that their health quickly deteriorates over time. While the initial ‘health advantage’ of economic migrants is attributed to the immigration system’s careful selection of “individuals with higher human capital,” the use of medical screening, and “positive self-selection,” the subsequent decline in their health is attributed to “difficulties in adjusting to a new environment, stress and/or adoption of risky health behaviours” (Lu & Ng, 2019).

2. How IEN Integration Policy Produces Disablement of Poor Communities in the Philippines

In this section, I delve into feminist political economy analyses of ‘global care chains’ and ‘care drain.’ I examine how the Philippines’ strategy of exporting nurses interacts symbiotically with Canadian integration policies, leading to the marginalization of impoverished Filipino communities. Global care chains refer to “a series of personal links between people across the globe based on the paid or unpaid work of caring” (Hochschild, 2015, p. 250). In feminist political economy, this concept has been instrumental in understanding how the mass migration of nurses and other caregivers from the Global South to the Global North reproduces global health and wealth inequalities (Arat-Koç, 2006; Bakan & Stasiulis, 2005; Ehrenreich & Hochschild, 2004; Gündüz, 2013; Kingma, 2006; Ortiga & Rivero, 2019; Parreñas, 2015; Valiani, 2012; Walton-Roberts, 2021; Williams, 2014; Yeates, 2009). Ehrenreich and Hochschild (2004, p. 17), who coined the terms, argue that due to the unequal ways women in poorer countries are integrated into global care chains, “as women who normally care for the young, the old, and the sick in their own poor countries move to care for the young, the old, and the sick in rich countries, whether as maids or nannies or as daycare and nursing-home aides,” the result is a “care drain,” or a displacement of women’s care labour power. Care drain constitutes a drain “not just on skills, social capital or trained resources but a drain on the ‘commons’ that families build up over time through everyday social and emotional reciprocity” (F. Williams, 2014, p. 22). For instance, studies have shown that children whose mothers emigrated are more often ill and that they experience more emotional distress and deprivation than children who live with their mothers. Their mother’s absence also develops into an animosity that does not quickly resolve itself, even after families are reunited (Gündüz, 2013).

Although the terms ‘global care chains’ and ‘care drain’ initially described a situation in which there is a one-way transfer of care labour from impoverished women to rich women, primarily driven by policies in ‘core’ countries, feminist political economists such as Yeates (2009, p. 48) have since broadened the application of the terms to (a) include analyses of policies in ‘peripheral’ countries, (b) complicate the portrayal of global care chains as being merely supplied by immiserated women to include those emigrating from middle-class families, and (c) challenge the “emphasis on the transfer of care rather than its transformation.” In this section, I engage with

these broadened understandings to explain how the Philippine government's labour market strategy of nurse export, through the overproduction of nurses and underfunding of the healthcare system, which is deeply embedded in Canada's system of IEN integration, produces the disablement of poor communities by displacing and transforming care to service the needs of those abroad, while also effectively barring them from immigrating¹⁵⁸.

As discussed in previous chapters, Canada is a signatory to international agreements and conventions that discourage “active” and “unethical” forms of recruitment of IENs, such as the 2003 *Commonwealth Code of Practice for the International Recruitment of Health Workers* and the 2010 *World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel*. Nonetheless, individual provinces and territories, as well as employers, are enabled by federal policy to recruit from countries like the Philippines by manufacturing demand for their skills abroad and favouring these skills for admission. Along with other factors, such as a long history of colonial policies of extraction, the effects of climate change, and IENs' desire for upper social mobility, this approach to IEN integration creates the conditions for Filipino nurses to gear their nursing education and training towards emigration and risk toiling away in ‘survival’ jobs for years, for the chance to, one day, access the profession, while also ensuring most never make it, thereby producing their disablement. The Philippine government's labour market strategy of exporting nurses exists in symbiosis with this approach to IEN integration: it (a) overproduces nurses and underfunds the healthcare system to encourage mass emigration and (b) adjusts how nurses are skilled to service the care needs of those abroad. By displacing nursing labour and transforming how IENs are skilled, which constitutes a form of care drain away, these policies produce the disablement of the poor communities IENs leave behind.

Regarding the displacement of nursing labour, the mass exodus of staff nurses, combined with low funding, has translated into a reduction and decline in the quality of health services in the Philippines. This reduction is evidenced by the closure of many hospitals, longer waiting times, dangerous nurse-to-patient ratios, increases in errors, and a decline in immunization rates. (Cabanda, 2017; Lorenzo et al., 2007; Ortiga & Rivero, 2019; Robredo et al., 2022). The pandemic especially “pushed the Philippine health system to the brink of collapse” as poor compensation

¹⁵⁸ In addition to migration being an incredible expensive process, immigration policies in Global North countries such as Canada have strict restrictions against admitting disabled people who would pose an ‘excessive demand’ on the healthcare system.

and deteriorating working conditions, such as being forced to work longer hours and increased risk exposure, resulted in mass resignations and further emigration. In fact, the situation worsened to such an extent that it prompted the government to ban emigration temporarily (Robredo et al., 2022). However, this temporary ban, on its own, is insufficient for dealing with the high attrition rates of nurses, as issues related to heavy workloads and poor remuneration persist. For those who are too poor or too disabled to emigrate, remittances are thus one of the only ways to access better care, the amount of which is, of course, contingent on their relatives' earning capacity abroad.

In addition to poor communities left behind to suffer from mass nurse emigration, the manufactured demand for nurses abroad has also transformed the skilling of nurses in the Philippines at the expense of deteriorating care conditions. Masselink and Lee (2010), for instance, explore the role of nursing schools in the Philippines as “migrant institutions” in the rapid expansion and commercialization of nursing education and how this has made it more challenging to regulate the quality of nursing education, contributed to the maldistribution of resources (e.g. fewer people training to become physicians), and encouraged corruption. Although the Philippine government's passing of the Nursing Act of 2002 led to the closing and monitoring of poorly performing schools and the issuing of a moratorium on new schools in 2004, this was done more out of concern for reestablishing the country's prestige on the world stage as a producer of high-quality nurses than for improving conditions of care at home (Cabanda, 2017; Masselink & Lee, 2010).

Similarly, Ortega and Rivero (2019, p. 1188) explore the adverse impacts on care provision of updating nursing curricula in 2007 “in line with ‘global standards’” by sharply increasing requirements for clinical fieldwork. While the subsequent massive influx of nursing students provides much-needed bedside care to underfunded public health settings, the authors find that it does not “fill the gap left by the emigration of experienced nurses” (p. 1189) but, instead, exacerbates inequalities between care providers, care providers and patients, and wealthy and poor patients.

In terms of inequalities between care providers, although “[o]n paper,” nursing students are “advised to simply observe procedures, administer medication, and monitor vital signs,” due to understaffing, they are expected to take on many tasks that overworked staff nurses do not have time for (Ortega & Rivero, 2019, p. 1190). These tasks resemble those performed by Canadian

PSWs, such as turning immobile patients, cleaning wounds, and changing bed sheets and bedpans. Therefore, even though nursing care in the Philippines is not technically tiered among different classes of providers, the massive influx of nursing students into an overburdened healthcare system effectively creates a tiered and fragmented care system. As I further explain below, tiered and fragmented care systems negatively affect care conditions, e.g., by interrupting the continuity of care. (Grinspun et al., 2016).

Regarding the reproduction of inequalities between wealthy and poor patients, as well as nursing students and poor patients, Ortega and Rivero (2019) also find that many Filipino nursing students (many of whom were middle or lower-middle class) prefer treating poor patients over wealthy ones because they consider it a valuable opportunity to enhance their skills. Poor patients often present with “interesting diseases”—a result of being unable to access care until their illness or condition has progressed to its final stage—meaning nursing students can gain much more knowledge and practical experience from treating them, which, in turn, better prepares and sets them apart when working overseas. Moreover, while wealthy patients often refuse care from their less-experienced caregivers, poor patients are less likely to complain and advocate for their needs because of their “charity ward status” (p. 1192). Given that poor patients serve as the “perfect,” “docile” bodies “compliant with the trials and errors of nursing students still honing their skills for dream jobs overseas” (p. 1192), the authors conclude that there is an “inherent inequality in the actual *skilling* of aspiring migrant nurses, where the poorest bodies allow them to provide better care to more privileged bodies higher up the chain” (p. 1194). By enabling better care for those abroad at the expense of poor Filipinos while also barring them from ever emigrating, the transformation of IENs’ skilling thus constitutes a form of disablement.

As noted in *Chapter Two*, Canadian nursing leaders and policymakers recognize the negative health effects of care drain on source countries. This awareness has led them to consistently advocate for strengthening the domestic nursing workforce instead of increasing dependency on IENs to meet labour demands. However, prioritizing domestic nurses over IENs not only fails to counteract labour-export policies in source nations and diminish the influx of IENs but also further enables their downward occupational mobility and exacerbates their disablement. Furthermore, viewing nurse emigration as the root cause of care drain—rather than a consequence of longstanding policies that create nursing demand in Canada while facilitating mass emigration

from the Philippines—compounds labour shortages. In particular, this approach reinforces the underlying issues, particularly the neoliberal restructuring of healthcare evident in care privatization and increased ancillary work. The next section illustrates how integration policy supports this neoliberal restructuring, arguing for a radically different approach that benefits everyone, except those profiting from healthcare.

PART TWO

1. Downward Occupational Mobility Among IENs: The Production of Disabling Conditions in Canada

Thus far, this chapter demonstrates that selective and assimilative integration policy produces the disablement of IENs and poor communities back home by transforming IENs' skilling, displacing their labour away from poor communities, and subsequently channelling IENs into subsidiary jobs upon arrival, all to service Canada's labour market needs. This is not a failure or misalignment of policy but rather a policy feature. Policies regulating immigration and nursing are co-constitutive gatekeeping mechanisms that produce greater safety among those designated as worthy (i.e., citizen-subjects) than among those designated as less so by (a) filtering the most undesirable and threatening (i.e., the disabled poor) elements while also crucially exploiting them as raw training material and (b) offloading the most disabling jobs and tasks to those granted conditional admission (i.e., IENs).

In necropolitical terms, integration policy 'folds into life' citizen-subjects through the process of 'leaving' others (i.e., the disabled poor) to die and 'marking' others (i.e., IENs and their families) for a slow death (Gorman, 2016). Within this understanding, the disablement of IENs is thus not simply a secondary effect of exploitation. Instead, building on Thobani's (2007, 20-21) analysis of how Canada's state policies and popular practices reinforce gendered and racial hierarchies, it is an exercise in exaltation, which:

[I]nvoles a particular subject position that can be inhabited only by the nation's insiders, or those who seek inclusion - and are allowed to do so - by effacing their difference from this position. The association of precious rights and entitlements with such an identity creates a material stake in protecting these from the encroachments of irresponsible and undeserving Others, and exaltation gives rise to the desire among insiders to defend and protect this valued nationality from the perversions and pollutions of the Other. It creates the desire to limit the Other's access to the much-coveted nationality it organizes. In Canada, this exercise of power has provided tangible benefits to the national subject, in the form of proprietorial access to land, citizenship, mobility, employment, social entitlements - in short, to all the accoutrements that the state accords its citizen-subjects. As such, exaltation wins over the national's support for the various disciplinary techniques deployed by the state against outsiders to preserve the

coherence of the nation, to preserve this subject's privileged access (even if ultimately illusory) to the state.

I utilize the foregoing conceptualization of exaltation for two reasons. First, this conceptualization allows us to understand what contributes to the persistence of the disablement of IENs. As an exercise in exaltation, their disablement produced by their downward occupational mobility involves deploying various 'disciplinary techniques' (i.e., licensing, credentialing) against outsiders to preserve the coherence of the nation (i.e., Canada's labour market needs and the supremacy of the Canadian nursing system) and the 'invocation of a particular subject position' that only the 'nation's insiders' can occupy (i.e., settler nurses and the public). Second, downward occupational mobility gains support from these insiders by claiming to protect them from potential 'encroachment' by 'undeserving' outsiders and by affording them relative benefits (e.g., access to better jobs and cheaper care).

Notwithstanding this exaltation, Thobani (2007) shows us why we all have a vested interest in challenging disablement. While the current integration approach has granted settlers and care recipients notable advantages over racialized nurses, this privileged status is, in reality, "ultimately illusory." Although IENs and their communities experience the disability produced by integration policy more acutely, domestic nurses and those who receive their care are not immune to the disabling implications of this process. In this section, I illustrate how the downward occupational mobility of IENs contributes to the deterioration of care conditions caused by neoliberal privatization. This occurs in two main ways: (a) it increases the pool of workers available as a reserve labour force, weakening the collective organizing power of healthcare workers and (b) it forces IENs into roles where they must utilize their nursing skills without a license, which heightens their exploitation and obscures care deficits.

1.1. Neoliberal Privatization and the Expansion of Subsidiary Nursing Work: IENs as a Reserve Army of Labour

The privatization of healthcare under neoliberalism consists of many elements, including (a) an increasing responsabilization of the individual and the household, away from the state, for the maintenance and provision of care, (b) an expanding reliance on for-profit providers, (c) the adoption of corporate managerial practices in the non-profit sector (e.g., New Public Management),

which prioritize cost savings or efficiencies over providing quality care, and (d) the deprioritization of care for people with dubious market value (e.g., seniors, disabled people, the unemployed) (Acker, 2004; Armstrong & Armstrong, 2023; Keith & Brophy, 2021; Picchio, 2000; Vosko, 2002, 2006).

Privatization has had severe disabling implications for healthcare workers and care recipients because it prioritizes the productive needs of the market over meeting the social reproductive needs of people. Numerous reports and studies over the past two decades (Armstrong et al., 2008; Armstrong & Armstrong, 2023; Grinspun et al., 2016; Health Canada, 2002; Keith & Brophy, 2021; RNAO, 2010, 2013, 2017; Walton-Roberts, 2023) document a decline in the quality of nurses' working conditions that coincides with a growing shift towards privatization, such as an increase in the number of injuries, stress levels, exposure to violence, absenteeism, and precarious work arrangements. Unhealthy work environments hinder nursing recruitment and retention, negatively affecting equitable and high-quality care. For example, they lead to longer wait times and disrupt continuity of care.

As care conditions deteriorate and care provision moves away from hospital settings to long-term facilities and homes, more work is being done by families and precariously positioned subsidiary workers. IENs provide a constant supply of workers for these subsidiary jobs, allowing for their expansive use, which only further displaces RN positions and creates downward pressure on their wages: “[t]he ability to draw new labour with precarious migration status from other national markets translates into a downward harmonizing force, as wages and other terms of employment tend to fall in all national labour markets involved” (Valiani, 2012, p. 30). For instance, the 2016 RNAO report *Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN* notes that the massive drops in the RN share of employment in all sectors coincide with considerable increases in the employment of RPNs and ‘unregulated care providers’ (that is, PSWs). While no data are provided for ‘unregulated care providers,’ the report notes that RPN employment growth rates in all sectors are more than double those of RNs. This trend is concerning because “fewer RNs means a heightened risk for patients and risks desired health outcomes, by increasing mortality and morbidity” (Grinspun et al., 2016, p. 30).

The report also found an increasing adoption of functional nursing models parallel to the growing displacement of RN positions by subsidiary occupations. The functional nursing model

divides patient care into tasks provided by different categories of providers, and it is most often contrasted with primary nursing care models, where one nurse continuously provides all care. The functional model of task-oriented, fragmented care is criticized for its devaluation of “aspects of psychosocial care,” its reliance on “rules and policies instead of professional judgment,” blurring lines of accountability, increasing the risk of cross-contamination, errors, costs (due to unmet patient needs and risk of re-admission), and patient morbidity and mortality, and creating “structural interruptions” that undermine the continuity of care (Grinspun et al., 2016, pp. 35–37). Despite these adverse impacts on health outcomes, the report notes that most health organizations have increasingly adopted this model of care provision due to budgetary constraints, primarily because it allows the replacement of RNs with cheaper, subsidiary workers.

Instead of working to raise the floor by increasing wages and status of subsidiary workers—thus preventing their extensive use as a cost-cutting tactic—RNs persist in employing the traditional strategy of raising their own relative status by highlighting the value of their ‘higher’ skill levels. For example, in 2005, when the Health Professions Regulatory Advisory Council was approached to consider making personal support work a self-regulated profession¹⁵⁹ to improve their relative status and the quality of care they deliver, the CNO and the other nursing associations spoke out against it. Their position is that, unlike nurses, PSWs’ scope of practice is too ambiguous and lacks a standardized body of knowledge (HPRAC, 2006; Kelly & Bourgeault, 2015). Although becoming a self-regulated profession may not improve the compensation levels and working conditions of PSWs but, instead, increase barriers to entry,¹⁶⁰ the response by nursing leaders illustrates how frictions and divisions over questions of skill negatively affect their capacity to organize and mobilize to demand better working conditions. By characterizing subsidiary workers as ultimately inferior due to their lower educational requirements, ergo less deserving, while also objecting to enhancing their education, RNs reproduce the very conditions that act as a downward force on their employment conditions.

Another example of differences in formal educational levels being mobilized to subvert the capacity of nurses to demand better conditions is reflected in the significant wage gap between

¹⁵⁹ Specifically, they were asked to consider the merits of self-regulation under the *Regulated Health Professions Act, 2001*, a potential registry, the standardization of training and education, as well as to consider the adequacy of their supervision (HPRAC, 2006).

¹⁶⁰ Professionalization creates additional barriers to admission, such as additional educational requirements and police background checks, which increase the time, effort, and cost of entering the profession.

RNs and RPNs. In an arbitration case, *Participating Hospitals v Canadian Union of Public Employees*, (2019) the union fought to close the gap by arguing that the substantial gap was “unwarranted given the similarity in the jobs.” Specifically, the union notes that although the scope of practice between RNs and RPNs overlaps approximately 90%, RPNs earn approximately 65% of the RN rate. However, the arbitrator denied their request, citing their “substantially different educational requirements” per nursing regulations. In response to inquiries about the significant wage disparity between RNs and RPNs, the RNPAO representative I spoke with pointed to educational differences to justify this pay gap: “We get calls every day saying ‘I do the same job as an RN why am I not making \$45 an hour.’ Then we have to talk about the depth and breadth of knowledge of an RN supported by a baccalaureate degree” (Interview 12, 2020).

In sum, by gatekeeping IENs out of the nursing profession, thereby increasing the availability of a cheap, flexible, highly educated nursing workforce to act as a reserve army of labour, integration policy thus only further enables the expansive use of subsidiary care providers, weakens the collective organizing power of healthcare workers to demand improvements, and deteriorates conditions of care. As Walton-Roberts (2023, p. 5) succinctly put it, the “growing presence of immigrants in core economies’ labour markets is arguably a symptom of the overall decline of working conditions, not a cause of it.” Although RNs hold relatively more power and privilege, the increased reliance on ‘low-skilled’ subsidiary care providers has emerged as a cheaper and politically favourable alternative to addressing the working conditions of nurses. As a result, nursing has remained a feminized occupation without equal access to the recognition and rewards accorded to physicians¹⁶¹ and continued to bear the brunt of budgetary cuts and work intensification measures (Banerjee et al., 2015; Kingma, 2006; Valiani, 2012; Walton-Roberts, 2023).

¹⁶¹ Despite the growing supply of men becoming nurses in recent years (15.4% increase in men versus 3.9% women from 2014-2019), women make up 91% of the nursing workforce (CNA, 2021). Beyond numerical makeup, gendered divisions are also reflected in nurses’ lower wages and subordination. Physicians earn between three to 13 times more per hour than nurses, even when doing similar duties,¹⁶¹ and exercise more significant levels of authority in the workplace. According to a recent report by CTV News, physicians deployed in the intensive care unit in Ontario earn up to \$450/hr or \$165/hr for administrative assignments. Meanwhile, a Registered Nurse (RN) earns between \$33 and \$48/hr, depending on years of experience. This disparity exists even when they do similar work (DeClerq, 2021).

1.2. How IENs in Subsidiary Occupations Obscure Care Deficits Created by Neoliberal Privatization

In addition to acting as a reserve army of labour consistently providing workers for subsidiary roles, IENs in those positions—such as personal support workers, domestic workers, and dietary aides—experience a uniquely exploitative environment compared to workers without a nursing background. These IENs are compelled to utilize their nursing skills without formal authorization to address care gaps and to cope with their downward mobility. Ironically, their use of these skills can mask care deficiencies, thereby perpetuating the very circumstances contributing to their downward mobility. This section first examines the factors driving IENs to employ their nursing skills and then investigates the resulting effects on conditions of work and care.

Keenly aware that they are not adequately compensated and could get in trouble for practicing without a licence, IENs sometimes hesitate to use their nursing skills. As discussed in the first section of this chapter, this can generate a lot of apathy and frustration. At the same time, IENs also find it difficult to completely abstain from using their skills. For instance, in a 2024 survey of close to two thousand IENs working in the healthcare sector in Ontario but not as registered nurses, 11% of respondents indicate that their job makes use of “all their nursing skills and experience,” 21% that their job makes use of “a lot” of their skills, 61% that their job makes use of “some,” and only 7% that their job “does not make use of any” (WES, 2024, p. 12).

Based on my interviews with IENs, they find it difficult to abstain from using their nursing education and training because their close contact and emotional affinities for the people they care for allow them to identify and attend to health issues that otherwise would go unnoticed (either by PSWs with no nursing background or when registered nurses are unavailable). For example, one of my participants, Maria, recalled one specific incident as follows:

I was working as a PSW with an elderly Italian client, and everything was going well until one day, he fell, and his character began to change. He started treating the other Filipina PSW who came to work with me very badly, and I would tell him, ‘She’s coming here to help; you can’t talk to her that way.’ I told his son’s wife, who was a nurse, that his behaviour had changed because he used to be a gentleman. She told me, ‘Oh Maria, it’s his age,’ and I replied that even though he was older, his behaviour had changed too drastically and that he had to get

checked out. Two days later, they called to tell me that he had a cerebral tumour (Interview 1, 2019).

Besides identifying health issues, Joanna described how her nursing experience enables her to provide more compassionate care than PSWs lacking this background:

Sometimes, the new grad PSW takes the behaviour from the resident personally because it seems like they don't understand what is going on in the aging process. So that's why sometimes they, I don't know how to say, it's not really abuse, but sometimes their temper is not great. That's mostly what I've observed. As a nurse back home, you know the disease process and how to deal with it. You are more knowledgeable to assess the patient rather than if you go to school for six months and you're not even taking anatomy courses or learning how to do a gentle, persuasive approach (Interview 3, 2019).

In a similar vein, David, who worked as a nurse for eight years back in the Philippines and as a PSW for three years before obtaining his RPN licence, said that his nursing background helps him not just in knowing how to handle equipment and identify symptoms, but also in how to work in fast-paced environments with many patients:

One of our advantages when we have a degree in the Philippines is knowing how to provide bedside care even though I work as a PSW. I know the proper body mechanics, how to turn people even though they are big, and how to use the lift. You also know when a client is dehydrated by the colour of their pee or if they have blood in their urine to tell the nurse about it. If I see a bedsore or a spot, I tell my client to tell the nurse because I cannot give a diagnosis, but it's helpful for me. That's our advantage and also how, for me, how to deal with lots of people. As a nurse back home, it's really hard because I'm working with 12 to 16 patients a day, so you have to be fast-paced, and you need to know each patient. Today, I'm also using those skills, knowing what they need on that day, how to organize your clients, and what to do with each one (Interview 6, 2020).

Mike, who holds a Master's degree in Nursing from the Philippines and worked as a clinical instructor before coming to Canada, also described how he uses his nursing background while working as a PSW in a retirement home. His testimony is particularly significant as it highlights not only the gaps in nursing care that IENs fill by assessing and monitoring residents who are

unable to advocate for themselves but also the institutional constraints and interprofessional conflicts that IENs encounter when they assert their knowledge:

I am using my nursing background when giving pills to residents. I am very aware of what I am giving to them, what the drugs are for, what we should watch out for, and the side effects of the drug. I also find the nursing background helpful because I can assess my residents or patients as opposed to those who don't have any background at all. Even though PSWs took a course, it's not really enough, especially when you are dealing with people living with dementia who cannot communicate, so you need to know what hurts them or what they are trying to tell you; you should be their eyes, ears, and mouth. So if you don't have that knowledge, you will certainly miss details that are very significant to care... There was this one time when I was doing the care of a specific resident, and I told those in the orientation of our unit that this resident's legs were swelling and asked, 'Has it been here before, or is it new?' They said, 'I don't know, his legs are swelling?' I told them, 'So he's been admitted for almost a month, and you haven't done a follow-up assessment of his condition?' I did not comment further. I just asked what is his medical history in order to care about the patient. They told me it was not my job to read the resident's medical history. I thought to myself, you should be familiar with every resident's medical history. You should probably also be familiar with what medicines they are taking and if they are taking diuretics. Or, like if the stools are black and you know the resident is taking iron, it would be expected for the poop to be black, and there's no reason to report it. So if you have that nursing background, you know what to expect, like you know what to do even if you can't do it alone and still need to report it to the RPN or the RN (Interview 7, 2019).

Others, such as Oscar, leverage their nursing skills to pinpoint and tackle health risks in the workplace. During his time as a dietary aide in a hospital, he remembers a situation where he used his nursing knowledge in demanding custom-fitted masks, safeguarding both himself and his colleagues from airborne threats diseases:

I called [my co-workers'] attention right away and explained why specialized masks are needed. Because I have nursing knowledge, I explained to them, 'If you don't get the mask, you can refuse to do the job, refuse to deliver the tray and report it to the supervisors.' It's unfair to the new staff that they don't know this. It's their right to have this mask fitting, which contributes to their safety (Interview 2, 2019).

Beyond enhancing care quality and efficiency, IENs are motivated to utilize their skills as a means to manage their downward occupational mobility. For example, Jacqueline, who spent six years working as a nurse in the Philippines and enrolled in a Chronic Disease Management program for IENs while taking on available PSW shifts from her friends, shared her fulfillment in contributing to her clients' health:

I have this client with rheumatoid arthritis who was complaining about always having headaches and muscle weakness, which gets worse every morning when she wakes up. I explained to her that it's normal to feel those symptoms, and she was so thankful because she said she didn't know that [her condition] could give her a headache because it is in relation to her legs, and we were laughing with each other... I have a lot of clients and deal with a lot of different cases. I love applying my previous knowledge (Interview 8, 2019).

Others, like Laura, derive confidence and motivation from using her nursing skills and cope with her exploitation by characterizing it as a rite of passage for migrant nurses:

It's inevitable to feel tired because we are nurses. If you are not mentally strong, you could give up because it's hard, because this isn't what I studied for, you'll always think about that. But it is what it is, you have to accept that if you want to change your future. We came here, and we should do what we've got to do; we can't say that we were nurses in the Philippines and doing this and that. If you come here and are a caregiver you do the work. As for me, I don't think I'm going to change anything because I'm happy with my job, but sometimes I also feel tired, but it's also up to you how you motivate yourself again (Interview 10, 2019).

The representative from the RPNAO similarly talked about how, in her counselling with IENs, being able to “tap into some of that [nursing] knowledge while they are here working as a PSW” provided IENs some relief from their otherwise chaotic lives:

When they are relatively new to Canada, under three years, their personal life circumstances have a way of distracting them from being able to focus. And I see that with all of my counselling IENs, their life is chaotic; they try to get all the dice in the roll, and they have to go through regulatory body hoops. I think when they get into the world of PSW, I feel like they relax a little and do what they love to do and care for people.. they can do a role that will give them some income and make them feel as though they are a nurse again (Interview 12, 2020).

This quote also reveals that nursing leaders, employers, and co-workers widely recognize the added value of nurses using their skills. For example, a manager at a hospital in Ontario mentioned that prior nursing experience is crucial in their choice to hire IENs as dietary aides, as it reduces training time resources:

To be hired as a dietary aid, you are required to have previous experience working in healthcare settings. When someone with a nursing degree from another country applies, we consider this a great asset. Although some of these nurses are overqualified and may eventually leave when they get their nursing licence, we hire them because they don't require much initial training and follow instructions well, especially regarding dietary restrictions (Interview 15, 2020).

Jasmine, who worked as a nurse for four years back home and entered Canada through the Interim Pathway for Caregivers Program, remarked that her employer, a nurse trained in Canada, “appreciated her nursing background” as it guarantees proper care for her children when they are sick or hurt. When one of her children under her care became ill, she promptly recognized the symptoms of Kawasaki's disease, monitored his condition closely, and administered his medication (Interview 4, 2019).

A domestically educated nurse I spoke to shared that her job at the nursing home is less demanding and stressful when partnered with PSWs who have a nursing background. She intentionally structures her work schedule to align with a PSW who was a nurse in her home country and is a reliable source of support. Additionally, she compares this positive experience to that of working with another domestically educated nurse who often assigns her unwanted tasks.

In nursing, we have a saying that ‘nurses eat their young.’ Whenever I used to work with Trish [who is an Ontario-educated nurse], she gave me all the most difficult tasks and residents she didn't want to deal with and didn't like it when I asked for help. I switched nights to work with Tina, who was a nurse back home but has been working as a PSW for ten years, and she's taught me a lot. I told her the place would fall apart without her, though I sometimes feel bad because I make more money than her, even though I just graduated (Interview 14, 2020).

These testimonies illustrate how IENs are motivated to utilize their nursing skills, as it allows them to deliver improved and more efficient patient care, tackle issues before they escalate, offer more empathetic support, recognize and mitigate workplace hazards, be better prepared to meet the demands of their roles, and cope with their downward mobility. Without the nursing skills of

IENs, many health conditions would deteriorate, pressure ulcers would go untreated, catheters and bandages would remain unchanged, and medications might be overlooked or incorrectly administered.

By continuing to utilize their nursing skills in subsidiary healthcare roles, IENs (a) complicate the idea that they merely lose their nursing skills when working in these positions. While deskilling remains a concern due to legal restrictions limiting their ability to fully apply their skills, it is important to recognize that their experiences with skill interruption differ from those of nurses who leave healthcare altogether; the latter, which, by the way, form the basis for changes made to the evidence of practice requirements in 2013 and were noted, in the previous chapter, to significantly hinder IEN integration.¹⁶² IENs also (b) challenge the notion that their ‘foreign’ nursing credentials and lack of ‘cultural competence’ present a significant danger to public safety. Instead, it reveals more pertinent risks to public safety, particularly the disablement IENs face through their downward occupational mobility, the dangers of chronic understaffing, and the fragmentation of care. And (c) demonstrate the importance of primary nursing care models in creating positive health outcomes.¹⁶³ This includes giving nurses the time to familiarize themselves with patients to intervene early, increasing autonomy and accountability, “improv[ing] clinical decision-making,” and more effective inter and intra-professional collaboration (Grinspun et al., 2016, p. 15).

Unfortunately, by using their nursing skills to fill gaps in care without commensurate recognition and compensation, IENs inadvertently obscure these gaps and reduce the demand for registered nurses. In the words of Aronson and Neysmith (2006, p. 37), IENs thus become “shock absorbers” of neoliberal restructuring, “insert[ing] themselves...between their clients and the damaging impacts of government policy.” While acknowledging the satisfaction and motivation

¹⁶² When the CNO council initially proposed revising regulation 275/94 under the *Nursing Act, 1991* to reduce the evidence of practice requirement from the previous five years to the previous three in 2009, they provided the following evidence to support this change: a summary of the legislative framework in Canada; a nursing jurisdictional review which compared evidence of practice requirements across Canadian, American, UK, New Zealand, and Australian jurisdictions; a jurisdictional overview of non-nursing Ontario regulatory bodies; and, perhaps more importantly, a literature review of research on the impact of not practicing on knowledge retention. The literature review only included studies where loss of knowledge was determined in the context of not practicing at all. See Appendix G: Council Note Cited in the December 3, 2009, CNO Council Meeting.

¹⁶³ While the functional model of task-oriented, fragmented care is fraught with issues that negatively affect work and health outcomes, primary nursing care models, where one nurse provides all care continuously, have been linked with producing positive work and health outcomes when “implemented through a supportive culture” (Grinspun et al., 2016, p. 15).

that IENs gain from applying their nursing skills in subsidiary roles, it is important to note that such utilization can contribute to their exploitation. They endure the negative consequences of this exploitation in the form of disablement, as the ability of citizen-subjects to access increasingly limited and privatized care depends on the availability of their labour and skills.

2. Conclusion

In this chapter, I built on Gorman's (2016) disablement framework to illustrate how integration policy produces the disablement of (a) IENs by channelling them into subordinate healthcare roles where they face higher risks and have reduced capacity to address them and (b) impoverished and disabled communities in the Philippines by reconfiguring their care system to meet Canadian healthcare needs and effectively barring the poor and disabled from immigrating. Although the disablement of IENs and Filipino communities supports the conditions for Canadian citizens to make disability claims at their expense, I also demonstrated that this seeming advantage is precarious and plagued with challenges. Specifically, I demonstrated how the downward occupational mobility of IENs contributes to neoliberal healthcare privatization, promoting the growth of subordinate jobs and the obfuscation of care deficits, which adversely affect both care quality and working conditions.

By considering how integration policy affects not only IENs and their communities back home but also how it contributes to the deterioration of care conditions in Canada, I echo Walton-Roberts' (2023, p. 7) call for an "an integrative approach that connects across all scales of regulated (nurses) as well as unregulated (care aides) occupational groups to fully analyze the contribution of immigrants to health and assess relevant immigration governance systems." As part of this integrative approach, I propose divesting from the current selective and assimilative integration approach and from making mere adjustments to ensure assessments are more procedurally fair. Instead, we must focus our efforts on the equitable and swift integration of IENs into the upper tiers of the nursing profession and on challenging skill-based hierarchies by closing compensation and other gaps (e.g., access to benefits and statutory protections) between healthcare workers. This transformative approach, moreover, calls for challenging the profitability ethos underpinning our healthcare system writ large. The next and final chapter synthesizes the key findings and contributions of each chapter and considers how to move forward in confronting skill-based hierarchies and profitability as organizing principles of healthcare.

CHAPTER SIX

Conclusion

As I write this conclusion, nursing regulators across Canada are rapidly changing entry-to-practice requirements to speed up the integration of IENs to address post-pandemic-related staffing needs. The findings from my critical policy analysis help us understand these changes and their effects and shift our understanding of integration policy. Below, I summarize the key findings and contributions of each chapter. Next, corresponding to the second part of the WPR question about what can be done to challenge and mitigate the adverse effects of dominant representations, I consider the implications of these findings for those interested in increasing the licensing rates of IENs and improving all conditions of work and care in our public health care system. This inquiry includes a discussion of key recommendations, particularly easing the evidence required to verify practice requirements for IENs in the short term and flattening job hierarchies in the long term. I conclude with a discussion of outstanding concerns and areas of future research.

1. Key Findings and Contributions

In *Chapter One*, titled *The Problem of Foreign Credential Recognition*, I presented the problematic at hand, particularly that many IENs remain unable to access the upper tiers of the Canadian nursing profession, resulting in widespread downward occupational mobility. Policy attributes this problem to the challenges IENs face in getting their credentials recognized and assessed, which negatively affect the quality of life and well-being of IENs and their families by preventing them from transforming their education into higher-paying jobs with greater social status and deprive the Canadian healthcare sector of essential nursing labour. Yet, despite widespread agreement that improvements are needed in the recognition and assessment of foreign credentials in Canada—and the hundreds of millions spent to date—IENs continue to be channelled into precarious and highly disabling subsidiary healthcare occupations.

Rather than merely seeking to increase IENs' access to the nursing profession by improving the existing system of recognition and assessment of their credentials, I sought to explore whether and, if so, *how* their downward occupational mobility and the government's failure to reverse this trend over the last twenty years are linked to racialized understandings about skill fundamental to the broader racial segmentation of care provision. Specifically, I aimed to question the notion of

skill as an objective measure of value and investigate how it contributes to the production of disability as abject, i.e., as a sorting mechanism through which workers are exposed to varied levels of risk based on their unequal access to compensation, benefits, job security, legal protections, and social status.

To achieve these objectives, this chapter and my dissertation as a whole built on Bacchi's (1999, 2009; Bacchi & Goodwin, 2016) WPR approach to critical policy analysis, Armstrong's feminist political economy analysis of the social construction of skill articulated across various publications (see in particular: Armstrong, 2013; Armstrong et al., 2008; Armstrong & Armstrong, 2010; Armstrong & Day, 2017), and Gorman's (2016) disablement framework. I selected these methodological and theoretical approaches as they allowed me to explore the deep historical origins of downward occupational mobility, its connection to the social relations of gender, race, and disability, and how it is integral to (rather than a failure of) policy. In addition to their analytical value, these approaches also allowed me to formulate alternative understandings of the problem that avoid the common pitfalls of upholding occupations characterized as 'high-skilled' as the sole access points to assurances in the workplace (e.g., future job security, decent income, access to regulatory protections and statutory entitlements, and control over working conditions).

Chapter Two, titled "*The System is Fragmented from the Beginning*": *The Problem of Foreign Credential Recognition as Lack of Coordination and Harmonization*, and Chapter Three, titled "*We Are Presumed And Treated Like Incompetents, Cheaters And Dummies Unless We Can Prove Otherwise*": *The Problem Of Foreign Credential Recognition As Lack Of Fair Access* began this empirical investigation by applying questions one through four of my modified version the WPR approach to federal and provincial FCR policies respectively: (1) What is the problem of FCR represented to be in policies related to the immigration and labour market integration of IENs? (2) How and where has this representation been produced, disseminated, and defended? (3) What are the deep-seated assumptions about this representation? (4) What are the effects (discursive, subjectification, lived) of this representation? Specifically, how has this representation framed or imposed limits on what can be said about the issue? How are IENs and their skills constituted in relation to domestically educated nurses? And how has it impacted the lived reality of IENs?

In *Chapter Two*, I demonstrated that federal-level policies represent the problem of FCR primarily as a problem of lack of harmonization and coordination of policy rooted in jurisdictional complexity, specifically the result of too many governance bodies involved in the FCR process, with independent scopes of authority and mandates acting in contravention of each other. This lack of coordination and harmonization makes assessing and recognizing IEN credentials procedurally problematic, notably lacking transparency, consistency, and timeliness, which act as barriers to integration. Within this framing of the problem, the federal government's approach thus involves two strategies: (1) the provision of centralized information and 'path-finding' services, preferably pre-arrival, to help IENs manage their expectations, navigate the complexity of the system, and prepare requirements in advance, and (2) the development of a more streamlined and standardized assessment process. Out of the many initiatives and programs developed within this problem framing, the NNAS, a centralized assessment agency that handles the initial steps of the assessment process and acts as the first point of contact for all IENs seeking licensure in Canada, is the most significant for IENs.

In *Chapter Three*, I demonstrated that provincial-level policies, with Ontario as the case study, represent the problem of FCR primarily as a one of lack of fair access, specifically the result of inadequate procedural protections for applicants holding 'foreign' credentials due to a lack of regulatory oversight. This lack of fair access makes assessing and recognizing IEN credentials procedurally problematic, notably lacking transparency, consistency, timeliness, and accountability, resulting in undue levels of discrimination. Within this problem framing, the Ontario government passed fair access legislation establishing a set of procedural criteria that all regulators and third-party assessors must abide by, along with an oversight body, the OFC. In its role, the OFC has overseen the implementation of dozens of changes to the CNO's registration policies and practices, such as clearer and more accessible information, the development of a new application portal, the introduction of additional alternative pathways to meet requirements, and the implementation of staff-training requirements). Subsequently, in 2016, the OFC classified the CNO as fully compliant with legislation and subject to minimal monitoring.

The most significant finding of these two chapters is that NNAS and fair access legislation are overwhelmingly commended for successfully improving IEN integration by creating a more procedurally fair process despite much evidence to the contrary. Upon examining applicant data

(e.g., the clearance rate of applications and the proportion of international licensees relative to domestic), the cost of licensing, official evaluations of the programs, and IENs' lived experiences, it is clear that these initiatives not only fail to improve integration substantially but also make the licensing process stricter, lengthier, and more expensive. Rather than a policy failure, I argued that these effects are a consequence of how these initiatives understand the problem of FCR in the first place, which is as a procedural issue located in entry criteria rather than in entry standards, i.e., in how IENs are assessed against occupational standards rather than a problem with the standards themselves. By analyzing the unproblematized assumptions underpinning this problem framing, I demonstrated how it produces the largely unacknowledged pressure for IENs to accept lower tiers of employment, such as RPNs or PSWs.

I also demonstrated that this problem framing, which primarily focuses on making entry criteria (not standards) procedurally fair, rests on two main related assumptions: (1) that promoting swift integration and ensuring public safety are essentially opposing policy goals and (2) that IENs' skills are potentially inferior, deficient, and fraudulent, while Canadian nursing standards constitute universal and impartial benchmarks for skill and public safety. I argued that through this racialized dichotomous depiction of nursing skills, regulators find it necessary and reasonable, as part of their role of safeguarding public safety, to restrict IEN integration as per the objectives of selectivity and assimilation, which involve intensifying the scrutinization of IENs and limiting access to those who best approximate Canadian nursing standards. As regulators increase their demands on IENs by imposing stricter entry requirements, the intricate bureaucracy that has been created by both public and private entities to assist with their integration shifts the extra costs, time, and administrative challenges of navigating this complex system onto IENs and their families. As a result of concentrating exclusively on procedural improvements, I argued that the various initiatives and regulatory reforms mask problems related to occupational standards and reinforce the gatekeeping practices of regulators, thereby neglecting or even worsening numerous systemic entry barriers.

In order to develop an alternative representation of the problem, *Chapter Four*, titled *Reconceptualizing the Problem of FCR: Challenging the Racialized Dichotomization of Nursing Skills*, and *Chapter Five*, titled *"I don't want to call it a depression. But I had a bad experience when I worked there. I was thinking, 'Why am I doing this?' I am licensed and trained to be a*

nurse, but you need a survival job”: The Downward Occupational Mobility of IENs as Disablement, applied the fifth and the first part of the sixth question of my modified WPR approach to the previous analysis of integration policies: (5) What is left unproblematic in dominant representations of the problem of FCR, and what are the silences? (6) How can the problem of FCR be reconceptualized, disrupted, or replaced?

Chapter Four focused on unpacking one of the unquestioned assumptions underpinning the dominant representations of the problem of FCR, specifically the racialized dichotomization of nursing skills. Building on Armstrong’s (2013) feminist political economy analysis of the social construction of skill, with insights from anti-racist feminist political economy scholars and nurse historians, this chapter offered a critical history of nursing in Canada to situate the racialized dichotomization of nursing skills as a continuation of long-standing gendered and racialized segmentations of care provision. I showed that not only is the problematic development of the nursing profession rife with racist and sexist prejudice, but that racialized and gendered dynamics are also essential to the development of nursing as a profession itself. White nurses in Canada have consistently elevated their relative power and privilege through the law (e.g. occupational standards, scopes of practice) and institutions (e.g. regulators, professional associations) in a shortsighted attempt to legitimate the profession by differentiating their work from tasks perceived as lower- or unskilled; that is, through the ideological and material subordination of labour historically associated with poor and racialized women, as well as the continuous reassertion of masculinist and colonial norms and beliefs about skill. Although racial segmentation might not provide nurses with the same socioeconomic benefits as other male-dominated fields, my analysis revealed that it (a) allows white nurses to play an essential role in the colonial nation-building project as reproducers of settlers, racial distinctions, and colonial ideologies and (b) creates a large pool of easily exploitable support workers to fulfill the nation’s increasing social reproductive needs.

Viewed through this alternative representation of the problem, the downward occupational mobility of IENs is revealed not simply an unfortunate remnant of jurisdictional complexity or prejudice (that can be addressed through procedural fixes) but rather as foundational to the development of the nursing profession and the expansion and maintenance of the settler-colonial capitalist state. Instead of relying on the outright exclusion of racialized nurses, I demonstrated

that the current regulatory regime is “managed” or constrained integration through selectivity and assimilation, mystified through race-neutral discourses appealing to protecting public safety and respecting applicants’ right to a fair assessment. In other words, occupational standards do not constitute objective measures of skill and public safety; they function, as I illustrate, as filtering mechanisms that work primarily to exclude many poor and racialized women from the upper tiers of the nursing profession and allow only those few who can dedicate the right time, money, and effort to approximate the established norm. Procedural improvements, such as NNAS and fair access legislation, only make these filtering mechanisms more effective and efficient, which, incidentally, further legitimizes them as ‘fair.’ Still, they do not affect their primary function, which is to channel poor and racialized women into the lower tiers of care provision.

Building on the foregoing analysis, *Chapter Five* unpacked the other related assumption underlying the dominant representations of the problem of FCR, specifically that facilitating the swift integration of IENs and protecting public safety are inherently conflicting objectives. Instead, this chapter considered how IENs’ downward occupational mobility threatens public safety more significantly than facilitating swift integration. Building on Gorman’s (2016) framework of disablement, with insights from feminist political economy analyses of global care chains, this chapter offered an overview of how the structural funnelling of IENs into lower tiers of employment has immense and cascading impacts on the health and well-being of IENs, the poor communities they leave behind in the Philippines, and communities in Canada.

The first part of the chapter discussed how IENs experience disablement by being disproportionately relegated to highly precarious subsidiary occupations where they are simultaneously exposed to greater risks and where these risks are rendered invisible and unmanageable. As a result, IENs are not only more likely to become disabled, but they are also effectively barred from accessing compensation, benefits, and protections to help them manage this disability. Next, I explored how impoverished communities in the Philippines experience disablement through (a) the displacement of care away from their communities as a result of policies that encourage the mass emigration of nurses and (b) the transformation of care as nursing students who aspire to migrate make use of their bodies to hone their skills to provide better care for communities abroad. Consistent with Mbembe’s (2003) analysis of necropolitics and Thobani’s (2007) concept of “exalted subjects,” I demonstrated that the disablement of IENs and

poor communities back home (i.e., the ‘marking’ of IENs ‘for death’ as they are channelled into the lower tiers of care provision and the ‘leaving’ of poor communities back home to ‘die’ as care is displaced and transformed at their expense) is integral to the ‘exaltation’ and biopolitical maintenance of citizen-subjects in the Global North. Through the framework of disablement, I explored how the disability IENs and their communities experience is not merely a secondary effect or symptom of class, race, and gender-based exploitation; rather, it operates in a dialectical relationship with these modalities of exploitation through (a) ensuring that poor, disabled people are unable to leave yet serve to hone the skills of IENs to provide better care for care recipients in the Global North and, (b) readily making available a reserve army of workers to facilitate disabled citizen-subjects’ access to care, while (c) simultaneously disqualifying these racialized workers as disabled subjects by preventing them from making claims on the state; thus, continuously re-constituting “the disabled subject as a white subject” (Gorman, 2016, p. 254).

Despite the relative benefits and advantages that the disablement of IENs and poor communities back home provide for Canadian citizen-subjects, the second part of *Chapter Five* linked the downward occupational mobility of IENs to the expansion of neoliberal privatization and the subsequent deterioration of care conditions in Canada. Acting as a reserve army of labour, IENs who remain unable to access the upper tiers of the nursing profession enable the expansive use of subsidiary occupations, a key element of neoliberal privatization. I argued that the growing use of subsidiary workers displaces nurses, undermines their collective bargaining power, and creates downward pressure on wages and working conditions, thus contributing to the deterioration of care conditions by exacerbating chronic understaffing and the fragmentation of care. I also demonstrated that IENs are not only filling these subsidiary occupations but are also placed in situations where they feel compelled to use their nursing skills to fill care gaps without proper compensation, which further obscures these gaps and discourages meaningful reforms.

In sum, *Chapter Five* highlighted that merely increasing access to ‘high-skilled’ jobs is inadequate to tackle the declining occupational mobility of IENs. This mindset perpetuates the harmful and divisive belief that jobs with low levels of socially recognized skill are unworthy of fair compensation, benefits, and protections. Instead, to confront the factors that render ‘low-skilled’ jobs risky and debilitating, we must challenge the notion of skill as an objective measure of value. Recognizing that the dominant notion of skill is used to undercut workers’ efforts to

demand better wages and working conditions, I maintain that we cannot challenge the notion of skill as an objective measure of value without challenging profitability as an organizing principle in care provision. In sum, to borrow Vosko's (2010 p. 208) words, the goal of my project was not simply to figure out how to "manage the precarious margins of the labour market but [how] to eliminate them." The following sections explore the implications of my findings on policy, offer some recommendations, and discuss outstanding concerns and areas for further research.

2. Implications of Research Regarding Recent Policy Changes

In the four years preceding the conclusion of this inquiry, nursing regulators, associations, and governments across Canada have made several changes to fast-track more IENs to get their licenses. *Table 1* offers an overview of the most significant ones as it pertains to IENs applying in Ontario. Although the full impact of these changes is not yet evident, it is important to recognize that thousands of international applicants are closer to obtaining their nursing licenses because of these changes. From 2021 to 2023, over 4,750 international applicants have met the education requirement using the NCLEX-RN (CNO, 2023c). As of March 2024, the CNO has matched 4,230 applicants with employers through the Supervised Practice Experience Partnership (SPEP) program, enabling 3,324 nurses to obtain their licenses (CNO, 2024b). Subsequently, the clearance rate of non-US international applications more than doubled (from 30% in 2020 to 80% in 2023). There has also been a significant increase in the proportion of non-US international members relative to total membership (from 11.3% in 2020 to 16.1% in 2023) (CNO, 2021, 2022, 2023a). I witnessed the incredible joy and relief with which these changes were received within IEN forums online, and I recognize that these changes are indicative of the extraordinary struggles of IENs and their allies, rather than simply the result of the College's or the government's desire to be more inclusive.¹⁶⁴

¹⁶⁴ For instance, I traced the acceptance of the NCLEX-RN as proof of educational equivalence back to an appeal made by an IEN to the Health Professions Appeal and Review Board in 2014. In *John v. CNO, 2014*, the Board ordered that the College reconsider the equivalency of the education and experience of an applicant who had successfully passed the NCLEX-RN by taking into consideration a September 18, 2014 motion passed by CNO Council to accept the passing of the NCLEX-RN from 1982 to 2014 as proof that applicants had passed the entrance exam to practice nursing in Ontario. Despite setting this precedent for subsequent appeals by international applicants, it took seven years for the College to accept the passing of the NCLEX-RN as proof of educational equivalence for international applicants policy. Even then, it took the subsequent efforts of Filipino IENs who lobbied CNO council members to extend the cut-off date of acceptance; it was extended to accept applicants who passed the exam after January 2015 to those who passed after April 2013. See Appendix H: Letter Submitted March 26, 2021, to CNO Council by IENs. However, this change is already under threat as CNO recently announced their

Table 1. Summary of Recent Provincial Initiatives Supporting IEN Integration				
Governance Body	2021	2022	2023	2024
CNO	Accept passing the NCLEX-RN as proof of educational equivalence. ^a	Supervised Practice Experience Partnership (SPEP) program introduced. ^a Alternatives to demonstrate language proficiency. ^a Temporary Class Registration. ^a		Council approves amending O.Reg 275/94 of the <i>Nursing Act, 1991</i> to accept a degree from any jurisdiction that is “substantially equivalent” to a baccalaureate degree in nursing, replacing a degree that is “at least equivalent to” it. ^d
Ontario Government^a	IEN Competency Upgrade Pathway: tuition-free upgrade courses. ^a Financial Supports for Enrollment in Educational or Bridging Courses. ^a	Funding for IEN bridging curriculum enhancements. ^a Funding to enhance SPEP program. ^a	Temporary Reimbursement of Registration Fees. ^a Clinical Scholar Program, for mentorship. ^a Shorter decision-making time limits for regulators assessing international applicants. ^a	SPEP program made permanent. ^c
RNAO		New membership category of IENs Associates. ^b #IENaction campaign: urged CNO to clear the backlog by amending the LTC Staffing Pool Program ¹⁶⁵ to incorporate a supervised practice model. ^b		
Data are from World Education Services ^a (2023), the RNAO ^b (2022a, 2022b), and the CNO (2024b c, 2024c d).				

At the same time, without dismissing the positive impact of these changes, my research findings reveal that these represent continuations rather than departures from the dominant approach to integration, i.e., one that forces IENs to accept exploitative conditions and diverts efforts away from improving healthcare working conditions. For instance, IENs who are granted

intentions to introduce new educational requirements for applicants who passed the NCLEX-RN in the US or Australia (NurseFact.com, 2023).

¹⁶⁵ The LTC Staffing Pool Program was launched by the Ontario government in 2022, and it directed CNO to identify a pool of IEN applicants to work in long-term care as personal support workers. The RNAO called this program exploitative as it would not allow IENs to count this work towards meeting their safe practice requirement (Merali, 2022).

a temporary licence are tied to a single employer until they meet all requirements for registration, which leaves them vulnerable to exploitation. The experience of Jolene, one of the nurses I interviewed, exemplifies how devastating temporary status can be, even for someone domestically educated. Because she had sought accommodations for her anxiety during her studies, she was granted temporary status until she could provide all the required documentation indicating she was fit to practice safely, even though she had already been working as a nurse at this facility for over a year. The arduous process of proving she was ‘disabled enough’ first to get accommodations and subsequently proving she was ‘not too disabled’ to practice was akin to a Kafkaesque bureaucratic nightmare that trapped her in an incredibly exploitative workplace for over a year (Interview 19, 2020).

Meanwhile, IENs matched with potential employers through the SPEP do not all receive compensation,¹⁶⁶ and those who do are subject to significantly lower levels.¹⁶⁷ Through recent informal conversations with domestically educated nurses among friends and family, I also discovered that due to chronic understaffing, IENs enrolled in the SPEP often practice with little supervision or support, which is not much different from nursing students' experiences. One nurse told me that, during and after completing the 140 hours of the program, her co-worker was paid the PSW rate while working as a nurse because her registration had not been finalized, a process that could still take several months. In this context of chronic understaffing, it is difficult to see how mentorship programs such as the new Clinical Scholar Program will fare much better.

The acceptance of the NCLEX-RN as proof of educational equivalence,¹⁶⁸ arguably the most impactful of these changes, has also raised concerns about a growing convergence with the American nursing system, which could have implications for patient safety. Although the switch to the NCLEX brand of exams¹⁶⁹ has enabled thousands more applicants (both domestic and

¹⁶⁶ The Frequently Asked Questions section of the program’s website states the following: “The program can be paid or unpaid. Once a match is determined, the applicant and employer will discuss whether compensation is provided as part of the hiring process” (CNO, 2024a)

¹⁶⁷ See Appendix I: SPEP Job Postings Examples, which shows that the starting rate for an IEN in this program is between \$19.81 and \$25-30 per hour for RN positions in the Greater Toronto Area compared to a domestically educated RN who makes between \$34.82 and \$56 per hour.

¹⁶⁸ Since the time of writing, citing “updated education requirements for nursing registration,” the CNO reversed the decision to accept the passing of the NCLEX-RN as proof of educational equivalence for IENs. This change will take effect starting on April 1, 2025 (CNO, 2025).

¹⁶⁹ In 2011, all nursing regulators (except Quebec) agreed to replace the Canadian Registered Nurse Examination with the US-based NCLEX-RN as the entry-to-practice examination for RNs by 2015. This change was encouraged

international) to access the exam year-round and sped up the issuing of exam results, questions remain as to whether its basis on the American nursing system adequately assesses the skills needed to provide safe care in the Canadian context. In particular, the two studies used to validate the applicability of the NCLEX-RN to Canadian testing populations had a lot of methodological concerns,¹⁷⁰ which led them to overlook fundamental differences between the two systems. For instance, in the “more prescriptive and directive” American system, clients/patients are emphasized as “objects of care.” In contrast, in the more “collaborative” Canadian system, they are emphasized as “partners in care,” which raises concerns about the applicability of the test to the Canadian nursing context (Salfi & Carbol, 2017). Nursing groups, such as the Canadian Association of Schools of Nursing, also criticize the swift and unilateral manner of the decision to switch entrance exams and cite significant issues with the French language version of the exam (Singh-Carlson & May, 2020).

I note these concerns about the NCLEX-RN not because I idealize the Canadian nursing system or assume that it abides by the principles it purports to uphold. Instead, I aim to demonstrate how hastily and recklessly concerns about the appropriateness of ‘foreign’ nursing skills are abandoned when serving particular socioeconomic and political interests. While Canadian nursing regulators claim that the switch is “evidence-based,” it is more indicative of a growing “market-driven convergence,” i.e., an increasing involvement of the private sector in encouraging “methods, practices, and standards in the healthcare industry to become more alike across jurisdictions” (Cortez, 2009, p. 704).

In addition to benefitting the private sector and increasing the dominance of American models of nursing practice, I am concerned that these changes are being made to avoid addressing the conditions that make healthcare work precarious and disabling and causing high attrition rates. The passing of legislation such as *An Act To Implement Moderation Measures In Respect Of*

by the Federal government to “ensure timely access of graduates to the profession in order to facilitate labour mobility” (Rowshan & Singh, 2014, p. 47). Since 2015, the NCLEX-RN has been administered to RN applicants in 9 out of 10 Canadian provinces and two out of three territories (Salfi & Carbol, 2017). In January 2022, the Regulatory Exam – Practical Nurse (REx-PN) replaced the Canadian Practical Nurse Registration Exam as the entry-to-practice exam for those applying to become a Registered Practical Nurse in Ontario or Licensed Practical Nurse in British Columbia (CNO, 2023b).

¹⁷⁰ These methodological concerns include the exclusion of Canadian nurses and IENs from the sample of nurses surveyed, the overreliance on a panel of four nurses to determine the one-to-one relationships between Canadian and American nursing competencies, and a potential conflict of interest as the research was funded by the same organization that developed the exam, the National Council of State Boards of Nursing (Salfi & Carbol, 2017).

Compensation In Ontario's Public Sector, 2019, the *Connecting People to Home and Community Care Act, 2020*, the *Your Health Act, 2023*, and the *Convenient Care at Home Act, 2023* are clear signs that the Conservative government intends to persist in privatizing every facet of healthcare provision. Absent other substantial efforts to address the abysmal state of the healthcare sector, newly licensed IENs thus serve as little more than 'cannon fodder,' reminiscent of when racialized men were suddenly allowed into the military at a time when governments were desperate to send more bodies to die on the front lines (Delgado et al., 2017).

As issues of attrition and overwork remain unaddressed, expediting the integration of IENs is also nourishing a growing resentment toward international applicants on the part of domestic nurses. On the social media forums I follow closely, I witness much hostility directed at IENs over policies that exclusively target them, such as the recent decision to refund the registration fees of international applicants. This is not to say that international applicants deserve or are responsible for this growing resentment, nor should it warrant the deprioritization of policies that exclusively target them. Rather, we should consider the implications of expediting IENs as an isolated policy on nurses' capacity to foster solidarity and organize collectively. The current approach pits nurses against each other and blames IENs for the downward harmonization of wages and working conditions, creating further fissions and conflicts. Yet, I could not find any large-scale, coordinated plan or effort to link these issues and place the blame where it belongs.

3. Moving Forward: Recommendations for Change

Recent initiatives to accelerate the integration of IENs follow a familiar trend: placing them in exploitative situations without tackling the underlying problems of worsening nursing conditions. However, there is something valuable we can glean from how these changes are unfolding, beyond just increasing access. The speed of these transformations highlights potential opportunities, particularly the malleability of notions of skill and public safety during urgent, exceptional circumstances. When there is adequate political support for improving access, it becomes clear that FCR is not quite the "complex file" it is often portrayed to be. We must harness the opportunities brought to light by this crisis to drive significant reforms.

In pursuit of meaningful change, we must divest from approaches that simply seek to uphold nursing standards as a proxy for public safety and hierarchical notions of skill as a measure of worthiness. Instead, healthcare policy analysts, unions, practitioners, and the public must urge

policymakers to focus on strategies that, as Armstrong (2013, p. 258) articulates, reconceptualize skill by considering not just formal qualifications but also time, risk, and various other factors. Furthermore, we must also reconceptualize how we think about skill by “ask[ing] new questions about the conditions that prevent people from developing and using the skills they need to do the work.” The following recommendations are not exhaustive or fully elaborated proposals but are meant to get us to think about the far-reaching, liberatory potential of reconceptualizing skills.

3.1. Ease Evidence of Practice Requirements

As I demonstrated in *Chapter Five*, IENs in subsidiary healthcare occupations often use their nursing education and training to provide better care. In recognition of this utilization and the fact that they are also getting oriented into the Canadian healthcare system (e.g. learning about regulations and terminology), I recommend that nursing regulatory bodies exempt IENs working in these subsidiary occupations from the three-year time limit requirement to provide evidence of practice. In other words, IENs working in these subsidiary occupations in the immediate last three years should have that time considered towards meeting this requirement instead of it being considered an interruption. This change would allow many IENs who would otherwise face years of delays to meet the practice requirement. This is not a drastic change. In fact, the Nova Scotia College of Nursing is already moving towards making it easier for IENs to meet this requirement by removing it altogether. Compared to that, this is a more gradual and feasible change.

3.2. Establish Accessible and Differentiated Supports to Help IENs Integrate and Amend the SPEP

The concern that ‘a nurse is not a nurse is not a nurse’ is valid—meaning that because nursing is context-specific and practiced across different settings and institutions, it is not appropriate to assume that nursing skills are easily transferable without some level of familiarization. We should also maintain certain safety expectations as it relates to practitioners’ knowledge and practice of culturally appropriate and patient-centric care, evidence-based medicine, and laws and regulations. However, the current regulatory approach’s understanding of public safety, which narrowly focuses on entry-to-practice requirements and professional guidelines as objective measures, fails to consider IENs’ well-being (and that of workers in the lower tiers) when considering public safety. At the same time, it amplifies the potential risk of IENs’ nursing skills to the detriment of minimizing the risk of other factors, such as chronic understaffing and privatization. In other words,

the current policy approach hyperfocuses on scrutinizing IENs and their skills to mitigate risk at their expense while exacerbating more prominent causes of danger.

To address concerns about the importance of context-specific knowledge, the need to maintain certain expectations of safety, and to shift the regulatory focus to factors that more substantially threaten public safety, I propose a shift in the kinds of supports offered to IENs (indeed to all nurses) to help them transition into different nursing settings and ensure they can practice safely. To replace the current fragmented and ad-hoc bridging, orientation, and mentorship programs that are highly inaccessible, all employers should be mandated to provide accessible and ongoing support and training programs to all nurses. Recognizing that Canadian nurses can greatly benefit from IENs, it is important to avoid conflating differences with deficiencies. By doing so, nurses can seize the chance to learn from each other through these programs, which should also emphasize the value of reciprocal learning.

These forms of support would align with Guo's (2010, pp. 164–165) concept of “transnational lifelong learning for recognitive justice,” offering an alternative to current “distributive” and “retributive” learning frameworks. “Distributive” models presume all individuals possess identical learning requirements, ignoring individual differences and social contexts while viewing cultural differences as shortcomings—thus perpetuating assimilation. Meanwhile, “retributive” models prioritize market-driven productivity and competition, blaming individuals for broader systemic failings. In contrast, Guo's “recognitive” approach embraces respect for difference and promotes proactive integration, fostering more equitable participation. Specifically, his framework “rejects the deficit model of lifelong learning that aims to assimilate migrants,” questions Eurocentric values and standards while recognizing marginalized knowledge as legitimate and valuable, and emphasizes accessible resources (such as language support and financial aid) for migrants to navigate integration challenges. Following this “recognitive” approach that supports more accessible learning that affirms difference, I also recommend amending the SPEP to ensure IEN participants (a) are compensated equally to domestically educated workers and (b) have the opportunity to share unique perspectives and knowledge with their colleagues.

3.3. Flatten Job Hierarchies

At the turn of the century, in the context of new and growing divisions of labour, there has been a growing emphasis¹⁷¹ on the need for healthcare providers to coordinate and combine their skills and efforts when delivering primary care, which is variably referred to as interprofessional collaborative practice, or the integration of multi- or inter-disciplinary teams (CIHI, 2011; Health Council of Canada, 2008; Romanow, 2002). Interprofessional collaborative practice is cited as beneficial to both health care workers and care recipients as it helps to manage increasing workloads, address staffing shortages, results in fewer injuries for staff, increases job satisfaction, reduces wait times, shorten and reduces the frequency of hospital stays, improves rural and remote accessibility, and improves health outcomes for patients (CNA, 2011; EICP Steering Committee, 2006, p. 2; Pan-Canadian Planning Committee on Unregulated Health Workers, 2008).

Despite being widely acknowledged as beneficial, these studies and reports identify problematic and persistent barriers to interprofessional collaboration. For instance, in the *Review of the 10-Year Plan to Strengthen Health Care*, the CNA identifies the medical colleges and associations' unwillingness to move away from traditional fee-for-service models towards alternative compensation models, such as a blended fee model, as one of the reasons why interprofessional collaboration has been challenging to implement in Canada (CNA, 2011). When it comes to the working relations between regulated and 'unregulated'¹⁷² health care providers specifically, the Pan-Canadian Planning Committee on Unregulated Health Workers identifies several challenges to interprofessional collaboration: the use of multiple and inconsistent titles, widely varying educational preparation, non-standardized roles and standards, inconsistent understanding of delegation, liability, lack of research on staff mix, and cultural incompatibilities (Pan-Canadian Planning Committee on Unregulated Health Workers, 2008). With these challenges in mind, the CNA, alongside other healthcare associations, argues that the following structural elements all had to be in place to support and sustain interprofessional collaboration: education;

¹⁷¹ Developing and implementing best practices related to interprofessional collaboration was one of the main components of the *Health Human Resource Strategy*, an initiative coming out of the 2003 First Ministers' Accord on Health Care Renewal, as well as part of the *10-Year Plan to Strengthen Health Care*, wherein the first ministers committed to ensuring that half of Canadians would have 24/7 access to multidisciplinary teams for primary health care by 2011 (CIHI, 2011; Health Council of Canada, 2008).

¹⁷² Health care providers that are not regulated by a self-regulating body such as a College are sometimes referred to as "unregulated health care workers." This is a misnomer, however, as the scopes of practice and the care provided by this workers is very much regulated by provincial, employer, and other types of statutes and regulations.

use, availability, and distribution of health human resources; adequate and reliable funding that supports the principles of collaboration; a liability framework that includes explicit legislated scopes of practice and insurance independent of employers; a regulatory framework that enables interprofessional collaboration; information and communications technology that supports continuity of care; management and leadership; and planning and evaluation (EICP Steering Committee, 2006).

These studies are valuable in helping us understand the value of interprofessional collaboration and the elements that need to be in place for this model of care to be realized. However, they leave one crucial factor unaddressed: specifically, the vast disparities in compensation, benefits, protections, and status among healthcare workers. These disparities make it impossible to incorporate working practices in ways that value all contributions equitably. Rather than acknowledging the centrality of these disparities, these studies attempt to address tensions between healthcare workers through education and training.

In the Romanow Commission Report (2002), for instance, healthcare providers and their organizations are called on to “set aside old grievances and entrenched positions, and begin to trust one another again,” and “to embrace far-reaching changes in the health workplace, some of which may change the nature of their work and especially their relationships with other health care providers” (p. 92). In a 2004 report prepared for Health Canada, although the authors recognize that the emphasis on teamwork in primary health care promotes substitution for less costly, more specialized health care providers, they maintain that with training and education, health care providers can be taught to “distinguish complementarity from substitution, the former pointing to ways in which roles can be mutually enhancing, the latter at replacement options” (North South Group Inc., 2004, p. 39). Setting aside past grievances, welcoming change, and understanding the complementary nature of roles, however, can only achieve so much in a context of structural inequality. Healthcare workers cannot be expected to regard and respect one another as equally important team members while treating them as anything but.

The most impactful way to facilitate interprofessional collaboration is to flatten job hierarchies between physicians and other self-regulated providers (e.g., nurses, dietitians, physiotherapists, etc.) and between RNs and other lower-tier providers, specifically RPNs, PSWs, and other ancillary workers by closing the gaps in compensation, benefits, protections, status, and

other dimensions of the labour market security. While some disparities, particularly in compensation, can be negotiated given that some positions are more demanding (in terms of added responsibilities, higher barriers of entry, and risk), the current situation—where a physician devotes minimal time and effort to patient care and receives hundreds of dollars per hour, whereas a PSW who dedicates all their time and back-breaking effort to patient care receives close to minimum wage—is entirely unethical, unsustainable, and at the root of so many systemic issues in healthcare. Reducing these immense disparities will make it easier for healthcare providers to develop the necessary respect and trust to collaboratively offer the “right service, provided at the right time, in the right place and by the right health professional.”¹⁷³ Alongside promoting collaboration, increasing labour costs for lower-tier care workers will reduce the incentive to expand their use for cost-cutting and to channel marginalized individuals toward these jobs. Gradually, by flattening job hierarchies, we can move away from functional, task-oriented care and implement primary, relational models that support both care providers and recipients.

As the next section discusses, one of the primary ways we legitimize closing gaps between workers is by factoring in time, risk, and other demands (e.g., how tedious and repetitive some jobs can be) when assessing skills in addition to formal education and training – and we can do so in principle and practice. Accordingly, the following section, in which I apply Armstrong’s (2013) seven unexplored dichotomies or tensions in the social construction of skill to my case study of IENs, opens up different points of analysis relevant to closing these gaps and working towards flattening job hierarchies.

¹⁷³ The Pan-Canadian Planning Committee on Unregulated Health Workers outlined the following elements as critical to interprofessional collaboration and best health outcomes: mutual trust and respect among all team members, knowledge, independent and shared responsibility and accountability, effective communication, and cooperation and coordination that promote the use of the skills of all team members (Pan-Canadian Planning Committee on Unregulated Health Workers, 2008, p. 12). Meanwhile, in *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care*, the CNA, alongside other healthcare associations, identified the following interrelated principles as foundational to interdisciplinary collaboration in primary health care in Canada: patient/client engagement; population health approach; best possible care and services; access to the “right service, provided at the right time, in the right place and by the right health professional;” trust and respect; and effective communication (EICP Steering Committee, 2006).

3.3.1. Transcending Seven Tensions in the Social Construction of Skill

The individual versus the job. Jobs require knowledge and experience, but there is “no automatic relationship between what a worker knows and what the job requires” (Armstrong, 2013, p. 259). On the one hand, employers may inflate the credentials or experience required for the job, yet these requirements may not affect workers’ performance at work. On the other hand, the skills needed for a job may not even be recognized as skills or as necessary. For example, for IENs who cannot practice as nurses, their nursing skills “often become an essential part of the work” (p. 260). As discussed in *Chapter Five*, while IENs have difficulty getting their nursing education and experience recognized for licensure in Ontario, employers consider these skills an asset when they employ IENs as PSWs. However, they do not compensate them more for having these skills. IENs should be compensated as nurses, regardless of their registration status.

Learned versus Unlearned. If we define skill as the “learned capacities required to get work done effectively and efficiently,” it begs the question of *how* to make that distinction (Armstrong, 2013, p. 261). Feminist political economists challenge the idea that caring and domestic skills are innate to women and make visible the effort it takes to learn and practice these skills. While this construction challenges the naturalized conception of effectively “women’s skills” and casts caring and domestic skills as learned, questions remain about where and how the learning process happens and its implications. This is a complicated discussion because there are many factors at play. For instance, while Prior Learning Assessment and Recognition¹⁷⁴ is touted as radical because it recognizes that learning also happens informally, in the context of FCR, it reproduces global skill inequalities by upholding the value of Canadian credentials above those of the Global South (Guo & Shan, 2013). At the same time, the devaluation of foreign credentials is also caught up in the contestation of neoliberal policies. For instance, the massive proliferation of nursing programs in the Philippines legitimated concerns about the government’s capacity to regulate them and treat Filipino credentials with suspicion (Kingma, 2006). Guo’s (2010) “recognitive” approach supports ongoing, accessible learning that affirms difference and, at the very least, aims at supporting all nurses in achieving a baseline level of context-specific knowledge rather than assuming the distinction between nurses’ levels of knowledge can be easily determined.

¹⁷⁴ This refers to the process that allows the recognition of prior working experience along with credentials in the assessment of skills for both licensure and educational purposes (Guo & Shan, 2013).

Individual versus Collective learning. As Armstrong (2013) notes, nurses frequently teach each other, but this is often not formally organized or recognized. Even when teaching is recognized, such as in the case of mentorship,¹⁷⁵ budget cutbacks and staffing shortages inhibit this collective process by making it virtually impossible for overworked nurses to dedicate time to mentorship. Teaching is also often assumed to be one-directional, which curtails the opportunity for mutual learning. To facilitate collective learning, structural factors, the most significant of which is understaffing, must be addressed.

Hard versus Soft. Historically, hard skills have been understood as “more likely to be easily measured and to result in a product or service, such as a chair or surgery” (Armstrong, 2013, p. 262). On the other hand, soft skills, such as caring and emotional labour, are more difficult to measure yet have gained prominence with the shift to the service economy. However, the dichotomy between hard and soft skills is unclear. A physician may benefit, like a nurse, from having soft skills such as bedside manner, but that does not mean they face the same type and level of scrutiny when failing to exercise these skills. Moreover, while soft skills, such as cultural competence, are increasingly valued for all nurses, there are different implications for domestically educated nurses versus IENs; IENs are expected to acquire these skills as a matter of public safety, while for domestically educated nurses, cultural competencies are merely suggested. These disparities need to be addressed by recognizing the need and value of both.

Manual versus Mental. As part of a long history of mind/body dualism, which has produced an association of the body, particularly of labourers, women, and non-Christians (read: racialized) people, with negative characteristics such as weakness, corruption, and idiocy (Goodey, 2011), people primarily working with their hands are considered less skilled than those doing mental work. As a result, nurses have increasingly shed manual tasks from their jobs to gain better recognition of their skills. Yet, this separation is arbitrary because all kinds of work combine mental and manual components in indistinguishable ways. For instance, Day (2014) elucidates the multiple ways in which cognitive processes and decision-making underlie the work of PSWs, thus challenging the idea that their work is menial, meaning not requiring critical and reflective thinking. It is essential to challenge this distinction by highlighting both the value and the disabling effects

¹⁷⁵ Mentorship is often talked about as a valuable means to both facilitate the integration of incoming nurses (domestically and internationally educated) and the employment of ageing nurses who may not be able to meet the physical demands of the job.

of manual labour, much like how trades workers have achieved considerable earnings through the masculinized valorization of their manual skills.

Routine versus Complex. The distinction between routine and complex parallels the distinction between manual and mental skills: both require significant mental, physical, and emotional effort. Additionally, the capacity to “work quickly and without conscious thought may appear routine and thus unskilled but may be the product of considerable and difficult learning.” Therefore, we ought to recognize, as with PSWs, the “ability to cope with such work as a skill in itself” (Armstrong, 2013, p. 264).

Visible versus Invisible. This discussion parallels the discussion between hard and soft skills, with the latter ‘being less visible and hard to measure’ (Armstrong, 2013, p. 264). A crucial component of the feminist political economy is identifying the processes that render the skills associated with women invisible and, therefore, not rewarded. Beyond reward, however, invisibilization also makes it challenging to use skills. As I mentioned, one of the most frustrating aspects for IENs is the inability to use their skills in contexts where using them could help their patients. At the same time, visibility alone is not what determines value; supply is also a factor. When particular capacities are visible yet considered plentiful in supply, it reduces their chance of being rewarded. The protectionism of the domestic nursing workforce operates under the assumption that increasing the supply of nurses would reduce the value of their skills. Yet, the supply of nurses is not determined by an absolute shortage in the number of nurses but rather by nurses withdrawing from the workforce due to cuts and the deterioration of working conditions (Valiani, 2012). This means that protectionist efforts, which merely target supply and demand based on absolute numbers, profoundly misunderstand issues of shortages and value.

Control versus lack of control. Lack of control or autonomy is often equated with a lack of skill; inversely, perceived high levels of skill are often associated with greater control and autonomy. For instance, Braverman (1998) argues that deskilling, defined as reducing work to simplified tasks, allows for greater exploitation and managerial control as workers become more easily replaceable and their work requires more supervision. In healthcare, deskilling is associated with the expansive use of subsidiary workers, the segmentation of care provision, and the proliferation of performance indicators. However, the relationship between skill and control is not necessarily causal. Deskilling is not the only way to exercise managerial control; control can also

be asserted through peer-to-peer forms of surveillance. Furthermore, simplifying tasks does not necessarily make them less skilled. Instead, it requires other capacities, such as speed or emotional control. Day (2014), for instance, discusses how PSWs employ great control in providing care rapidly due to staffing shortages.

These dichotomies or tensions are not exhaustive and bear more significant examination. Nonetheless, I present them to encourage a much-needed ideological shift, specifically the need for healthcare workers—and by extension regulators, associations, and unions—to reject the colonial, capitalist, patriarchal, and disablist mindset about the inherent superiority of specific sets of skills over others (e.g., mental/manual, hard/soft, complex/routine, clinical/ancillary) and of the settings wherein these skills were learned (e.g., baccalaureate degrees over college diplomas, Canadian over ‘foreign’). By reconceptualizing skills beyond formal credentials and making their contingent and complex character explicit, my aim is similar to Armstrong’s (2013, p. 267)—namely, to “allow those skills to develop and flourish” and to gear them towards meeting society’s social reproductive needs rather than capitalist accumulation. When healthcare workers are provided opportunities to learn and share their knowledge in supportive environments where differences are affirmed, and everyone is appropriately compensated, this is what actually contributes to appropriate and safe practice.

3.3.2. Emphasize Labour Power Rather than Skills as the Source of Value

While the above recommendations provide a starting point, they cannot be achieved through dialogue alone. To achieve them, healthcare workers must affirm that their power comes from their labour, which they can remove at any point, and their capacity to organize collectively rather than from their narrowly defined skills. To this end, those at the upper end of the hierarchy need to disavow themselves of the notions that their relative privilege and power can only come at the expense of those at the bottom and that any advancements by those at the bottom represent a necessary threat. This kind of divisive, zero-sum mentality does not align with the primary goal of healthcare, which should be to provide the best care possible.

Instead, those at the top of the hierarchy must adopt approaches that uplift the most precarious workers first. This approach has to be overtly and uncompromisingly anti-capitalist, meaning that it must reject individualism and profitability as organizing principles in providing

care. This includes shifting how we govern liability away from solely responsabilizing individual practitioners for problems with broader structural causes and attending to the needs of healthcare workers and recipients, regardless of the impact of attending to these needs on institutions' profitability. This type of radical change cannot be achieved by appealing to the conscience or rationality of those in power. It is only possible through mass mobilization, which rejects the divisive and oppressive claims that 'skill' constitutes an objective sorting mechanism through which workers should be accorded vastly differential treatment and rewards.

4. Outstanding Concerns and Areas of Research

As mentioned, over the course of writing this dissertation, many changes have been introduced to speed up the integration of thousands of IENs into the upper tiers of nursing. Early on, as I watched these changes being introduced, I could not help but wonder if downward occupational mobility would soon cease to be a problem. I asked myself repeatedly: had my research come too late? However, as I watch, with great horror, the violent dismantling of the public healthcare system in Ontario by successive centrist and right-wing governments, my research highlights why focusing only on helping more IENs get their licence is a short-sighted goal, particularly when what we are helping them access is a burning house. Instead of blaming IENs for setting the house on fire, we should dedicate our efforts to figuring out how to put out the fire and rebuild a better home together. To this end, we must understand what roles labour unions and cross-racial solidarity movements can play in securing longer-lasting and more far-reaching improvements. While I did encounter examples of these movements in the history of nursing (see for instance: Calliste, 1996; McCallum, 2014; McPherson, 2003a), I could not properly investigate them, which remains an outstanding area of research.

As the RNAO demands the re-establishment of the status quo to educational requirements for IENs due to concerns about the implications of "down-skilling" on patient safety (RNAO, 2024), my research also highlights the limits and dangers of relying on formal education as a proxy for skill and occupational standards as a proxy for public safety. Although I reject the RNAO's view that these changes represent a "down-skilling," I share the concern that they could affect patient safety because they are indicative of the broader "market-driven convergence" I mentioned earlier, specifically a growing dominance of the NCLEX-RN as the definitive measure of nursing

skill. As such, the RNAO's fight to reestablish the status quo is misguided because it ignores the current regulatory regime's failures in protecting public safety.

The shift away from fetishizing formal educational requirements and occupational standards is not to say that we should dispense with them altogether; rather, that we should stop upholding them as objective and understand that they, as is, cannot keep us safe when nurses work in increasingly understaffed, fragmented, and precarious contexts. To achieve this goal of redesigning occupational standards, we need to critically examine nursing education policies, particularly, as Calliste (1996) notes, how educators (un)consciously reproduce interlocking systems of social oppression, as well as the significant disconnect between what nurses are being taught in school, what they are being tested on, and what actual knowledge and support they require when practicing. While the previous section on the seven tensions of skill is meant to encourage further investigation into addressing this disconnect, this remains an outstanding research area.

Finally, it bears repeating that no substantial, equitable change to healthcare working conditions can be made without challenging privatization in its many iterations. Right now, we are witnessing the mass exodus of nurses into private staffing agencies that offer two to three times the compensation with only a fraction of the responsibility of being a staff nurse. A recent report published by the Canadian Federation of Nurses Unions, *Opening the Black Box: Unpacking the Use of Nursing Agencies in Canada*, notes an exponential rise in costs (a six-fold increase from \$247.9 million to an estimated \$1.5 billion, with an additional \$3.2 billion in federal contracts) and the total number of agency hours (a 3.4-fold increase from 2.1 million to 7.3 million total hours for RNs and licensed practical nurses) used by healthcare facilities over the last four years (CFNU, 2024). Beyond the massive cost increase, agency nursing has incredibly harmful implications for care conditions, most significantly for continuity of care and for fostering meaningful relationships among co-workers.

This growing reliance on staffing agencies is concerning and troubling as it reveals that governments have adequate funds to hire and properly compensate more nurses. Instead, they opt to direct those funds to the private sector, creating situations where nurses work in isolated, non-unionized settings. This pattern illustrates that neoliberalism has never been about fiscal responsibility; rather, it aims to weaken collective organizing and shift wealth from the public sector to private interests. There is no justification for the existence of these exploitative agencies.

To preserve a functioning public healthcare system, we must focus all efforts on eliminating them and any entity that seeks to profit from providing care.

BIBLIOGRAPHY

- Abella, R. S. (Ed.). (1984). *Report of the Commission on Equality in Employment*. Minister of Supply and Services Canada. <https://publications.gc.ca/site/eng/471737/publication.html>
- Acker, J. (2004). Gender, Capitalism and Globalization. *Critical Sociology*, 30(1), 17–41. <https://doi.org/10.1163/156916304322981668>
- Acker, J. (2006). *Class Questions: Feminist Answers*. Rowman & Littlefield.
- Alboim, N. (2002). *Fulfilling the promise: Integrating immigrant skills into the Canadian economy*. Caledon Institute of Social Policy. <https://maytree.com/publications/fulfilling-the-promise-integrating-immigrant-skills-into-the-canadian-economy/>
- Almost, J. M., VanDenKerkhof, E. G., Strahlendorf, P., Caicco Tett, L., Noonan, J., Hayes, T., Van hulle, H., Adam, R., Holden, J., Kent-Hillis, T., McDonald, M., Paré, G. C., Lachhar, K., & Silva e Silva, V. (2018). A study of leading indicators for occupational health and safety management systems in healthcare. *BMC Health Services Research*, 18(1), 296. <https://doi.org/10.1186/s12913-018-3103-0>
- Arat-Koç, S. (1999). Gender and Race in “Non-discriminatory” Immigration Policies in Canada. In E. Dua & A. Robertson (Eds.), *Scratching the surface: Canadian, anti-racist, feminist thought* (pp. 208–237). Women’s Press.
- Arat-Koç, S. (2006). Whose Social Reproduction? Transnational Motherhood and Challenges to Feminist Political Economy. In *Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism* (pp. 75–92). McGill-Queen’s Press - MQUP.
- Arat-Koç, S. (2010). New Whiteness(es), Beyond the Colour Line? Assessing the Contradictions and Complexities of Whiteness in the (geo)Political Economy of Capitalist Globalism. In S. Razack, M. Smith, & S. Thobani (Eds.), *States of race: Critical race feminism for the 21st century*. Between the Lines.
- Arat-Koç, S. (2012). Invisibilized, Individualized, and Culturalized: Paradoxical Invisibility and Hyper-Visibility of Gender in Policy Making and Policy Discourse in Neoliberal Canada. *Canadian Woman Studies*, 29(3), 6–17. Canadian Business & Current Affairs Database; Literature Online.
- Armstrong, P. (2013). Puzzling Skills: Feminist Political Economy Approaches. *Canadian Review of Sociology/Revue Canadienne de Sociologie*, 50(3), 256–283. <https://doi.org/10.1111/cars.12015>

- Armstrong, P., & Armstrong, H. (2010). *The Double Ghetto: Canadian Women and Their Segregated Work*. Oxford University Press.
- Armstrong, P., & Armstrong, H. (2023). How Privatization Infects the Canadian Health Care System. *New Labor Forum*, 32(3), 42–49. <https://doi.org/10.1177/10957960231194053>
- Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008). *Critical to Care: The Invisible Women in Health Services*. University of Toronto Press.
- Armstrong, P., Choiniere, Jacqueline., & Day, E. (1993). *Vital signs nursing in transition*. Garamond Press.
- Armstrong, P., & Day, S. (2017). *Wash, Wear, and Care: Clothing and Laundry in Long-Term Residential Care*. McGill-Queen's Press - MQUP.
- Aronson, J., & Neysmith, S. M. (2006). Obscuring the costs of home care: Restructuring at work. *Work, Employment and Society*, 20(1), 27–45. <https://doi.org/10.1177/0950017006061272>
- Augustine, J. (2012). Working Toward Fair Access in the Regulated Professions. *Best Practices in Countering Racism in the Workplace*, 9(1). Canada Commons. <https://canadacommons.ca/artifacts/2198920/best-practices-in-countering-racism-in-the-workplace/>
- Augustine, J. (2015). Immigrant Professionals and Alternative Routes to Licensing: Policy Implications for Regulators and Government. *Canadian Public Policy*, 41(Supplement 1), S14–S27. <https://doi.org/10.3138/cpp.2014-022>
- Bacchi, C. L. (1999). *Women, policy and politics the construction of policy problems*. SAGE.
- Bacchi, C. L. (2009). *Analysing policy: What's the problem represented to be?* Pearson.
- Bacchi, C. L., & Goodwin, S. (2016). *Poststructural policy analysis: A guide to practice*. Palgrave Macmillan.
- Bakan, A., & Stasiulis, D. (2005). *Negotiating Citizenship: Migrant Women in Canada and the Global System* (1 edition). University of Toronto Press, Scholarly Publishing Division.
- Banerjee, A., Armstrong, P., Daly, T., Armstrong, H., & Braedley, S. (2015). “Careworkers don’t have a voice:” Epistemological violence in residential care for older people. *Journal of Aging Studies*, 33, 28–36. <https://doi.org/10.1016/j.jaging.2015.02.005>

- Banerjee, A., Daly, T., & Armstrong, H. (2008). *Out of control: Violence against personal support workers in long-term care*. York University.
<http://www.library.yorku.ca/eresolver/?id=1235576>
- Bannerji, H. (2005). Building from Marx: Reflections on Class and Race. *Social Justice*, 32(4 (102)), 144–160.
- Baylon, J. (2021, August 13). Amidst Nationwide Nursing Shortage, Foreign-Trained Nurses Unable to Practice. *New Canadian Media*. <https://newcanadianmedia.ca/amidst-nationwide-nursing-shortage-foreign-trained-nurses-unable-to-practice/>
- Block, S., & Galabuzi, G.-E. (2011). *Canada's Colour Coded Labour Market*. Canadian Centre for Policy Alternatives. <https://www.policyalternatives.ca/publications/reports/canadas-colour-coded-labour-market>
- Block, S., & Galabuzi, G.-E. (2018). *Persistent Inequality: Ontario's Colour-coded Labour Market*. <https://www.deslibris.ca/ID/10099045>
- Bloom, M. R., & Grant, M. (2001). *Brain gain: The economic benefits of recognizing learning and learning credentials in Canada*. Conference Board of Canada.
- Bourgeault, I. L. (2006a). *Push!: The Struggle for Midwifery in Ontario*. McGill-Queen's Press - MQUP.
- Bourgeault, I. L., Neiterman, E., Viers, K., Winkup, J., & LeBrun, J. (2010). *Brain gain, drain & waste: The experiences of internationally educated health professionals in Canada*. Ontario Health Human Resource Research Network.
<http://www.library.yorku.ca/e/resolver/id/2331246>
- Bourgeault, I. Lynn. (2006b). On the move the migration of health care providers in Canada. *Working Paper Series (HRSDS-IC-SSHRD Skills Research Initiative)*.
- Braverman, H. (1998). *Labor and monopoly capital: The degradation of work in the twentieth century* (25th anniversary ed.). Monthly Review Press.
- Cabanda, E. (2017). Higher Education, Migration and Policy Design of the Philippine Nursing Act of 2002. *Higher Education Policy*, 30(4), 555–575. <https://doi.org/10.1057/s41307-017-0038-8>
- Calliste, A. (1996). Antiracism Organizing and Resistance in Nursing: African Canadian Women. *Canadian Review of Sociology/Revue Canadienne de Sociologie*, 33(3), 361–390. <https://doi.org/10.1111/j.1755-618X.1996.tb02457.x>

- Campbell, A. L. (2016). *Invisible Worker(s), Invisible Hazards: An Examination of Psychological and Physical Safety Amongst Frontline Workers in Long-term Residential Care Facilities in the “New” Global Economy* [York University (Canada)].
<http://hdl.handle.net/10315/32263>
- Canadian Heritage. (2005). *Canada’s action plan against racism: A Canada for all : an overview*. Department of Canadian Heritage. http://epe.lac-bac.gc.ca/100/200/301/cdn_heritage/canadas_action_plan_racism-e/index.html
- Canadian Heritage. (2019). *Building a foundation for change: Canada’s anti-racism strategy*. Department of Canadian Heritage.
http://publications.gc.ca/collections/collection_2019/pch/CH37-4-29-2019-eng.pdf
- CAPLA. (2011). *Helping Increase Assessment Capacity and Efficiencies Among Regulatory and other Stakeholder Bodies*. Canadian Association for Prior Learning Assessment (CAPLA). <https://capla.ca/?wpdmact=process&did=MTAuaG90bGluaw==>
- CASN. (2012). *Final Report on the Pan-Canadian Framework of Guiding Principles & Essential Components for IEN Bridging Programs* (pp. 1–27). Canadian Association of Schools of Nursing (CASN). <https://www.hhr-rhs.ca/fr/outils/bibliotheque/english/pan-canadian-framework-of-guiding-principles-essential-components-for-ien-bridging-programs/visit.html>
- CASN. (2018). *Accreditation Manual for Internationally Educated Nurses (IEN) Bridging Programs* (pp. 1–104). Canadian Association of Schools of Nursing (CASN).
- CASN. (2021). *Accredited Canadian IEN Bridging Programs 2021-2022*. Canadian Association of Schools of Nursing (CASN).
http://w6s7f2j9.stackpathcdn.com/content/user_files/2017/04/Accredited-IEN-Programs_ENG_FR_Aug-2021.pdf
- CEHPEA. (2014). *Expanding Our Reach: PROGRESS REPORT 2013–2014*. Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA).
https://touchstoneloop.wordpress.com/wp-content/uploads/AnnualReport_2013_14.pdf
- CFNU. (2024). *Opening the Black Box: Unpacking the Use of Nursing Agencies in Canada* (pp. 1–238). Canadian Federation of Nurses Unions (CFNU). <https://nursesunions.ca/wp-content/uploads/2024/09/Agency-Full-Report-Final-English-20Sept2024.pdf>

- CGFNS International. (2021). *Company Milestones*. Commission on Graduates of Foreign Nursing Schools (CGFNS). <https://www.cgfns.org/milestones/>
- Chartrand, T., & Vosko, L. F. (2021). Canada's Temporary Foreign Worker and International Mobility Programs: Charting Change and Continuity Among Source Countries. *International Migration*, 59(2), 89–109. <https://doi.org/10.1111/imig.12762>
- Chen, C., Smith, P. M., & Mustard, C. (2019). Gender differences in injuries attributed to workplace violence in Ontario 2002–2015. *Occupational and Environmental Medicine*, 76(1), 3–9. <https://doi.org/10.1136/oemed-2018-105152>
- Chen, C., Smith, P., & Mustard, C. (2010). The prevalence of over-qualification and its association with health status among occupationally active new immigrants to Canada. *Ethnicity & Health*, 15(6), 601–619. <https://doi.org/10.1080/13557858.2010.502591>
- Choy, C. C. (2003). *Empire of care: Nursing and migration in Filipino American history*. Duke University Press.
- Church, K., Diamond, T., & Voronka, J. (2004). In profile: Personal support workers in Canada. *rBc Institute for Disability Studies Research and Education, Ryerson University*.
- CIC - Evaluation Division. (2010). *Evaluation of Canada's Action Plan Against Racism*. Citizenship and Immigration Canada (CIC). https://www.canada.ca/content/dam/ircc/migration/ircc/english/pdf/research-stats/er201103_01e_capar.pdf
- CIC - Evaluation Division. (2012). *Evaluation of the overseas orientation initiatives*. Citizenship and Immigration Canada (CIC). <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/reports-statistics/evaluations/overseas-orientation-initiatives.html>
- CIC - Evaluation Division. (2013). *Evaluation of the Foreign Credentials Referral Office (FCRO)*. Citizenship and Immigration Canada (CIC). <https://central.bac-lac.gc.ca/.item?id=Ci4-104-2013-eng&op=pdf&app=Library>
- CICan. (2019). *2018—2019 Annual Report*. <https://annualreport.collegesinstitutes.ca/2018-2019/>
- CICIC. (2012). *Pan-Canadian Quality Assurance Framework for the Assessment of International Academic Credentials (QaF)*. Canadian Information Centre for International Credentials (CICIC) at the Council of Ministers of Education, Canada (CMEC). https://www.cicic.ca/docs/2012/Quality_Assurance_Framework_EN.pdf

- CIHI. (2005). *Canada's Health Care Providers: 2005 chartbook* (Update). Canadian Institute for Health Information. https://secure.cihi.ca/free_products/HCP_Chartbook05_e.pdf
- CIHI. (2008). *Regulated nurses--trends, 2003 to 2007: Registered nurses, licensed practical nurses, registered psychiatric nurses*. Canadian Institute for Health Information = Institut canadien d'information sur la santé. https://publications.gc.ca/collections/collection_2008/cihi-icis/H115-28-2007E.pdf
- CIHI. (2011). *Health Care in Canada, 2011: A Focus on Seniors and Aging*. Canadian Institute for Health Information = Institut canadien d'information sur la santé. https://publications.gc.ca/collections/collection_2011/icis-cihi/H115-15-2011-eng.pdf
- CIHI. (2016). *Regulated Nurses, 2015*. Canadian Institute for Health Information = Institut canadien d'information sur la santé. https://www.hhr-rhs.ca/images/stories/CIHI_Nursing_Report_2015_en.pdf
- CIHI. (2021). *COVID-19 cases and deaths in health care workers in Canada*. Canadian Institute for Health Information. <https://www.cihi.ca/en/covid-19-cases-and-deaths-in-health-care-workers-in-canada>
- CIHI. (2024). *Tracking workplace measures*. Canadian Institute for Health Information. <https://www.cihi.ca/en/the-state-of-the-health-workforce-in-canada-2022/tracking-workplace-measures>
- CIMM 02: Hearing before the Standing Committee on Citizenship and Immigration*, House of Commons 40th Parliament, 2nd Session (2009). <https://www.ourcommons.ca/Content/Committee/402/CIMM/Evidence/EV3660274/CIMMEV02-E.PDF>
- CIMM 05 - March: Hearing before the Standing Committee on Citizenship and Immigration*, House of Commons 37th Parliament, 3rd Session (2004). <https://www.ourcommons.ca/DocumentViewer/en/37-3/CIMM/meeting-5/evidence>
- CIMM 05 - October: Hearing before the Standing Committee on Citizenship and Immigration*, House of Commons 38th Parliament, 1st Session (2004). <https://www.ourcommons.ca/Content/Committee/381/CIMM/Evidence/EV1440716/CIMMEV05-E.PDF>

CIMM 07: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 37th Parliament, 3rd Session (2004).

<https://www.ourcommons.ca/DocumentViewer/en/37-3/CIMM/meeting-7/evidence>

CIMM 09: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 37th Parliament, 3rd Session (2004).

<https://www.ourcommons.ca/DocumentViewer/en/37-3/CIMM/meeting-9/evidence>

CIMM 25: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 38th Parliament, 1st Session (2005).

<http://www.ourcommons.ca/Content/Committee/381/CIMM/Evidence/EV1694532/CIMMEV25-E.PDF>

CIMM 28: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 38th Parliament, 1st Session (2005).

<https://www.ourcommons.ca/DocumentViewer/en/38-1/CIMM/meeting-28/evidence>

CIMM 30: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 40th Parliament, 2nd Session (2009).

<https://www.ourcommons.ca/Content/Committee/402/CIMM/Evidence/EV4178131/CIMMEV30-E.PDF>

CIMM 38: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 41st Parliament, 2nd Session (2015).

<https://www.ourcommons.ca/Content/Committee/412/CIMM/Evidence/EV7842564/CIMMEV38-E.PDF>

CIMM 44: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 38th Parliament, 1st Session (2005).

<https://www.ourcommons.ca/Content/Committee/381/CIMM/Evidence/EV1772889/CIMMEV44-E.PDF>

CIMM 79: Hearing before the Standing Committee on Citizenship and Immigration, House of Commons 37th Parliament, 2nd Session (2003).

<https://www.ourcommons.ca/DocumentViewer/en/37-2/CIMM/meeting-79/evidence>

CNA. (2011). *Review of the 10-year plan to strengthen health care: Brief to the Senate of Canada Standing Committee on Social Affairs, Science and Technology*. Canadian Nurses' Association (CNA). <https://hl-prod-ca-oc-download.s3-ca-central->

- 1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Brief_10_year_plan_e.pdf
- CNA. (2021). *Nursing Statistics*. Canadian Nurses Association. <https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-statistics>
- CNCAP. (2015, January 20). CNO News: IENCAP OSCE Exam fee increase to \$400 from Nov 2015. *Canadian Nursing Career Assistance Program*. <https://cncap.ca/osce/cno-iencap-osce-exam-fee-increase-nov-2015/>
- CNO. (2007). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/college_of_nurses_of_ontario_english.pdf
- CNO. (2008). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_2008.pdf
- CNO. (2009). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_2009.pdf
- CNO. (2010). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_2010.pdf
- CNO. (2011). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_2011.pdf
- CNO. (2012). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_2012.pdf
- CNO. (2013a). *Annual Report*. College of Nurses of Ontario (CNO). https://epe.lac-bac.gc.ca/100/201/300/ar_college_nurses_on/2013.pdf
- CNO. (2013b). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_2013.pdf

- CNO. (2014). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). <https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/notices/nursingfairregistrationpracticesreport2014.pdf>
- CNO. (2015). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). <https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/notices/nursingfairregpracticesreport2015.pdf>
- CNO. (2016a). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). <https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/notices/nursingfairregpracticesreport2016.pdf>
- CNO. (2016b). *FAQs: Internationally Educated Nurses Competency Assessment Program*. College of Nurses of Ontario (CNO). <https://web.archive.org/web/20160607215800/http://www.cno.org/en/become-a-nurse/registration-requirements/education/faq-iencap/>
- CNO. (2016c, September 22). *Council Meeting Materials*. College of Nurses of Ontario (CNO). <https://web.archive.org/web/20180806151620/http://www.cno.org/globalassets/1-whatiscno/council/meetings/2016/09-22-2015-observer-package.pdf>
- CNO. (2016d, September 22). *Council Meeting Minutes*. College of Nurses of Ontario (CNO). <https://web.archive.org/web/20180806151620/http://www.cno.org/globalassets/1-whatiscno/council/meetings/2017/council-minutes---september-2016.pdf>
- CNO. (2017). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_fair-registration-practices-report-2017.pdf
- CNO. (2018a). *Entry-to-practice competencies for Registered Nurses* (Pub. No. 41037). College of Nurses of Ontario (CNO). <https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf>
- CNO. (2018b). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_fair-registration-practices-report-2018.pdf

- CNO. (2019a). *Entry-to-practice competencies for Ontario Registered Practical Nurses* (Pub. No. 41042). College of Nurses of Ontario (CNO).
https://www.cno.org/globalassets/docs/reg/41042_entrypracrpn-2020.pdf
- CNO. (2019b). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/Nurses_fair-registration-practices-report-2019.pdf
- CNO. (2020a). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/2020%20FRP/2020%20FRPs/Nurses%20-%20CNO%20FRP%202020.pdf
- CNO. (2020b). *Internationally Educated Nurses Competency Assessment Program (IENCAP)*. College of Nurses of Ontario (CNO). <https://www.cno.org/en/become-a-nurse/registration-requirements/education/internationally-educated-nurses-competency-assessment-program/>
- CNO. (2021). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). <https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/notices/fair-registration-practices-report-2021.pdf>
- CNO. (2022). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). <https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/notices/fair-registration-practices-report-2022.pdf>
- CNO. (2023a). *Fair Registration Practices Report (Nurses)*. Office of the Fairness Commissioner (OFC). <https://cno.org/Assets/CNO/Documents/What-is-CNO/fair-registration-practices-report-2023.pdf>
- CNO. (2023b). *REX-PN: Frequently asked questions*. College of Nurses of Ontario (CNO). <https://www.cno.org/en/become-a-nurse/entry-to-practice-examinations/rpn-exam/faq-rexpn/>
- CNO. (2023c, June 8). *Council Briefing Package*. College of Nurses of Ontario (CNO). <https://www.cno.org/globalassets/1-whatiscno/council/meetings/2023/council-briefing-package---june-2023.pdf>

- CNO. (2024a). *Supervised Practice Experience Partnership: Frequently asked questions*. College of Nurses of Ontario (CNO). <https://www.cno.org/en/become-a-nurse/registration-requirements/evidence-of-practice/supervised-practice-experience/faqs/>
- CNO. (2024b, April 3). Making SPEP permanent in Ontario budget. *The Standard*. <https://www.cno.org/en/news/2024/april-2024/cno-welcomes-ontarios-investment-in-nursing/>
- CNO. (2024c, May 21). Council greenlights updated education requirements. *The Standard*. <https://www.cno.org/en/news/2024/may-2024/council-greenlights-updated-education-requirements/>
- CNO. (2025). *FAQs: NCLEX-RN as education assessment for IENs*. College of Nurses of Ontario (CNO). <https://www.cno.org/become-a-nurse/registration-requirements/nursing-education/faqs-nclex-rn-as-education-assessment-for-iens#>
- Cohen, M., & Kiran, T. (2020). Closing the gender pay gap in Canadian medicine. *Canadian Medical Association Journal*, 192(35), E1011–E1017. <https://doi.org/10.1503/cmaj.200375>
- College of Physicians and Surgeons of Ontario (CPSO). (2020). *Fair Registration Practices Report (Physicians)*. Office of the Fairness Commissioner (OFC). https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/2020%20FRP/2020%20FRPs/Physicians%20&%20Surgeons-FRP%202020%20Form.final.pdf
- Connell, R. (2013). *Gender and power: Society, the person and sexual politics* /.
- Cornelissen, L. (2021). *Profile of immigrants in nursing and health care support occupations* (Catalogue no. 75-006-X). Statistics Canada. <https://publications.gc.ca/site/eng/9.900211/publication.html>
- Cortez, N. (2009). International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization. *Wisconsin International Law Journal*, 26, 646.
- Covell, C. L., Neiterman, E., & Bourgeault, I. L. (2015). Forms of Capital as Facilitators of Internationally Educated Nurses' Integration into the Registered Nursing Workforce in Canada. *Canadian Public Policy*, 41(Supplement 1), S150–S161. <https://doi.org/10.3138/cpp.2013-056>

- Covell, C. L., Primeau, M.-D., Kilpatrick, K., & St-Pierre, I. (2017). Internationally educated nurses in Canada: Predictors of workforce integration. *Human Resources for Health*, 15(1), 26. <https://doi.org/10.1186/s12960-017-0201-8>
- Cumming, P. A., Lee, E., & Oreopoulos, D. G. (Eds.). (1989). *ACCESS!* Ontario Ministry of Citizenship. <https://archive.org/details/accesstaskforceo00cumm>
- Da Silva, C., Torres, A., Kapralos, B., Peisachovich, E. H., Anyinam, C., Coffey, S., Graham, L., & Dubrowski, A. (2022). International Educated Nurse-Centered Virtual Serious Game. *2022 13th International Conference on Information, Intelligence, Systems & Applications (IISA)*, 1–6. <https://doi.org/10.1109/IISA56318.2022.9904347>
- Das Gupta, T. (2009). *Real Nurses and Others: Racism in Nursing*. Fernwood Pub.
- Day, S. L. (2014). *Making it Work: A Study of the Decision-Making Processes of Personal Support Workers in Long-Term Residential Care*. York University. http://yorkspace.library.yorku.ca/xmlui/bitstream/10315/29922/2/Day_Suzanne_L_2014_PhD.pdf
- Dean, J. A., & Wilson, K. (2009). “Education? It is irrelevant to my job now. It makes me very depressed ...”: exploring the health impacts of under/unemployment among highly skilled recent immigrants in Canada. *Ethnicity & Health*, 14(2), 185–204. <https://doi.org/10.1080/13557850802227049>
- DeClerq, K. (2021, May 8). Ontario nurses call for better pay after redeployed doctor funding shows drastic differences for similar work. *CTV News*. <https://toronto.ctvnews.ca/ontario-nurses-call-for-better-pay-after-redeployed-doctor-funding-shows-drastic-differences-for-similar-work-1.5419623>
- Delgado, R., Stefancic, J., & Harris, A. P. (2017). *Critical race theory: An introduction* (Third edition). New York University Press.
- Denton, M., Zeytinoglu, I. U., Brookman, C., Davies, S., & Boucher, P. (2018). Personal support workers’ perception of safety in a changing world of work. *Safety in Health*, 4(1), 2. <https://doi.org/10.1186/s40886-018-0069-x>
- D’Hondt, A., Kaasalainen, S., Prentice, D., & Schindel Martin, L. (2012). Bathing residents with dementia in long-term care: Critical incidents described by personal support workers: *Bathing residents with dementia in LTC. International Journal of Older People Nursing*, 7(4), 253–263. <https://doi.org/10.1111/j.1748-3743.2011.00283.x>

- Dumont, J.-C., Zurn, P., Church, J., & Le Thi, C. (2008). International Mobility of Health Professionals and Health Workforce Management in Canada: Myths and Realities. *OECD Health Working Papers*, 40, 1.
- Ehrenreich, B., & Hochschild, A. R. (Eds.). (2004). *Global Woman: Nannies, Maids, and Sex Workers in the New Economy* (Reprint edition). Holt Paperbacks.
- EICP Steering Committee. (2006). *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care*. The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative.
<https://docplayer.net/docview/24/4023180/#file=/storage/24/4023180/4023180.pdf>
- Erevelles, N. (2011). *Disability and Difference in Global Contexts: Enabling a Transformative Body Politic*. Springer.
- ESDC - Evaluation Division. (2020). *Evaluation of the Foreign Credential Recognition Program: Report*. Employment and Social Development Canada (ESDC).
http://publications.gc.ca/collections/collection_2020/edsc-esdc/Em16-21-2020-eng.pdf
- Fair Access to Regulated Professions and Compulsory Trades Act, 31 S.O. (2006).
<https://www.ontario.ca/laws/statute/06f31>
- FCRO (Ed.). (2008). *Progress report 2007-2008*. Foreign Credentials Referral Office (FCRO).
https://publications.gc.ca/collections/collection_2008/cic/Ci1-12-2008E.pdf
- Federici, S. (2014). *Caliban and the witch* (Second, revised edition). Autonomedia.
- Ferguson, R. (2014, January 27). Deb Matthews announces higher wages for personal support workers. *The Toronto Star*.
https://www.thestar.com/news/canada/2014/01/27/ontario_health_minister_announces_higher_wages_for_personal_support_workers.html
- FLMM. (2009). *A pan-Canadian framework for the assessment and recognition of foreign qualifications*. Forum of Labour Market Ministers (Canada).
<https://www.canada.ca/content/dam/esdc-edsc/documents/programs/foreign-credential-recognition/CA-561-11-09-EN.pdf>
- FLMM. (2014). *Report on Foreign Qualifications Recognition and Alternative Careers* [Research Report commissioned by the Best Practices and Thematic Task Team of the Foreign Qualification Recognition Working Group]. Forum of Labour Market Ministers

- (FLMM). <https://capla.ca/report-on-foreign-qualifications-recognition-and-alternative-careers/>
- Flynn, K. (2009). Beyond the Glass Wall: Black Canadian Nurses, 1940–1970. *Nursing History Review*, 17(1), 129–152. <https://doi.org/10.1891/1062-8061.17.129>
- Fontana, J. (2002a). *Building a Nation: The Regulations under the Immigration and Refugee Protection Act* (Report of the Standing Committee on Citizenship and Immigration 3). House of Commons Canada.
<https://www.ourcommons.ca/Content/Committee/371/CIMM/Reports/RP1032067/cimmrp03/cimmrp03-e.pdf>
- Fontana, J. (2002b). *Competing for Immigrants* (Report of the Standing Committee on Citizenship and Immigration 4). House of Commons Canada.
<https://www.ourcommons.ca/Content/Committee/371/CIMM/Reports/RP1032164/cimmrp04/cimmrp04-e.pdf>
- Fontana, J. (Ed.). (2003). *Settlement and Integration: A Sense of Belonging: “Feeling at home”;* Report of the Standing Committee on Citizenship and Immigration.
<https://publications.gc.ca/site/eng/245989/publication.html>
- Frank, K., & Hou, F. (2018). Over-education and well-being: How does education-occupation mismatch affect the life satisfaction of university-educated immigrant and non-immigrant workers? *Ethnicity & Health*, 23(8), 884–901.
<https://doi.org/10.1080/13557858.2017.1316832>
- Frank, K., Park, J., Cyr, P., Weston, S., & Hou, F. (2023). Characteristics and Labour Market Outcomes of Internationally Educated Health Care Professionals in Canada. *Health Canada*. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/health-human-resources/characteristics-labour-market-outcomes-internationally-educated-health-care-professionals-canada/characteristics-labour-market-outcomes-internationally-educated-health-care-professionals-canada.pdf>
- Gabriel, C. (2011). Migration and Globalized Care Work: The Case of Internationally Educated Nurses in Canada. In R. Mahon & F. Robinson (Eds.), *Feminist ethics and social policy: Towards a new global political economy of care* (pp. 39–59). UBC Press.
- Gabriel, C. (2013). NAFTA, Skilled Migration, and Continental Nursing Markets. *Population, Space and Place*, 19(4), 389–403. <https://doi.org/10.1002/psp.1780>

- Galabuzi, G.-E. (2004). Racializing the Division of Labour: Neoliberal Restructuring and the Economic Segregation of Canada's Racialized Groups. In L. F. Vosko, J. Stanford, & International Working Group on Labour Market Regulation and Deregulation (Eds.), *Challenging the market: The struggle to regulate work and income* (pp. 175–204). Challenging the Market Conference, Montréal. McGill-Queen's University Press.
- Galabuzi, G.-E. (2006). *Canada's Economic Apartheid: The Social Exclusion of Racialized Groups in the New Century*. Canadian Scholars' Press.
- Gardner, K. (2023). Building an Abolitionist Ethic: A Roundtable with the Toronto Prisoners' Rights Project. In Editorial Collective (Ed.), *Upping the Anti: Vol. Issue 23* (p. 221). <https://uppingtheanti.org/journal/article/23-building-an-abolitionist-ethic>
- George, U., Chaze, F., Fuller-Thomson, E., & Brennenstuhl, S. (2012). Underemployment and Life Satisfaction: A Study of Internationally Trained Engineers in Canada. *Journal of Immigrant & Refugee Studies*, 10(4), 407–425. <https://doi.org/10.1080/15562948.2012.717827>
- Goodey, C. F. (2011). *A History of Intelligence and "Intellectual Disability": The Shaping of Psychology in Early Modern Europe*. Ashgate Publishing, Ltd.
- Gorman, R. (2006). *Class consciousness, disability, and social exclusion: A relational/reflexive analysis of disability culture*. Library and Archives Canada = Bibliothèque et Archives Canada.
- Gorman, R. (2016). Disablement In and For Itself: Toward a 'Global' Idea of Disability. *Somatechnics*, 6(2), 249–261. <https://doi.org/10.3366/soma.2016.0194>
- Government of Canada. (2005, April 25). Government of Canada Announces Internationally Trained Workers Initiative. *Canada.Ca*. <https://www.canada.ca/en/news/archive/2005/04/government-canada-announces-internationally-trained-workers-initiative.html>
- Government of Canada. (2010, August 27). Government of Canada helping internationally trained nurses enter the labour market: Canada's Economic Action Plan addresses labour market challenges, helps to improve quality of life. *Canada.Ca*. <https://www.canada.ca/en/news/archive/2010/08/government-canada-helping-internationally-trained-nurses-enter-labour-market-canada-economic-action-plan-addresses-labour-market-challenges-helps-improve-quality-life.html>

- Grinspun, D., Harripaul-Yhap, A., Jarvi, K., & Lenartowych, T. (2016). *Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN*. Registered Nurses' Association of Ontario (RNAO). <http://rnao.ca/policy/reports/mind-safety-gap-health-system-transformation-reclaiming-role-rn>
- Gündüz, Z. Y. (2013). The Feminization of Migration: Care and the New Emotional Imperialism. *Monthly Review*, 65(7), 32–43. https://doi.org/10.14452/MR-065-07-2013-11_3
- Guo, S. (2010). Toward recognitive justice: Emerging trends and challenges in transnational migration and lifelong learning. *International Journal of Lifelong Education*, 29(2), 149–167. <https://doi.org/10.1080/02601371003616533>
- Guo, S. (2015). The colour of skill: Contesting a racialised regime of skill from the experience of recent immigrants in Canada. *Studies in Continuing Education*, 37(3), 236–250. <https://doi.org/10.1080/0158037X.2015.1067766>
- Guo, S., & Shan, H. (2013). The politics of recognition: Critical discourse analysis of recent PLAR policies for immigrant professionals in Canada. *International Journal of Lifelong Education*, 32(4), 464–480. <https://doi.org/10.1080/02601370.2013.778073>
- Hango, D., & Moyser, M. (2018). *Harassment in Canadian workplaces* (Catalogue no. 75-006-X; Insights on Canadian Society). Statistics Canada. https://publications.gc.ca/collections/collection_2018/statcan/75-006-x/75-006-2018-37-eng.pdf
- Hannah, E., & Hillmer, M. (2022, January 17). *Memorandum to Long-Term Care (LTC) Home Licensees Re: Long-Term Care Staffin Pool*. <https://ltchomes.net/LTCHPORTAL/Content/Snippets/AssocDM-ADM-Memo-LTC-Staffing-Pool-2022-01-17-signed.pdf>
- Hansard T-15: Hearing on ISSN 1180-4319 before the Standing committee on Regulations and Private bills*, Legislative Assembly of Ontario 38th Parliament, 2nd Session (2006). https://www.ola.org/sites/default/files/node-files/hansard/document/pdf/2006/2006-11/committee-transcript-2-EN-2006-11-15_pdfT015.pdf
- Hansard T-19: Hearing on ISSN 1180-4319 before the Standing committee on Regulations and Private bills*, Legislative Assembly of Ontario 38th Parliament, 2nd Session (2006).

- https://www.ola.org/sites/default/files/node-files/hansard/document/pdf/2006/2006-12/committee-transcript-2-EN-2006-12-06_pdfT019.pdf
- Hapsari, A. P., Ho, J. W., Meaney, C., Avery, L., Hassen, N., Jetha, A., Lay, A. M., Rotondi, M., Zuberi, D., & Pinto, A. (2022). The working conditions for personal support workers in the Greater Toronto Area during the COVID-19 pandemic: A mixed-methods study. *Canadian Journal of Public Health*, 113(6), 817–833. <https://doi.org/10.17269/s41997-022-00643-7>
- Health Canada. (2002). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses—Canada.ca* [Final Report of the Canadian Nursing Advisory Committee]. Advisory Committee on Health Human Resources. <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/nursing/health-future-creating-quality-workplaces-canadian-nurses-final-report-canadian-nursing.html>
- Health Canada. (2006, May 9). *ARCHIVED - A 10-year Plan To Strengthen Health Care* [Transparency - other]. <https://www.canada.ca/en/health-canada/services/health-care-system/health-care-system-delivery/federal-provincial-territorial-collaboration/first-ministers-meeting-year-plan-2004/10-year-plan-strengthen-health-care.html>
- Health Canada. (2008). *Pan-Canadian Health Human Resource Strategy: 2007/08 Report*. Health Canada. <http://www.hc-sc.gc.ca/hcs-sss/pubs/hhrhs/2008-ar-ra/index-eng.php>
- Health Canada. (2012). *Health Care Policy Contribution Program Annual Report: 2010–2011* (H22-1/2-2011E-PDF). Minister of Health Canada. www.hc-sc.gc.ca/hcs-sss/pubs/hhrhs/2011-ar-ra/index-eng.php
- Health Council of Canada (Ed.). (2008). *Rekindling reform: Health care renewal in Canada, 2003-2008*. Health Council of Canada = Conseil canadien de la santé.
- HealthForceOntario. (2020, May 8). Access Centre for Internationally Educated Health Professionals. *Ontario Health*. https://www.healthforceontario.ca/en/Home/All_Programs/Access_Centre
- Higginbottom, G. M. (2011). The transitioning experiences of internationally-educated nurses into a Canadian health care system: A focused ethnography. *BMC Nursing*, 10(1), 1.
- Hine, D. C. (1989). *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950*. Indiana University Press.

- Hochschild, A. R. (2015). Global Care Chains and Emotional Surplus Value. In D. Engster & T. Metz (Eds.), *Justice, Politics, and the Family* (pp. 249–261). Taylor and Francis.
- Howell, J., Rafferty, A. M., Wall, R., & Snaith, A. (2013). Nursing the tropics: Nurses as agents of imperial hygiene. *Journal of Public Health*, 35(2), 338–341.
<https://doi.org/10.1093/pubmed/fdt016>
- HPRAC. (2006). *Regulation of Health: Professions in Ontario: New Directions: A Report to the Minister of Health and Long-Term Care on regulatory issues and matters respecting personal support workers*. Health Professions Regulatory Advisory Council (HPRAC).
- HUMA 05: *Hearing before the Standing Committee on Human Resources Development and the Status of Persons with Disabilities*, House of Commons 41st Parliament, 1st Session (2011).
<https://www.ourcommons.ca/Content/Committee/411/HUMA/Evidence/EV5179161/HU-MAEV05-E.PDF>
- HUMA 10: *Hearing before the Standing Committee on Human Resources Development and the Status of Persons with Disabilities*, House of Commons 41st Parliament, 1st Session (2011).
<https://www.ourcommons.ca/Content/Committee/411/HUMA/Evidence/EV5234995/HU-MAEV10-E.PDF>
- HUMA 25: *Hearing before the Standing Committee on Human Resources Development and the Status of Persons with Disabilities*, House of Commons 37th Parliament, 2nd Session (2003). <https://www.ourcommons.ca/DocumentViewer/en/37-2/HUMA/meeting-25/evidence>
- HUMA 65: *Hearing before the Standing Committee on Human Resources Development and the Status of Persons with Disabilities*, House of Commons 39th Parliament, 1st Session (2007).
<http://www.ourcommons.ca/Content/Committee/391/HUMA/Evidence/EV2806561/HU-MAEV65-E.PDF>
- ICN. (2019). *International career mobility and ethical nurse recruitment*. International Council of Nurses (ICN). https://www.icn.ch/system/files/documents/2019-11/PS_C_International%20career%20mobility%20and%20ethical%20nurse%20recruitment_En.pdf

- IRCC - Evaluation Division. (2018). *Evaluation of pre-arrival settlement services*. Immigration, Refugees, and Citizenship Canada (IRCC).
- Jeans, M., Hadley, F., Green, J., & Da Prat, C. (2005). *Navigating to Become a Nurse in Canada; Assessment of International Nurse Applicants* (pp. 1–101). Canadian Nurses Association.
- Jimenez, M. (2003, October 25). “We are capable people.” *The Globe and Mail*.
<https://www.theglobeandmail.com/news/national/we-are-capable-people/article1203983/>
- Keith, M., & Brophy, J. T. (2021). *Code White: Sounding the Alarm about Violence Against Healthcare Workers*. Between the Lines.
<https://www.vlebooks.com/vleweb/product/openreader?id=none&isbn=9781771135665>
- Kelly, C., & Bourgeault, I. L. (2015). The Personal Support Worker Program Standard in Ontario: An Alternative to Self-Regulation? *Healthcare Policy*, 11(2), 20–26.
- Kelm, M.-E. (2010). Part of a Large Company of White Folk: Making ‘Whiteness,’ Marking Gender in the Letters of Nurse Margaret Butcher. In M. Rutherdale (Ed.), *Caregiving on the periphery: Historical perspectives on nursing and midwifery in Canada* (pp. 127–157). McGill-Queen’s University Press.
- Kergin, D. J. (1969). Nursing Assistants are here to stay. *The Canadian Nurse*, April, 1–52.
- Kingma, M. (2006). *Nurses on the Move: Migration and the Global Health Care Economy*. Cornell University Press.
- Kirby, M. J. (Ed.). (2002). *The health of Canadians: The Federal Role. Final Report on the state of the health care system in Canada* (Vol. 6). The Standing Senate Committee on Social Affairs, Science and Technology. <https://publications.gc.ca/collections/Collection/YC17-372-1-01E.pdf>
- Kolářová, K. (2015). *Disability in Eastern Europe and the former Soviet Union: History, policy and everyday life*. 30(4), 656–659.
- Kolawole, B. (2009). Ontario’s internationally educated nurses and waste in human capital. *International Nursing Review*, 56(2), 184–190.
- Komarnicki, E. (2012). *A Framework for Success: Practical Recommendations to Further Shorten the Foreign Qualification Recognition Process* (Report of the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities 4; p. 44). House of Commons Canada.

- <https://www.ourcommons.ca/Content/Committee/411/HUMA/Reports/RP5456697/humarp04/humarp04-e.pdf>
- Kontos, P. C., Miller, K.-L., & Mitchell, G. J. (2010). Neglecting the Importance of the Decision Making and Care Regimes of Personal Support Workers: A Critique of Standardization of Care Planning Through the RAI/MDS. *The Gerontologist*, 50(3), 352–362. <https://doi.org/10.1093/geront/gnp165>
- Lawrence, B. (2003). Gender, Race, and the Regulation of Native Identity in Canada and the United States: An Overview. *Hypatia*, 18(2), 3–31.
- Lewchuck, W., Wolff, A. de, King, A., & Polanyi, M. (2006). The Hidden Costs of Precarious Employment: Health and the Employment Relationship. In L. F. Vosko (Ed.), *Precarious employment: Understanding labour market insecurity in Canada* (pp. 141–162). McGill-Queen's University Press. <http://www.library.yorku.ca/e/resolver/id/2374656>
- Lilly, M. B. (2008). Medical versus social work-places: Constructing and compensating the personal support worker across health care settings in Ontario, Canada. *Gender, Place & Culture*, 15(3), 285–299. <https://doi.org/10.1080/09663690801996288>
- Little, L. (2007). Nurse Migration: A Canadian Case Study. *Health Services Research*, 42(3 Pt 2), 1336–1353. <https://doi.org/10.1111/j.1475-6773.2007.00709.x>
- Longfield, J. (2002). *Promoting Equality in the Federal Jurisdiction: Review of the Employment Equity Act* [Report of the Standing Committee on Human Resources Development and the Status of Persons with Disabilities]. <https://www.ourcommons.ca/Content/Committee/371/HUMA/Reports/RP1032138/humarp09/humarp09-e.pdf>
- Long-Term Care Staffing Study Advisory Group. (2020). *Long-Term Care Staffing Study*. Ministry of Long-Term Care (MOLTC). <https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf>
- Lorenzo, F. M. E., Galvez-Tan, J., Icamina, K., & Javier, L. (2007). Nurse Migration from a Source Country Perspective: Philippine Country Case Study. *Health Services Research*, 42(3p2), 1406–1418. <https://doi.org/10.1111/j.1475-6773.2007.00716.x>
- Lourdes, V. (2014). *OSCE Now Delivered at Touchstone Institute (Information and FAQs)*. CARE Centre of Internationally Educated Nurses. <https://care4nurses.org/osce-information-and-faqs/>

- Lu, C., & Ng, E. (2019). Healthy immigrant effect by immigrant category in Canada. In *Health Reports: Vol. Volume 30* (p. Issue 4 April 2019 Pages 3-11). Government of Canada, Statistics Canada. <https://doi.org/10.25318/82-003-X201900400001-ENG>
- Lum, J. M., Sladek, J., & Ying, A. (2010). *Ontario personal support workers in home and community care: CRNCC/PSNO survey results*. Canadian Research Network for Care in the Community,. <http://www.library.yorku.ca/e/resolver/id/2659193>
- Marani, H., McKay, S., & Marchildon, G. (2021). The Impact of COVID-19 on the Organization of Personal Support Work in Ontario, Canada. *Journal of Long Term Care*, 283–293. <https://doi.org/10.31389/jltc.70>
- Masselink, L. E., & Lee, S.-Y. D. (2010). Nurses, Inc.: Expansion and commercialization of nursing education in the Philippines. *Social Science & Medicine*, 71(1), 166–172. <https://doi.org/10.1016/j.socscimed.2009.11.043>
- Masters, K. (Ed.). (2023). *Role development in professional nursing practice* (Sixth edition). Jones & Bartlett Learning.
- Mbembe, A. (2003). Necropolitics. *Public Culture*, 15(1), 11–40. <https://doi.org/10.1215/08992363-15-1-11>
- McCallum, M. J. L. (2014). *Indigenous Women, Work, and History: 1940-1980*. Univ. of Manitoba Press.
- McPherson, K. M. (2003a). *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. University of Toronto Press.
- McPherson, K. M. (2003b). Nursing and Colonization: The Work of Indian Health Service Nurses in Manitoba, 1945–1970. In G. D. Feldberg (Ed.), *Women, health and nation: Canada and the United States since 1945* (pp. 223–246). McGill-Queen’s University Press.
- Mendel, J. (2022, June 7). *Info about Risk Profiles of Different Regulators* [Personal communication].
- Merali, F. (2022, January 25). *RNAO calls province’s work offer to internationally educated nurses “exploitative”* | CBC News. CBC. <https://www.cbc.ca/news/canada/toronto/rnao-blasts-move-to-bring-iens-to-work-as-psws-ucps-1.6325172>
- Ministry of Government and Consumer Services. (2015). *Ontario Government Agency History: Access to Professions and Trades Unit*. Archives Descriptive Database.

http://ao.minisisinc.com/scripts/mwimain.dll/144/ARCH_AUTHORITY/AUTH_DESC_DET_REP/SISN%209540?SESSIONSEARCH

- Mohanty, C. T. (2006). *Feminism Without Borders: Decolonizing Theory, Practicing Solidarity* (5th print). Duke University Press.
- Neiterman, E., & Bourgeault, I. L. (2013). Cultural Competence of Internationally Educated Nurses: Assessing Problems and Finding Solutions. *Canadian Journal of Nursing Research Archive*, 45(4). <http://cjr.archive.mcgill.ca/article/view/2429>
- Neiterman, E., & Bourgeault, I. L. (2015a). Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada. *Social Science & Medicine*, 131(Complete), 74–81. <https://doi.org/10.1016/j.socscimed.2015.02.043>
- Neiterman, E., & Bourgeault, I. L. (2015b). The shield of professional status: Comparing internationally educated nurses' and international medical graduates' experiences of discrimination. *Health*, 19(6), 615–634. <https://doi.org/10.1177/1363459314567788>
- Neysmith, S. M., & Aronson, J. (1996). Home care workers discuss their work: The skills required to “use your common sense.” *Journal of Aging Studies*, 10(1), 1–14. [https://doi.org/10.1016/S0890-4065\(96\)90013-4](https://doi.org/10.1016/S0890-4065(96)90013-4)
- NNAS. (2015). *Annual Report*. National Nursing Assessment Service. https://www.nnas.ca/wp-content/uploads/2018/08/NNAS_AnnualReport2015.pdf
- NNAS. (2016). *Annual Report*. National Nursing Assessment Service. https://www.nnas.ca/wp-content/uploads/2018/08/NNAS_AnnualReport2016.pdf
- NNAS. (2017). *Annual Report*. National Nursing Assessment Service. https://www.nnas.ca/wp-content/uploads/2018/08/NNAS_AnnualReport_2017.pdf
- NNAS. (2018). *Annual Report*. National Nursing Assessment Service. https://www.nnas.ca/wp-content/uploads/2018/09/AnnualReport2018_ID_19.pdf
- NNAS. (2019). *Annual Report*. National Nursing Assessment Service. <https://www.nnas.ca/wp-content/uploads/2019/09/NNAS-2018-2019-Annual-Report.pdf>
- NNAS. (2020a). *Annual Report*. National Nursing Assessment Service. <https://www.nnas.ca/wp-content/uploads/2020/09/NNAS-2019-2020-Annual-Report-EN-Final-Sept-11-20.pdf>
- NNAS. (2020b). *NNAS Applicant Handbook V3b: An Introduction to National Nursing Assessment Service (NNAS)*. National Nursing Assessment Service (NNAS).

- https://www.nnas.ca/wp-content/uploads/2020/10/NNAS_ApplicantHandbookV3b-Modified-Aug-10-2020_.pdf
- NNAS. (2021a). *Annual Report*. National Nursing Assessment Service. <https://www.nnas.ca/wp-content/uploads/2021/10/NNAS-2021-Annual-Report-EN.pdf>
- NNAS. (2021b). *National Nursing Assessment Service Strategic Plan 2019-2021: Taking Our Nursing Assessment Service to a Whole New Level*. National Nursing Assessment Service. <https://www.nnas.ca/wp-content/uploads/2019/06/NNAS-Strategic-Plan-2019-2021-.pdf>
- North South Group Inc. (2004). *Literature Review and Environmental Scan of Preferred Practices for Deployment of Health Human Resources and Decision Support Tools: Final Report* (p. 198). Health Canada. https://publications.gc.ca/collections/collection_2012/sc-hc/H22-4-7-2004-eng.pdf
- Nuernberger, K., Atkinson, S., & MacDonald, G. (2018). Seniors in Transition: Exploring Pathways Across the Care Continuum. *Healthcare Quarterly*, 21(1), 10–12. <https://doi.org/10.12927/hcq.2018.25529>
- NurseFact.com. (2023, October 23). *CNO May Change Educational Requirements soon for RN and RPNs*. <https://nursefact.com/ien/cno-may-change-educational-requirments-for-nurses/>
- OFC. (2007a). *Study of Registration Practices of the College of Nurses of Ontario*. Office of the Fairness Commissioner.
- OFC. (2007b). *Study of Registration Practices of the College of Physicians and Surgeons of Ontario*. Office of the Fairness Commissioner. https://www.fairnesscommissioner.ca/en/Professions_and_Trades/PDF/college_of_physicians_and_surgeons_of_ontario_english.pdf
- OFC. (2008). *Ontario's Regulated Professions: Report on the 2007 Study of Registration Practices*. Office of the Fairness Commissioner.
- OFC. (2009). *Audit Report for the College of Nurses of Ontario*. Office of the Fairness Commissioner (OFC).
- OFC. (2010). *2009-2010 Annual Report*. Office of the Fairness Commissioner (OFC). https://www.fairnesscommissioner.ca/en/Publications/PDF/Annual%20Reports/OFC_Annual_Report_2009-2010_English.pdf

- OFC. (2012a). *2011-2012 Annual Report*. Office of the Fairness Commissioner (OFC).
<https://www.fairnesscommissioner.ca/en/Publications/PDF/Annual%20Reports/OFC%20Annual%20Report%202011-2012%20English.pdf>
- OFC. (2012b). *Registration Practices Assessment Report: Summary CNO*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/Registration-Practices-Assessment-Report-2014---CNO.aspx
- OFC. (2013). *A Fair Way to Go: Access to Ontario's Regulated Professions and the Need to Embrace Newcomers in the Global Economy*. Office of the Fairness Commissioner (OFC). <https://www.deslibris.ca/ID/236464>
- OFC. (2014a). *2013-2014 Annual Report*. Office of the Fairness Commissioner (OFC).
<https://www.fairnesscommissioner.ca/en/Publications/PDF/Annual%20Reports/OFC%20Annual%20Report%202013-14%20English.pdf>
- OFC. (2014b). *Registration Practices Assessment Report: Summary CNO*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/Registration-Practices-Assessment-Report-2012---CNO.aspx
- OFC. (2015a). *Assessment of Registration Practices: Progress and Problems in 2013-14*. Office of the Fairness Commissioner (OFC).
- OFC. (2015b). *Audits of Registration Practices: Guidelines for Ontario's Regulatory Bodies*. Office of the Fairness Commissioner.
- OFC. (2015c). *Conducting Entry-to-Practice Reviews: Guide for Ontario's Regulatory Bodies*. Office of the Fairness Commissioner (OFC).
- OFC. (2015d). *Fair Registration Practices Reports: Guidelines for Ontario's Regulatory Bodies*. Office of the Fairness Commissioner (OFC).
- OFC. (2015e). *Strategy for Continuous Improvement*. Office of the Fairness Commissioner (OFC). <https://www.fairnesscommissioner.ca/en/Compliance/Strategy/Pages/Strategy-for-Continuous-Improvement.aspx>
- OFC. (2016a). *2015-2016 Annual Report*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Publications/PDF/Annual%20Reports/OFC_Annual_Report_2015-2016_English_AODA.pdf

- OFC. (2016b). *Registration Practices Assessment Guide: For Regulated Professions and Health Regulatory Colleges*. Office of the Fairness Commissioner.
- OFC. (2016c). *Registration Practices Assessment Report: Summary CNO*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/Registration-Practices-Assessment-Report-2016---CNO.aspx
- OFC. (2017). *2016-2017 Annual Report*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Publications/PDF/Annual%20Reports/OFC_Annual_Report_2016-2017.pdf
- OFC. (2021a). *2020-2021 Annual Report*. Office of the Fairness Commissioner (OFC).
<https://www.fairnesscommissioner.ca/en/PDF/OFC%20Annual%20Report%202020-2021.pdf>
- OFC. (2021b). *College of Nurses of Ontario*. Office of the Fairness Commissioner.
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/College-of-Nurses-of-Ontario.aspx
- OFC. (2021c). *Risk-informed Compliance Framework and Policy*. Office of the Fairness Commissioner (OFC).
<https://www.fairnesscommissioner.ca/en/Compliance/Documents/Risk-informed%20Compliance%20Framework%20and%20Policy.pdf>
- OFC. (2022a). *Glossary*. Office of the Fairness Commissioner (OFC).
https://www.fairnesscommissioner.ca/en/Publications/PDF/OFC_WA_Glossary.pdf
- OFC. (2022b). *Professions and Trades*. Office of the Fairness Commissioner.
https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/default.aspx
- Ogilvie, L., Leung, B., Gushuliak, T., McGuire, M., & Burgess-Pinto, E. (2007). Licensure of internationally educated nurses seeking professional careers in the province of Alberta in Canada. *Journal of International Migration and Integration/Revue de l'integration et de La Migration Internationale*, 8(2), 223–241.
- Ontario Regulators for Access. (2003a). *Access to Ontario's Regulated Professions by International Candidates: Challenges & Solutions*. Steering Committee of Ontario Regulators for Access.

- Ontario Regulators for Access. (2003b). *Access to Ontario's Regulated Professions by International Candidates: Research Report & Compendium of Promising Practices*. Steering Committee of Ontario Regulators for Access.
- Ortiga, Y. Y., & Rivero, J. A. (2019). Bodies of work: Skilling at the bottom of the global nursing care chain. *Globalizations*, 16(7), 1184–1197.
<https://doi.org/10.1080/14747731.2019.1576321>
- Pan-Canadian Planning Committee on Unregulated Health Workers. (2008). *Valuing Health-Care Team Members: Working with Unregulated Health Workers: A Discussion Paper*. Canadian Nurses' Association (CNA).
https://web.archive.org/web/20110720085335/http://www.cna-nurses.ca/CNA/documents/pdf/publications/UHW_Final_Report_e.pdf
- Parreñas, R. S. (2015). *Servants of globalization: Migration and domestic work* (Second edition.). Stanford University Press,.
- Participating Hospitals v Canadian Union of Public Employees, 58060 (L.A.C. May 26, 2019).
<https://canlii.ca/t/j167c>
- Picchio, A. (2000). Wages as a reflection of socially embedded production and reproduction processes. In L. Clarke, P. de Gijssel, & J. Janssen (Eds.), *The Dynamics of Wage Relations in the New Europe* (pp. 195–214). Springer Science & Business Media.
- PlanningForCanada.ca. (2021). *Frequently Asked Questions*. Planning For Canada.
<https://www.planningforcanada.ca/faq/>
- Premji, S., & Shakya, Y. (2017). Pathways between under/unemployment and health among racialized immigrant women in Toronto. *Ethnicity & Health*, 22(1), 17–35.
<https://doi.org/10.1080/13557858.2016.1180347>
- Raxus Online (Director). (2021, October 14). *The Difference between Canadian RN and Philippine RN - Why Compare Them Though?* [Video recording].
<https://www.youtube.com/watch?v=qnN7QFttJ28>
- Reitz, J. G., Curtis, J., & Elrick, J. (2014). Immigrant Skill Utilization: Trends and Policy Issues. *Journal of International Migration and Integration*, 15(1), 1–26.
<https://doi.org/10.1007/s12134-012-0265-1>
- RNAO. (2008). *Recruitment of Internationally Educated Nurses (IENs)* [Policy Brief]. Registered Nurses' Association of Ontario (RNAO). <https://rnao.ca/sites/rnao->

- ca/files/storage/related/4083_Recruitment_of_Internationally_Educated_Nurses_(IENs)._November_10_2008.pdf
- RNAO. (2010). *Workplace Health, Safety and Well-being of the Nurse* (Healthy Work Environments) [Best Practice Guidelines]. Registered Nurses' Association of Ontario (RNAO). https://rnao.ca/sites/rnao-ca/files/bpg/HWE._Workplace_Health_Safety_and_Well-Being_0.pdf
- RNAO. (2013). *Developing and Sustaining Nursing Leadership* (Best Practice Guidelines Second Edition; Health System, Healthy Work Environment (HWE)). Registered Nurses' Association of Ontario (RNAO). <https://rnao.ca/bpg/guidelines/developing-and-sustaining-nursing-leadership>
- RNAO. (2014). *Submission to Employment and Social Development Canada's Panel on Employment Challenges of New Canadians*. Registered Nurses' Association of Ontario (RNAO). <https://rnao.ca/fr/policy/submissions/employment-challenges-new-canadians>
- RNAO. (2017). *Developing and Sustaining Safe, Effective Staffing and Workload Practices* (Best Practice Guidelines Second Edition; Health System, Healthy Work Environment (HWE)). Registered Nurses' Association of Ontario (RNAO). <https://rnao.ca/media/3853/download>
- RNAO. (2020). *Long-Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations*. Registered Nurses' Association of Ontario (RNAO). https://rnao.ca/sites/rnao-ca/files/RNAO_LTC_System_Failings_June_2020_1.pdf
- RNAO. (2022a). *#IENaction*. Registered Nurses' Association of Ontario. <https://rnao.ca/covid19/ienaction>
- RNAO. (2022b, June 24). *New membership category: Internationally educated nurse associates*. Registered Nurses' Association of Ontario. <https://rnao.ca/news/new-membership-category-internationally-educated-nurse-associates>
- RNAO. (2024). *RNAO submission to Lieutenant Governor in Council on proposed regulatory changes to education requirements for nurse registration*. Registered Nurses' Association of Ontario (RNAO). <https://rnao.ca/media/7404/download?inline>
- Robert, A.-M., & Gilkinson, T. (2012). *Mental health and well-being of recent immigrants in Canada: Evidence from the Longitudinal Survey of Immigrants to Canada*. Research and Evaluation, IRCC.

- <https://www.canada.ca/content/dam/ircc/migration/ircc/english/pdf/research-stats/mental-health.pdf>
- Robredo, J. P., Ong, B., Eala, M. A., & Naguit, R. J. (2022). Outmigration and unequal distribution of Filipino physicians and nurses: An urgent call for investment in health human resource and systemic reform. *The Lancet Regional Health - Western Pacific*, 25, 100512. <https://doi.org/10.1016/j.lanwpc.2022.100512>
- Roediger, D. R. (1999). *The Wages of Whiteness: Race and the Making of the American Working Class*. Verso.
- Romanow, R. J. (2002). *Building on values: The future of health care in Canada : final report*. Commission on the Future of Health Care in Canada. <https://www.deslibris.ca/ID/207365>
- Ronquillo, C. (2012). Leaving the Philippines: Oral histories of nurses' transition to Canadian nursing practice. *The Canadian Journal of Nursing Research = Revue Canadienne De Recherche En Sciences Infirmieres*, 44(4), 96–115.
- Rossiter, K., & Godderis, R. (2020). Essentially invisible: Risk and personal support workers in the time of COVID-19. *Sociology of Health & Illness*, 42(8). <https://doi.org/10.1111/1467-9566.13203>
- Rowshan, A., & Singh, M. (2014). A New Era on the Horizon—Challenges and Implications of the NCLEX-RN Exam in Canada. *International Journal of Nursing and Health Science*, 1(6), Article 6.
- RPNAO. (2018). *Changing An Unacceptable Reality: Enabling Nursing Knowledge for Quality Resident Outcomes in Ontario's Long Term Care Homes*. Registered Practical Nurses Association of Ontario (RPNAO). https://www.werpn.com/wp-content/uploads/2019/11/RPNAO_LTC_2018_ONLINE-v.2_0_0.pdf
- RPNAO. (2021). *We Are Advocates*. Registered Practical Nurses Association of Ontario (RPNAO). <https://www.werpn.com/advocacy/policy-issues/scope-of-practice/>
- Sakai, J. (1983). *Settlers: The Mythology of the White Proletariat*. Morningstar Press.
- Salami, B., & Nelson, S. (2014). The downward occupational mobility of internationally educated nurses to domestic workers. *Nursing Inquiry*, 21(2), 153–161. <https://doi.org/10.1111/nin.12029>

- Salami, B., Nelson, S., Hawthorne, L., Muntaner, C., & McGillis Hall, L. (2014). Motivations of nurses who migrate to Canada as domestic workers. *International Nursing Review*, 61(4), 479–486. <https://doi.org/10.1111/inr.12125>
- Salfi, J., & Carbol, B. (2017). The Applicability of the NCLEX-RN to the Canadian Testing Population: A Review of Regulatory Body Evidence. *International Journal of Nursing Education Scholarship*, 14(1). <https://doi.org/10.1515/ijnes-2016-0078>
- Samuel, J. (2004). Are there racial barriers to access to professions and trades for the foreign-trained in Ontario? *Ontario Human Rights Commission (OHRC), Race Policy Dialogue Papers*. <https://www.ohrc.on.ca/en/race-policy-dialogue-papers/are-there-racial-barriers-access-professions-and-trades-foreign-trained-ontario>
- Santa Mina, E. E., Bhatti, A., Bradley, P., Manafo, E., Ormiston, A., Patrick, L., & Woodend, K. (2023). University Competency-based Courses for Internationally Educated Nurses (IENs) in Ontario: A Pilot Education Pathway to Registered Nurse (RN) Licensure. *Quality Advancement in Nursing Education - Avancées En Formation Infirmière*, 9(1). <https://doi.org/10.17483/2368-6669.1378>
- Sethna, C. (2013). *Understanding Personal Support Workers and their Role in Ontario*. University of Ontario Institute of Technology.
- Shaffer, F. A., Robinson, M. A., Dutka, J. T., & Tuttas, C. (2016). A New Model for Assessing Entry-Level Education of Internationally Educated Nurses: A Retrospective Perspective. *Journal of Nursing Regulation*, 6(4), 51–57. [https://doi.org/10.1016/S2155-8256\(16\)31008-0](https://doi.org/10.1016/S2155-8256(16)31008-0)
- Shakespeare, T. (2006). *Disability Rights and Wrongs*. Routledge.
- Simosko, S. (2012). *Assessing the Skills and Competencies of Internationally Trained Immigrants: A Manual for Regulatory Bodies, Employers and Other Stakeholders*. Canadian Association for Prior Learning Assessment (CAPLA). <https://capla.ca/assessing-the-skills-and-competencies-of-internationally-trained-immigrants-a-manual-for-regulatory-bodies-employers-and-other-stakeholders-2/>
- Singh-Carlson, S., & May, K. A. (2020). Adoption of NCLEX-RN for licensure in Canada: Faculty concerns and implications for nursing education. *Journal of Professional Nursing*, 36(2), 77–82. <https://doi.org/10.1016/j.profnurs.2019.08.003>

- Sinha, M. (2004). *Gender and Nation*. In B. G. Smith (Ed.), *Women's History in Global Perspective*. University of Illinois Press.
- Stasiulis, D. K., & Bakan, A. B. (2003). *Negotiating citizenship: Migrant women in Canada and the global system*. Palgrave Macmillan.
- Statistics Canada. (2023). *Work-related stress most often caused by heavy workloads and work-life balance* (2 Component of Statistics Canada Catalogue no. 11-001-X; The Daily). Statistics Canada. <https://www150.statcan.gc.ca/n1/daily-quotidien/230619/dq230619c-eng.pdf>
- Stenberg College. (2020, October 15). *Messages from the President and from Jackie G.RN*. [Online post]. Facebook. <https://www.facebook.com/StenbergCollege/posts/pfbid02euRpyYnHzPhMcmA21gwkoCpzLDWgTXjGmpDuSp9jXoB5XaheRD74Tfh3d5RkEtYgl>
- Syed, I., Daly, T., Armstrong, P., Lowndes, R., Chadoin, M., & Naidoo, V. (2016). How do work hierarchies and strict divisions of labour impact care workers' experiences of health and safety? Case studies of long term care in Toronto. *The Journal of Nursing Home Research Sciences*, 2, 41–49. <http://dx.doi.org/10.14283/jnhrs.2016.6>
- TASC. (2010). *Who Does What in Foreign Credential Recognition: An Overview of Credentialing Programs and Services in Canada*. The Alliance of Sector Councils. http://en.copian.ca/library/research/tasc/foreign_credential_recognition/foreign_credential_recognition.pdf
- Thobani, S. (2007). *Exalted Subjects: Studies in the Making of Race and Nation in Canada*. University of Toronto Press.
- Thomson, G. M. (2005). *Review of appeal processes from registration decisions in Ontario's regulated professions: Report to the Ontario Minister of Citizenship and Immigration*. Ministry of Citizenship and Immigration.
- Tilson, D. (2015). *Promoting Economic Prosperity Through Settlement Services* (Report of the Standing Committee on Citizenship and Immigration 7; p. 30). House of Commons Canada. <https://www.ourcommons.ca/Content/Committee/412/CIMM/Reports/RP8041316/cimmrp07/cimmrp07-e.pdf>

- Toman, C. (2010). "My Chance Has Come at Last!": The Weston Hospital, the Women's Christian Temperance Union, and Indian Nurses in Canada, 1917-1929. *Native Studies Review*, 19(2), 95–119.
- Touchstone Institute. (2018, September 2). *Internationally Educated Nurses Competency Assessment Program (IENCAP)*.
<https://web.archive.org/web/20180902215121/http://www.touchstoneinstitute.ca/assessment/iencap.aspx>
- Touchstone Institute. (2019, September 2). *Internationally Educated Nurses Competency Assessment Program (IENCAP)*.
<https://web.archive.org/web/20190223012824/http://www.touchstoneinstitute.ca/assessment/iencap.aspx>
- Touchstone Institute. (2020, September 2). *Internationally Educated Nurses Competency Assessment Program (IENCAP)*.
<https://web.archive.org/web/20191019100327/http://www.touchstoneinstitute.ca/assessment/iencap.aspx>
- Touchstone Institute. (2022, September 2). *Internationally Educated Nurses Competency Assessment Program (IENCAP)*. <https://touchstoneinstitute.ca/assessment/iencap/>
- Touchstone Institute. (2023). *RNCCAP Exam Blueprint Specifications* (p. 10). Touchstone Institute. https://touchstoneinstitute.ca/wp-content/uploads/RNCCAP_Blueprint_Final2023_ExamineeVersion.pdf
- Tregunno, D., Peters, S., Campbell, H., & Gordon, S. (2009). International nurse migration: U-turn for safe workplace transition. *Nursing Inquiry*, 16(3), 182–190.
<https://doi.org/10.1111/j.1440-1800.2009.00448.x>
- Tremain, S. (2006). On the Government of Disability: Foucault, Power, and the Subject of Impairment. In L. J. Davis (Ed.), *The Disability Studies Reader* (pp. 185–196). Taylor & Francis.
- Turcotte, H. (2004). Hospitals for Chinese in Canada: Montreal (1918) and Vancouver (1921). *Historical Studies*. <https://www.highbeam.com/doc/1G1-117259057.html>
- Turcotte, M., & Savage, K. (2020). *The contribution of immigrants and population groups designated as visible minorities to nurse aide, orderly and patient service associate occupations* (45280001). Statistics Canada.

- Valiani, S. (2011). *Valuing the invaluable: Rethinking and respecting caring work in Canada*. Ontario Nurses' Association. <http://www.library.yorku.ca/e/resolver/id/2436865>
- Valiani, S. (2012). *Rethinking Unequal Exchange: The Global Integration of Nursing Labour Markets*. University of Toronto Press.
- Vogler, S. (2021, September 30). *Strategic Plan 2021-2024: Update*. CNO Council Meeting.
- Vosko, L. F. (2002). The Past(s) (and Futures) of Feminist Political Economy in Canada: Reviving the Debate. *Studies in Political Economy*, 68(1), 55–83.
<https://doi.org/10.1080/19187033.2002.11675191>
- Vosko, L. F. (2006). *Precarious Employment: Understanding Labour Market Insecurity in Canada*. McGill-Queen's Press - MQUP.
- Vosko, L. F. (2010). *Managing the margins: Gender, citizenship, and the international regulation of precarious employment*. Oxford University Press.
- Vosko, L. F. (2019). *Disrupting deportability: Transnational workers organize*. ILR Press, an imprint of Cornell University Press.
- Vosko, L. F. (2025). *Migrant Work by Another Name: Differential Inclusion and Precarity in Canada's International Mobility Program*. University of Toronto Press.
- Walton-Roberts, M. (2021). Intermediaries and transnational regimes of skill: Nursing skills and competencies in the context of international migration. *Journal of Ethnic and Migration Studies*, 47(10), 2323–2340. <https://doi.org/10.1080/1369183X.2020.1731988>
- Walton-Roberts, M. (2023). The Future of Health Care Work and the Place of Migrant Workers within It: Internationally Educated Nurses in Ontario Canada during the COVID-19 Pandemic. *Journal of Immigrant & Refugee Studies*, 21(1), 59–72.
<https://doi.org/10.1080/15562948.2022.2153393>
- Walton-Roberts, M., Guo, J., Williams, K., & Hennebry, J. L. (2014). *Immigration Policy Changes and Entry to Practice Routes for Internationally Educated Nurses (IENs)*. <https://scholars.wlu.ca/cgi/viewcontent.cgi?article=1020&context=imrc>
- WES. (2023). *Summary of Recent Provincial Initiatives Supporting Internationally Educated Health Professionals (IEHPs)*. World Education Services. https://www.wes.org/wp-content/uploads/2024/01/Provincial-IEHP-Initiatives-Last-Updated-November-2023_1.pdf

- WES. (2024). *Counting on Care: A Survey of Internationally Educated Nurses Not Working as Nurses in Ontario*. World Education Services. <https://knowledge.wes.org/rs/317-CTM-316/images/wes-canada-report-ien-survey.pdf>
- Wiens, M. (2016, September 26). Meet the home care worker who inspired a health minister to bring new respect to the field. *CBC News*. <http://www.cbc.ca/news/canada/toronto/home-care-worker-juliette-chestney-reunites-with-deb-matthews-1.3777232>
- Williams, C. (2012). *Indigenous Women and Work: From Labor to Activism*. University of Illinois Press.
- Williams, F. (2014). Making Connections Across the Transnational Political Economy of Care. In B. Anderson & I. Shutes (Eds.), *Migration and Care Labour* (pp. 11–30). Palgrave Macmillan UK. https://doi.org/10.1057/9781137319708_2
- Wright, M. W. (2006). *Disposable women and other myths of global capitalism*. Routledge.
- WSIB. (2024). *Injury characteristics | Provincial statistics*. Workplace Safety and Insurance Board. https://safetycheck.onlineservices.wsib.on.ca/safetycheck/explore/provincial/SH_12/injurycharacteristics?characteristic=occ&lang=en
- Yassi, A., Gilbert, M., & Cvitkovich, Y. (2005). Trends in Injuries, Illnesses, and Policies in Canadian Healthcare Workplaces. *Canadian Journal of Public Health*, 96(5), 333–339. <https://doi.org/10.1007/BF03404026>
- Yeates, N. (2009). *Globalizing care economies and migrant workers: Explorations in global care chains*. Palgrave MacMillan. <http://us.macmillan.com/globalizingcareeconomiesandmigrantworkers>
- Zagrodney, K., Deber, R., Saks, M., & Laporte, A. (2023). The Disadvantaged Home Care Personal Support Worker: Differences in Job Characteristics, Unionization, Pensions, Participation, and Wages by Care Sector in Canada. *Journal of Applied Gerontology*, 42(4), 758–767. <https://doi.org/10.1177/07334648221146260>
- Zagrodney, K., & Saks, M. (2017). Personal Support Workers in Canada: The New Precariat? *Healthcare Policy = Politiques De Sante*, 13(2), 31–39. <https://doi.org/10.12927/hcpol.2017.25324>

Zeytinoglu, I. U., Denton, M., Davies, S., & Plenderleith, J. M. (2009). Casualized employment and turnover intention: Home care workers in Ontario, Canada. *Health Policy*, 91(3), 258–268. <https://doi.org/10.1016/j.healthpol.2008.12.004>

APPENDICES

Appendix A: Ethics Approval



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Certificate #:	STU 2018 - 085
Approval Period:	07/26/18-07/26/19

ETHICS APPROVAL

To: **Thania Vega**
Graduate Student of Political Science, Faculty of Liberal Arts & Professional Studies
thania.vega@gmail.com

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Veronica Jamnik, Chair, Human Participants Review Committee)

Date: Thursday, July 26, 2018

Title: **The Social Construction of Skill Among Internationally Educated Nurses Working as Personal Support Workers**

Risk Level: ☒ Minimal Risk ☐ More than Minimal Risk

Level of Review: ☒ Delegated Review ☐ Full Committee Review

I am writing to inform you that this research project, "**The Social Construction of Skill Among Internationally Educated Nurses Working as Personal Support Workers**" has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Note that approval is granted for one year. Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics (ore@yorku.ca) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, "**RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE**".

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: acollins@yorku.ca.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LL.M
Sr. Manager and Policy Advisor,
Office of Research Ethics



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Certificate #:	STU 2018 - 085
Initial Approval:	07/26/18-07/26/19
Amendments:	Amendment approved: 09/13/19
Renewals:	09/13/19-09/13/20
Current Approval Period:	09/13/19-09/13/20

ETHICS AMENDMENT – RENEWAL APPROVAL

To: **Thania Vega**
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thania.vega@gmail.com

From: Allison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Jennifer Kuk, Chair, Human Participants Review Committee)

Date: Friday September 13, 2019

Title: **The Social Construction of Skill Among Internationally Educated Nurses Working as Personal Support Workers**

Risk Level: ☒ Minimal Risk ☐ More than Minimal Risk

Level of Review: ☒ Delegated Review ☐ Full Committee Review

With respect to your research project entitled, “**The Social Construction of Skill Among Internationally Educated Nurses Working as Personal Support Workers**”, the committee notes that, as there are no substantive changes to either the methodology employed or the risks to participants in and/or any other aspect of the research project, a renewal of approval re the proposed amendment(s) to the above project is granted.

Any further changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics0 (ore@yorku.ca) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, “**RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE**”.

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: acollins@yorku.ca.

Yours sincerely,

Allison M. Collins-Mrakas M.Sc., LL.M
Sr. Manager and Policy Advisor,
Office of Research Ethics

Appendix B: Interview Data

Interviewee	Graduation year, school name, and nursing experience prior to Canada	Immigration pathway	Re-accreditation/integration in Canadian nursing workforce	Work History
Maria – Interview 1, 2019	Began nursing degree in 1974 but left after two and a half years due to disagreements with professors who were part of the dictatorship of the time Re-enrolled in 1983 and graduated in 1986 Worked in all kinds of nursing for both public and private hospitals until 2004 (18 years)	Went to US in 2004 and applied for asylum in Canada and lived here, but got denied Spousal Sponsorship in 2008	Applied for assessment in 2005 to CNO but there were errors in documents of employment history from public hospital, was not informed of this error and was asked to pay again; was highly discouraged by process Went to U of T to get degree evaluated with the Credential Evaluation Services and they said she had equivalent of Bachelor of Nursing but was not allowed to write licensing test Got 6-month PSW certificate in 2006 from Vercore Business Academy which was a “waste of time and money but needed the piece of paper.”	Villa Colombo Homes for the Aged Inc in Toronto for seven years as PSW The Neighbour Group until Summer of 2019 as PSW; took medical leave due to knee injury acquired in January during work (but asymptomatic at first so could not claim as workplace injury); tried to go back in March of 2020 but pandemic hit, now retired.
Oscar – Interview 2, 2019	Graduated in 2008 from Metropolitan College of Nurses in the Philippines Worked on and off as a nurse until migration	Spousal sponsorship, arrived 2015 Wife was in nursing school but dropped out and entered Canada through Live-in Caregiver Program; had long distance relationship for six years	Enrolled in Modern Tech Nursing Review Centre to help with assessment of nursing credentials Considered CARE centre but had too many gaps in nursing practice Used the NNAS which identified 102 gaps in his knowledge, currently trying to address those gaps	First job in Canadian Tire for a month Began work at an Ontario hospital as dietary aid in 2015
Joanna – Interview 3, 2019	Graduated in 1991 from St. Pedro College Worked as company nurse in manufacturing company until migration	Applied to the points-system in 2002, and was approved in 2008 Relatives in Canada Left kids back home for two months until they settled here	Applied to CNO for assessment (also applied for the US NCLEX-RN); about a year later told that only eligible for RPN because needed to upgrade 8 courses Passed test to provide medication to residents in retirement home before getting RPN licence Passed RPN exam in 2010 and got licence in December	Worked as PSW at Revera Constitution Retirement Home (no longer works there) Hired as a full-time PSW (back then, you PSW certificate was not required if you were an IEN, now they require it) at Mississauga Lifecare Centre (now

			Doesn't plan on getting RN because she is "too old to be worth the effort/cost."	Cooksville). Upgraded to RPN in 2010 Works part-time in Trillium hospital as RPN - assesses residents for Behavioural Specialized Unit pilot program VP in union representing RPNs and PSWs
Jasmine – Interview 4, 2019	Graduate in 2013 from UV Gullas College of Medicine - University of Visayas College of Nursing Volunteered for one year and worked full-time for three years in a private hospital	Sponsored by relatives to take care of nephews via the Temporary Foreign Worker Program and used Interim Pathway for Caregivers to get Permanent Residence, arrived in 2017	Applied to NNAS for assessment and was eligible for both RPN and RN in September 2019 Boasts that updated curriculum and high ranking/reputation of school facilitated swift assessment	Worked for two years as caregiver, now on-call caregiving for children in private home for woman who is RN Struggling to find work in hospitals or LTC because of lack of "Canadian experience"
Martha – Interview 5, 2019	Graduated in 2008 from Far Eastern University in Manila Worked as a nurse and in the insurance industry	Provincial Nominee Program, arrived in 2016	No NNAS when she applied in 2010 from Philippines, but despite being eligible for RPN could not get work permit Re-applied six years later, but NNAS process more stringent Passed OSCE in 2017 but had to wait two years to get into bridging program, and ultimately deferred due to pregnancy	Left front-line healthcare provision, and started work in insurance office managing medical claims
David – Interview 6, 2019	Graduated in 2008 from Far Eastern University in Manila Worked as nurse for almost eight years at one location up to time of migration	Provincial Nominee Program, arrived in 2016	Started NNAS process in 2018; Passed RPN exam and English exam, waiting for result of safe practice and then will become RPN Completed PSW certificate	Has two PSW part-time jobs, one at private agency, the other at an independent living facility
Mike – interview 7, 2019	Graduated in 2011 from the University of Northern Philippines, and Graduated in 2012 with a Masters in Nursing	Began migration process in 2014, but by the time he finished his Master's program and had sufficient	Started at NNAS in August 2019 and received advisory report in December 2019. Education not comparable to Canadian education so was	Used pre-arrival services to land full-time position as PSW in mixed LTC facility

	Volunteered a few months before getting hired as staff Worked seven years as a nurse in the same hospital; as a nurse generalist, then in intensive care, then promoted to nurse trainer	nursing experience, the points requirement was higher Provincial Nominee Program, arrived in 2019 Great aunt financed studies so he wanted to pay her back	presented two options: the IENCAP or bridging courses Plan is to register for IENCAP but demand too high Looking to enroll for online courses in Alberta or Nova Scotia to address competency gaps Plan B is to get NNAS assessment as RPN	Allowed to provide medications because different regulations in regards to retirement homes
Jacqueline – Interview 8, 2019	Graduated in 2012 from STI West Negros University Worked two years in the Philippines then four in Saudi Arabia as a nurse	International student visa, arrived in 2019 with husband and baby Left two older kids in the Philippines	Did not apply yet, advised to apply to RPN route by teacher Enrolled in Chronic Disease Management program for IENs at Seneca	Home care PSW, relies on shifts provided by friends Wants job in LTC for greater job security and protections, one of her friends was threatened to have her pay docked because the client fell Shift work challenging for childcare
Erica – Interview 9, 2019	Graduated in 2010 from Doña Remedios Trinidad Romualdez Medical Foundation Started as volunteer for 3 months, absorbed as nurse reliever (on call) because they don't hire regular staff until spot is vacant Worked until 2013 when typhoon hit province and hospital closed Worked in Saudi Arabia in pediatric care until migration	Used immigration agency <i>Enhance Visa</i> from the Philippines and paid \$4 thousand for Study to Permanent Residency Pathway Arrived in 2019, temporarily separated from husband and child According to the agency she used, the Seneca PSW certificate she is enrolled in will make her eligible to apply for a post-graduate work permit	Will apply once she received permanent residence; using time to save money for the process Agency provided list of documents she needed pre-departure US process simpler but came to Canada because of the health care system; left Saudi Arabia because of strict laws, closed work permit	Applied for PSW jobs but they require the certificate, so in the meantime working at Ardene's Would prefer working in one facility rather than travelling around
Laura – Interview 10, 2019	Graduated in 2013 from Wesleyan University-Philippines Went to Saudi Arabia to work as a nurse but had to leave because they	Went to Hong Kong as domestic a worker because she was told it would be easier to apply to Canada from there	Applied to NNAS on November 2019; was found ineligible because she cannot provide employment that is less than 3 years old; plans on starting with RPN route then doing RN	Worked as caregiver for family member for six months Provides full-time, live-in childcare for a

	require two years nursing experience prior to taking exam Sold beauty products for about a year then took up company nurse position until migration	Relatives tried to sponsor her but used incorrect forms and got denied Hired <i>Best Care Immigration Consulting</i> and applied through Temporary Foreign Worker Program using Labour Market Impact Assessment; arrived in 2018 and subsequently used the Interim Pathway for Caregivers to get permanent residence		pair of eight year old twins Overnight, home care PSW for person with Alzheimer's during weekends, alongside other PSW Home care PSW for person with Parkinson's for one 24 hour shift to provide relief for other PSW Cleaning job on weekends Wants to volunteer at Baycrest to learn more about the healthcare system meet other IENs
Arnold – Interview 11, 2020	Graduated in 1992 with a Bachelor of Arts and Economics from St Pedro Enrolled for a Master's in Business Administration but did not finish Graduated in 2007 from the Bicol Christian Medical College Worked in community nursing and volunteered until migration	Applied to the points-system in 2002, and was approved in 2008 Relatives in Canada Left kids back home for two months until they settled here	Became RPN in 2010 after applying directly to CNO Tried to get help from CARE Centre for IENs, but did not find helpful Graduated in 2012 from the York University bridging program for IENs of 5 semesters) at York graduated in 2012 practiced as nurse until Started graduate school in 2015 and is doing his PhD	PSW from Nov 2009 for about six months at Cooksville Care Centre; then hired as RPN from 2010 to 2012; then hired as RN from 2012 to 2015

Non-IEN Participants:

- Representative from the RPNAO – Interview 12, 2020
- Representative from the CARE Centre for IENs – Interview 13, 2020
- **AAA**, Domestically educated RPN – Interview 14, 2020
- Manager from Ontario-based hospital – Interview 15, 2020
- Manager from Ontario-based LTC –Interview 16, 2020
- Home care client – Interview 17, 2020
- Representative from the Canadian Association of Schools of Nursing Accreditation – Interview 18, 2020
- **Jolene**, Domestically educated RPN – Interview 19, 2020

Appendix C: Sample Informed Consent

Note: I used two different consent forms for the two different groups of participants: nurses and key representatives from nursing organizations. Only the “What is involved in this study?” section differed between the two consent forms; I included the two different sections here.

Informed Consent Form

The Social Construction of Skill Among Internationally Educated Nurses Working as Personal Support Workers

Investigator: Thania Vega, PhD Candidate
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tvega@yorku.ca

Why am I doing this study?

A great number of Internationally Educated Nurses (IENs) who migrate to Canada, and Ontario in particular, fail to gain entry into the nursing workforce because they do not meet the requirements for registration. A central aim of my research is to understand the experiences of IENs who work outside the nursing workforce, a highly under-researched group of workers. In particular, I am interested in learning about the experiences of those who resort to personal support work, how their skills are constructed, and the implications on their conditions of work and employment (e.g. health and wellbeing, pay, social status, control over their working conditions, and access to protections and benefits). My research asks: how does holding credentials as a nurse affect your conditions of work and employment as well as your experiences as PSWs?

FOR NURSE PARTICIPANTS:

What is involved in this study?

As someone who holds nursing credentials from a country in the Global South you are being asked to participate in an interview about your experiences working in personal support work. To ensure accuracy, the interview will be recoded and a subsequent transcript of the interview can be shared with you at your request.

You will be asked questions about your decision to pursue a nursing degree, your journey into Canada, how you became a PSW, and about your experiences working as a PSW. These questions generally aim to explore what your everyday look likes at work, what skills you use in your work, and what your conditions of work and employment are like. The interview is expected to last between 1-2 hours.

You will also be asked if you would be willing to recommend someone for me to interview who also holds a degree as a nurse from the Global South and is currently working as a PSW.

FOR REPRESENTATIVES FROM KEY ORGANIZATIONS:

What is involved in this study?

As a key figure from a relevant decision-making body relating the regulation of health care professionals you are being asked to participate in an interview about how your organization conceptualizes the skills and the conditions of employment and work of PSWs more generally, and specifically those who hold nursing degrees from non-Canadian institutions. To ensure accuracy, the interview will be recoded and a subsequent transcript of the interview can be shared with you at your request.

You will be required to provide your name and position title within your organization. You will also be asked questions about how your organization interprets the nature of personal support work, including the skills and their conditions of employment and work, and the role of PSWs vis-à-vis other health care professionals. The interview is expected to last between 30 minutes to an hour.

Risks and Discomforts:

I do not foresee any risks or discomfort from your participation in this research project. If any discomfort does arise, please let me know immediately and we can pause the interview, skip specific questions, or stop the interview altogether.

Benefits of the Research and Benefits to You:

In Canada, and Ontario especially, there is a significant amount of Internationally Educated Nurses (IENs) who work outside the nursing workforce. However, there is a poor understanding of these workers' experiences. My research sheds light on some of the issues these workers face in the hope that it will help the development of better strategies to improve their working conditions. So, indirectly your participation can lead to the development of better policies regarding personal support work, more generally, and migrant nurses more specifically. Directly, you may experience a sense of empowerment or relief from sharing your story. Of course, throughout the study your rights to confidentiality and privacy will be fully protected.

In order to compensate you for your time in participating in this study, you will receive a \$20 gift card which you can keep even if you refuse to answer particular questions or withdraw from the interview.

Voluntary Participation, Ongoing Consent, and Withdrawal

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future. You can choose not to answer any questions. You are also encouraged to give feedback throughout the research process, and to express ways that the research process can be more accessible to you as a participant.

Your decision to stop participating in the interview, or to refuse to answer particular questions will not result in the loss of your \$20 gift card. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete. Beyond this specific research project, data collected from your participation may be used in journal articles, community or academic presentations, activist publications, and other research related purposes until January 1st, 2023 at which point all hard-copy and electronic data will be destroyed.

Confidentiality:

Unless you choose otherwise, all information you supply during the interview will be held in confidence and, unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Confidentiality will be provided to the fullest extent possible by law.

Your data will be safely stored in an encrypted file on my password-protected laptop and only I will have access to this information in full; you will have access to specifically your contributions if you wish.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me at tvega@yorku.ca or my supervisor, Leah F. Vosko at lvosko@yorku.ca 416-736-2100 Ext: 33157. You may also contact the Graduate Program in the Department of Politics at lapspols@yorku.ca and/or 416-736-5264. This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

I, _____ consent to participate in “The Social Construction of Skill Among Internationally Educated Nurses Working as Personal Support Workers” conducted by Thania Vega. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

I, _____ have received my \$20 gift card.

I, _____ consent to the audio-recording of my interview(s).

Signature _____
Participant

Date _____

Signature _____
Principal Investigator

Date _____

Consent to waive anonymity

The use of your real name is completely optional. If you do not sign below, your anonymity will be protected by use of a pseudonym.

I, _____ consent to the use of my name in the publications arising from this research. My signature below indicates my consent.

Signature _____
Participant

Date _____

Signature _____
Principal Investigator

Date _____

Appendix D: Overview of Other Federally-Funded FCR Initiatives

1. Internationally Educated Health Professionals Initiative

1.1. Access Centre

A program out of HealthForceOntario started in 2006 as part of passing the *Fair Access to Regulated Professions and Compulsory Trades Act, 2006*. It provides a one-stop information, path-finding, and counselling service for IEHPs with the “primary goal of helping them become trained, licensed, and employed in their profession or an alternative career” (HealthForceOntario, 2020). Between 2010-2011, Health Canada boasted that more than 3635 new IEHPs had accessed the Centre (Health Canada, 2012, p. 43). The Access Centre also expanded assessment services for IENs at the TouchStone Institute, previously known as the Centre for the Evaluation of Health Professionals Educated Abroad. This institute offers nursing-specific tests such as the Canadian English Language Benchmark Assessment for Nurses and the IENCAP. Both were developed to provide national standardized tools to assess the language skills and competencies of IENs (CIMM 25, 2005; Simosko, 2012). The Canadian English Language Benchmark Assessment for Nurses test costs around \$300, and the IENCAP costs between \$1500-1750.

1.2. Canadian Association of Schools of Nursing Accreditation Program

The Canadian Association of Schools of Nursing is a member-driven organization representing the schools of nursing nationwide. Its mandate is to improve the quality of nursing education in the public's interest through the accreditation of nursing programs (Interview 18, 2020). The Canadian Association of Schools of Nursing Accreditation program approved for \$340 thousand in funding in 2010 and launched in 2018, provides a “national framework of guiding principles and essential components” for bridging programs for IENs (Health Canada, 2012, p. 45). A pan-national advisory committee developed this program, which comprises faculty members, educators, and leaders from across the country, including regulators and NNAS. It was designed by gathering input from a national forum of 32 participants, conducting a literature review of IEN bridging programs and nurse examination reports, surveying existing programs, and through further consultation on the early drafts developed (NNAS) (CASN, 2012).

The program outlines a set of best practices along four “overarching quality dimensions” and seven “standards.” The four quality dimensions are relevance, accountability, relatedness, and uniqueness. The seven standards bridging programs are measured against target the following domains: 1) the IEN learner, specifically building on their prior knowledge and experience; 2) partnerships/relationships, by ensuring collaboration; 3) teaching and learning, by providing a culturally safe learning environment; 4) resources, meaning appropriately resourcing the program; 5) communication, by providing accessible and transparent information; 6) program evaluation, established for continuous improvement; and, 7) program outcomes, determined by the successful integration into the Canadian nursing workforce (CASN, 2018). These are meant to be carried out by the separate units responsible for program delivery (e.g., faculty and administration), followed by the bridging programs’ curriculum and course content. Accreditation is voluntary and conducted first via self-assessment, followed by an on-site visit, and finally decided upon by a committee (CASN, 2018).

As of 2022, only four of over 20 programs in Canada (two in Ontario) have been accredited through this program (CASN, 2021).

2. Foreign Credential Recognition Office Initiative

The Foreign Credential Recognition Office was launched in May 2007 under the Department of Citizenship and Immigration Canada (currently known as Immigration, Refugees and Citizenship Canada). It was founded following “two extensive rounds of consultations” with “key stakeholders,” in particular Health Canada, Human Resources and Skills Development Canada, the Canadian Network of National Associations of Regulators, the Alliance of Sector Councils, the Canadian Federation of Independent Businesses, the Canadian Chambers of Commerce, and other organizations (FCRO, 2008).

According to Diane Finley, Minister of Citizenship and Immigration at the time, the Foreign Credential Recognition Office fulfilled the federal government’s “responsibility to give newcomers the information and references they need to find how their professional credentials could be assessed and recognized, what upgrades they

might need to meet Canadian standards, and what jobs might be available in various fields” (CIMM 2007, p. 4). Rather than providing information directly, it was meant to act as a “one-stop shop” to help internationally educated immigrants navigate through “what too often appears to be an impenetrable maze and links them directly into federal and provincial programs, path-finding tools and services” (TASC, 2010, p. iii).

At the time of launch, it offered “access to information,” “path-finding,” and “referral services” through its website (credentials.gc.ca), over the phone, or in-person at Service Canada centres (FCRO, 2008). At the time of launch, the website was credentials.gc.ca and featured the *Working in Canada* tool, a search tool for information on specific occupations, which linked to the regulatory bodies and provided information about labour market prospects based on location. The Executive Director of the Foreign Credential Recognition Office claimed that by September 2009, the website had received over 732k visits, the majority from overseas (Prince St-Amand, *CIMM 30*, 2009, p. 2). While the Foreign Credential Recognition Office website is no longer operational, the *Working in Canada* tool continues to operate under a new name, the Foreign Credential Recognition in Canada Tool. It is operated by Employment and Social Development Canada.

The Foreign Credential Recognition Office also developed communication tools to help integrate internationally educated immigrants, including several *Occupational Fact Sheets*, two web-based tools, the *Employers Roadmap: Hiring and Retaining Internationally Trained Workers* and the handbook for newcomers called *Planning to Work in Canada. An Essential Workbook for Newcomers*; and a defunct website called the International Qualifications Network, launched in December 2011, which was meant to “promote knowledge exchange on successful foreign credential recognition practices amongst FCR intermediaries” (TASC, 2010, p. 9). It also mailed thousands of its products to immigrant-serving organizations throughout Canada (CIC - Evaluation Division, 2013).

The Foreign Credential Recognition Office is also responsible for “fostering collaboration and support engagement” across P/Ts and federal organizations by helping to “build awareness of and consensus” related to implementing the 2009 Framework (CIC - Evaluation Division, 2013). For instance, the Foreign Credential Recognition Office was part of conferences such as the Canadian Chamber of Commerce Annual General Meeting, Canada’s Top 100 Employers Summit, Metropolis, and several Internationally Educated Professionals conferences.

Since 2010, the Foreign Credential Recognition Office has played a vital role in providing pre-arrival support, mainly through funding the Canadian Immigration Integration Project, currently known as Planning for Canada. As of 2021, assuming funding has remained consistent, the Foreign Credential Recognition Office has cost around \$120 million.¹⁷⁶

2.1. Canadian Immigration Integration Project, known as Planning for Canada since 2021.

The Canadian Immigration Integration Project was launched as a pilot project in 2007 as part of the FCRP. It became a Foreign Credential Recognition Office program in 2010. It changed its name to Planning for Canada in 2021. As of 2018, it was one of 28 federally-funded pre-arrival services to “provide more comprehensive tailored in-person, and web-based pre-arrival orientation and supports” (IRCC - Evaluation Division, 2018, p. 13). The program is delivered through the College and Institutes Canada, formerly the Association of Canadian Community Colleges. It offers free group orientation sessions and individual consultations for people selected for permanent residency in Canada (including their spouses and working-age dependents) to enable them to “effectively prepare to meet foreign credential requirements and achieve labour market integration” (CIC - Evaluation Division, 2012, p. 21).

The group orientation presents an overview of all aspects of living and working in Canada, helps set “realistic expectations,” and “provides accurate information” to prepare for a “successful economic and social integration in Canada.” The in-person group orientation lasts 7 hours, while the online version has two options: a shorter 4-hour version or a more extended version split over two days in two 3.5-hour sessions. All versions of the group orientation cover the same content, just in varying amounts of detail (PlanningForCanada.ca, 2021). After the group session, each participant participates in “an individualized one-on-one session with a Planning for Canada facilitator” called a

¹⁷⁶ By 2015 the initiative was estimated to have received close to \$60M, and assuming funding has remained consistent at \$8.8 million yearly since, by 2021 it would have received an additional \$60 million (CIC - Evaluation Division, 2013).

Personalized Planning Session. This is a 60-minute session where participants work with a facilitator to “develop a personalized Action Plan tailored to your specific settlement and employment needs and intended destination in Canada.” Participants are put in touch with “expert in-Canada advisors” who help them “research and implement aspects” of the Action Plan and connect them with other post-arrival organizations in the city/town of destination (PlanningForCanada.ca, 2021).

The program initially had three pilot offices abroad, one in Manila, one in Guangzhou in China, and one in New Delhi, the 3 major source countries for Federal Skilled Workers. India, China, and the Philippines accounted for 37.5% of Federal Skilled Workers who landed in Canada between 2006 and 2010 (CIC - Evaluation Division, 2012, p. 59). In 2010, it added an office in London, UK. It began offering satellite services in over 25 other countries, which covered about 75% of applicants under the Foreign Skilled Worker Program and 44% under the Provincial Nominee Program (Komarnicki, 2012, p. 8). As of 2021, in-person sessions are only offered in two countries with expanded service—India (New Delhi, Mumbai, Bangalore, Ahmedabad, Chandigarh, Chennai and Hyderabad) and the Philippines (Manila, Cebu and in other cities depending on demand)—and online (real-time) for all other countries (CICM 02, 2009; PlanningForCanada.ca, 2021).

The program has served over 48 thousand newcomers since its inception (average of 4 thousand/year), representing less than 10% of eligible newcomers under the Federal Skilled Workers and Provincial Nominee programs.¹⁷⁷ The program has cost around \$50 million (average of \$3.5 million per year) since launch, which represents between 10-15% of the total amount spent annually on pre-arrival services, and amounts to just over \$2 thousand per user (an amount that is considered to be lower than expected) (CIC - Evaluation Division, 2012; CICan, 2019; IRCC - Evaluation Division, 2018).

This program has been described as helping to fulfill the mandate of the Foreign Credential Recognition Office to help immigrants prepare for integrating into the Canadian labour market (CICM 02, 2009, p. 16). The program was also seen as crucial in re-directing internationally educated health professionals to other destination cities other than Toronto and Vancouver where the “person might have an easier time” (Tilson, 2015, p. 8), or to provinces where the economy was “hot” (Tapley, CICM 38, 2015, p. 9). Three separate evaluations of the program determined that (a) participants reported “positive economic outcomes,” specifically that “within three months of arrival in Canada, 47% were employed and 63% of those working in their field of expertise (Tilson, 2015, p. 8), (b) received “high praise” from immigrant-serving organizations and user informants (FLMM, 2014, p. 62), and (c) was characterized as “needed and useful” in helping newcomers prepare before departure (IRCC - Evaluation Division, 2018, p. 6).

However, a closer reading of these program evaluations paints a more complicated picture. First, the evaluations determined that pre-arrival services did not impact longer-term employment outcomes significantly. The 2012 evaluation of the program noted that regardless of receiving pre-arrival orientation, immigrants continued to face challenges related to employment: 61.3% of participants reported high levels of difficulty compared to 67.8% of participants who did not participate in any orientation, with most difficulties reported in “getting a job that matched their skills” (CIC - Evaluation Division, 2012, p. 47 fn. 89-90). The 2018 evaluation also noted that while clients of these services indicated some differences in terms of having less difficulty getting credentials recognized and finding/accessing job-related training opportunities, these differences were, at best, minimal (IRCC - Evaluation Division, 2018, pp. 40–41). Secondly, these evaluations have many methodological concerns with how skill-matching and integration are defined. In the case of IENs, working as a PSW can be categorized as “related at least to some extent” to their education and training, which incorrectly skews the data towards assuming full integration.

¹⁷⁷ The 2012 program evaluation notes that the program provided orientation to about 8% of eligible newcomers under the Federal Skilled Workers and Provincial Nominee programs in the locations offered. Since the number of landed immigrants (around 300 thousand/year) and the rate of use of the program (around three thousand/year) have remained steady since then, I calculated that only around 10% of eligible immigrants have access to the program (CIC - Evaluation Division, 2012, p. viii).

Appendix E: List of OFC's Recommendations to the CNO from 2012 to 2016

The following recommendations correspond to the 2012, 2014, and 2016 Registration Practices Assessments by the OFC of the CNO's registration practices and processes. 'Required' recommendations correspond to practices regulators must demonstrate to meet the specific duties in the legislation, and those marked "Good" to the practices the OFC encourages a regulatory body to adopt to meet the general duties in the legislation.

1. 2012 Registration Practices Assessment (eight recommendations):

- Duty: Information for Applicants
 - o Simplify the online presentation of registration information, so the information can be easily downloaded and printed. [Required]
 - o Include exemptible requirements for Registered Nurse and Registered Practical Nurse in the CNO's registration application guide for applicants. [Good]
 - o On the website, provide French-language registration materials, and instructions for directing questions to a Call Centre representative. [Good]
 - o Include a link on the CNO website to the Nursing Career Map (on the Ontario government's website). The map states that the CNO can assess applicants' applications while they are still in their home countries and describes the steps in the registration process that can be started outside of Canada. [Good]
 - o Provide the following in the registration application guide:
 - information about opportunities to appeal the results of a qualifications assessment [Required]
 - the amount of time the registration process may take for each application type [Required]
 - an estimated range or maximum amount of time for each stage of the application process, and variables that may slow down the process [Required]
 - o Provide links to language testers on the CNO website. [Good]

2. 2014 Registration Practices Assessment (34 recommendations):

- Information for Applicants
 - o Clarify how it evaluates international academic credentials. While the CNO states that international academic credentials are evaluated against the Competencies for Entry-Level Registered Nurse Practice, it should clarify exactly how this is done. In particular, it should clarify whether an international program must meet all of these competencies to be considered equivalent to Canadian standards. The CNO should also clarify how this is measured (for example, are all competencies equally weighted?).
 - o Clarify how the Objective Structured Clinical Examination (OSCE) – a clinical, competency-based examination – is a valid and reliable measure of academic equivalency.
- Assessment of Qualifications
 - o Be more transparent and explicit about the scoring methodology for the OSCE. The CNO website states that OSCE results “will determine whether the applicant has demonstrated entry-to-practice competencies in order to meet the program requirements.” The CNO should expand on what this means. For example, the CNO should clarify:
 - whether an applicant must obtain a specific threshold score related to each entry-to-practice competency tested by the OSCE. If so, the CNO should state the threshold score required.
 - whether scores for all competencies are averaged or whether an applicant must demonstrate a threshold score for each individual competency. In either case, the CNO should state the threshold score required.
 - whether the CNO accepts OSCE results as submitted by the Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA) at face value, or whether the CNO conducts its own further evaluation of the results. If the latter, the CNO should clarify the criteria used in its evaluation.

- Work with relevant stakeholders to develop an integrated approach to bridging education for internationally educated applicants that enables them to address their identified competency gaps. The integrated approach should also address the following:
 - consistent application of nursing educational standards/criteria
 - refining processes and policies to better inform and communicate the educational needs and requirements of applicants
 - processes to verify educational completion
 - evaluation of process effectiveness
- Ensure that the CNO's assessment methodology for evaluating an applicant's OSCE results is clear and consistent. In particular, the CNO should explain its methodology for assessing competency when OSCE results are used to supplement the paper-based competency assessment of academic qualifications.
- Review its interpretation of the Declaration of Registration Requirements for objectivity, validity and reliability. If deficiencies are found, these should be corrected.
- Review its interpretation of OSCE results for objectivity, validity and reliability. If deficiencies are found, these should be corrected.
- Give applicants more detailed information about their competency gaps in the OSCE, including the specific aspects within each competency where there are deficiencies.
- Inform applicants about the criteria for scoring the OSCE. (This recommendation overlaps with the first recommendation in this sub-section).
- Transparency
 - Establish a process for reviewing registration policies on a regularly scheduled basis.
 - Incorporate visuals into the "Become a Nurse" section of the CNO website in order to enhance clarity.
 - Refine the information in the online registration guides to clarify that applicants can be registered with terms, conditions and limitations if they do not have documentation of Canadian citizenship, permanent residency, or other authorization under the Immigration and Refugee Protection Act (Canada) to practise nursing in Ontario.
 - Include sample scenarios in the information that describes how the CNO evaluates health and conduct.
 - Identify where an applicant may incur costs through a third-party process, including bridging education. The CNO should provide links on its website to any additional information about these processes and their costs.
 - Take measures to show applicants that documented policies have been followed in their case. In particular, this applies to policies concerning timelines for processing applications.
 - Commit to timelines for responding to applicants' inquiries and communicate the timelines on the CNO website.
 - Be more frank about the specific additional education and/or training requirements for internationally educated Registered Nurse (RN) applicants whose academic credentials are deemed to be not equivalent to Canadian standards. That is, the CNO should communicate to applicants that a separate exam is required (i.e., the OSCE) and that regardless of the number or type of competency gaps identified through this exam, applicants must take bridging education if they wish to remain under consideration for RN licensure. The CNO should also communicate that bridging education must entail university-level courses offered through select institutions and that the courses must be completed as part of an entire bridging program (as opposed to discrete courses, regardless of the competency gaps identified).
- Inform applicants about the assessment methodology used in grading the OSCE. This includes clarifying:
 - whether applicants need to demonstrate each of the required competencies or whether their performance on all competencies in total is averaged
 - whether there is a minimum threshold for demonstrating the competencies, either individually or averaged

- what the minimum threshold scores are for demonstrating competencies
- whether the CNO accepts the OSCE results at face value as they are received by CEHPEA, or whether the CNO performs additional evaluation of the results
- Fairness
 - In the interest of eliminating or reducing duplication, clarify why the OSCE includes assessment of self-regulation and ethics when applicants are required to complete a separate jurisprudence exam.
 - Demonstrate that the move to the OSCE approach was done through a transparent and impartial process. For example, there was stakeholder consultation, the exam was validated by experts, the questions were tested on recent Canadian BScN graduates, etc.
 - Demonstrate that there either is a current process or a plan to develop a process for evaluating the OSCE for ongoing relevance and necessity as the preferred method of assessing international education credentials that are deemed to be not equivalent to Canadian standards. This could include consideration of the following, for example:
 - how to minimize the differential impact and unintended consequences that result from requiring only internationally educated applicants to take the OSCE
 - whether there are alternative ways to assess the academic credentials of international applicants
- 3. 2016 Registration Practices Assessment (one recommendation):
 - Assessment of Qualifications
 - That the College work with the NNAS to clarify for applicants the purpose of collecting practice and employment information.

Appendix F: CNO Membership and Applicant Data

Table 2. CNO Membership Data Based on Jurisdiction where Members were Initially Trained in Nursing

Year	Ontario	Other Canadian	USA	Non-US IEN	Unknown	Philippines	Total	Percentage of Non-US IENs
2007	127,794	3,931	1,274	14,272	0	N/A	147,271	9.7%
2008	129,531	4,134	1,310	13,622	687	N/A	149,284	9.1%
2009	132,625	4,315	1,403	14,111	657	N/A	153,111	9.2%
2010	134,697	4,378	1,451	14,429	627	N/A	155,582	9.3%
2011	134,754	4,380	1,457	15,202	24	N/A	155,817	9.8%
2012	139,635	4,718	1,533	16,675	24	N/A	162,585	10.3%
2013	138,449	8,958	1,527	16,324	31	N/A	165,289	9.9%
2014	140,807	8,764	1,549	16,969	27	N/A	168,116	10.1%
2015	143,180	8,670	1,541	17,712	161	5,746	171,264	10.3%
2016	145,535	8,696	1,553	18,180	154	5,926	174,118	10.4%
2017	149,158	8,749	1,573	18,892	149	6,234	178,521	10.6%
2018	152,046	8,931	1,602	19,635	132	6,577	182,346	10.8%
2019	154,300	8,877	1,615	20,467	126	6,972	185,385	11.0%
2020	156,925	8,888	1,644	21,362	120	7,356	188,939	11.3%
2021	158,307	8,907	1,463	23,724	0	8,193	192,401	12.3%
2022	160,394	8,594	1,482	28,641	0	9,636	199,111	14.4%
2023	163,726	8,685	1,491	33,356	0	11,162	207,258	16.1%

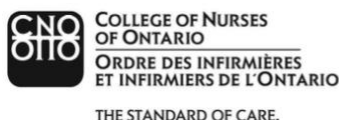
Data are from the CNO's Fair Registration Practice Reports (2007, 2008, 2009, 2010, 2011, 2012, 2013b, 2014, 2015, 2016a, 2017, 2018b, 2019b, 2020a, 2021, 2022, 2023a). Prior to 2015, data was not disaggregated by country of origin.

Table 3. CNO Applicant Data

Year	Domestic apps	Domestic became licensed	Non-US IEN apps	Non-US IENs became licensed	Total apps	Total became licensed
2005^a	5,617	5,711	1,351	1,144	7,013	6,944
2006^a	7,471	6,798	1,716	380	9,344	7,230
2007	9,469	8,468	2,114	541	11,754	9,104
2008	10,007	9,006	2896	674	13,154	9,808
2009	9,854	9,356	3303	739	13,412	10,253
2010	9,171	5,756	3,878	772	13,284	6,617
2011	11,112	7,643	4,870	1,012	16,214	8,777
2012	11,009	8,287	5,517	1,761	16,711	10,164
2013	8,341	6,868	4,123	742	12,634	7,685
2014	8,233	8,085	3,635	1,372	11,990	9,556
2015	9,139	7,675	1,115	1,569	10,333	9,312
2016	8,964	8,048	2,967	1,263	12,054	9,389
2017	9,624	8,734	3,758	1,335	13,528	10,164
2018	9,465	10,564	4,710	1,883	14,300	12,557
2019	10,490	8,735	4,556	1,958	15,192	10,783
2020	11,036	8,230	6,315	2,123	17,602	10,457
2021	9,705	7,604	7,110	2,394	17,464	12,449
2022	9,121	6,905	7,193	5,087	17,020	15,436
2023	10,357	9,437	10398	7,947	20,945	17,521

Data are from the OFC's 2007 Study of Registration Practices of the CNO,^a and the CNO's Fair Registration Practice Reports (2007, 2008, 2009, 2010, 2011, 2012, 2013b, 2014, 2015, 2016a, 2017, 2018b, 2019b, 2020a, 2021, 2022, 2023a).

Appendix G: Council Note Cited in the December 3, 2009, CNO Council Meeting



AGENDA ITEM 5.1

Date: November 13, 2009

To: Council

From: Erin Tilley, Policy Analyst

Subject: **Evidence of Practice**

ISSUE

How does the College of Nurses of Ontario (CNO) ensure that nurses are safe to practice?

ACTION

Support in principle.

RECOMMENDATION

That Council support the following:

1. That revisions be made to regulation 275/94 under the *Nursing Act, 1991* to amend evidence of practice requirements to “during the past three years”¹.
2. That revisions be made to regulation 275/94 under the *Nursing Act, 1991* to add a provision requiring members to have practised within the past three years to maintain registration as a practising member (i.e., a condition to maintain a general certificate of registration)².

PUBLIC INTEREST RATIONALE

Healthcare is changing at a rapid pace. New technologies are emerging, best practices are changing, scopes of practice are evolving and interprofessional care is becoming more prominent. In this challenging and dynamic healthcare environment, the College has a duty to protect the public by setting appropriate entry-to-practice and continuing competency requirements.

¹ The three year requirement would be applied consistently for all evidence of practice requirements related to registration and reinstatement, regardless of category or class.

² This requirement would be linked to the proposed non-practising class (discussed at March 2009 Council). Members who are unable to meet the ongoing practice requirement will be able to move to the non-practising class.

BACKGROUND

Definitions

Evidence of nursing practice: evidence that an individual is applying nursing knowledge, skill and judgment, and has a direct or indirect effect on the recipients of healthcare service in Ontarioⁱ.

Evidence of nurse practitioner (NP) practice: evidence that an individual is using advanced knowledge and decision-making skills in assessment, diagnosis and healthcare managementⁱⁱ.

Legislative Framework

Summary of Regulation 275/94 under the Nursing Act, 1991

For a general certificate of registration, a registered nurse (RN) or registered practical nurse (RPN) must have evidence of safe practice within the past five years.

For an extended certificate of registration, an applicant must have practised for at least two years in the last five years including at least one of those years practising in a nursing role that required him or her to use advanced knowledge and decision-making skills in assessment, diagnosis and healthcare management.

A former member applying for reinstatement must have evidence of safe practice within the past five years.

Summary of Changes to Agreement on Internal Trade, 1995

Amendments to Chapter Seven, the Labour Mobility chapter, of the *Agreement on Internal Trade (AIT)*, 1995, took effect April 1, 2009. The amendments reinforce Canada's commitment to unimpeded labour mobility across the country. "The goal is that a worker qualified and certified for an occupation in one province/territory is recognized as qualified and certified to practice anywhere in Canada without additional material training, experience, examinations or assessments"ⁱⁱⁱ. The underlying philosophy of the AIT is standardization of occupational standards across Canada.

Ontario has received direction from the Ministry of Training, Colleges and Universities (MTCU) that regulatory bodies cannot require AIT applicants to meet a "currency" standard³. For example, CNO cannot require an RN applicant to have completed 1,125 hours in the last five years. Therefore, in accordance with our current regulations, for applicants coming from another Canadian jurisdiction, CNO must accept any amount of

³ Page 10 of MTCU's Guide to the AIT ("active practice") states: "Additional requirements can be imposed on individuals who have not practiced in a specific period of time and who apply to be certified in Ontario. Where a person has not practiced within a specific time period, regulatory authorities can impose additional training, experience, examinations or assessments as a condition of certification. This allows regulatory authorities to ask whether a worker has practiced at all in the last XX years, and if they have not, require them to undergo additional training, experience, examinations or assessments. However, regulatory authorities are not allowed to require workers to meet a "currency" standard (e.g. practice 1500 hours in the last five years) as a condition of certification."

practice within the last five years. However, CNO's current five years requirement may not be sufficient to ensure applicants are safe to practise.

Summary of the Fair Access to Regulated Professions Act, 2006

"The purpose of this Act is to help ensure that regulated professions and individuals applying for registration by regulated professions are governed by registration practices that are transparent, objective, impartial and fair"^{iv}. In other words, there is an expectation that CNO's registration requirements are "transparent, objective, impartial and fair" for *all* applicants.

Summary of the Nursing Jurisdictional Review

The proposed three year requirement for entry-to-practice is consistent with some nursing regulatory bodies and inconsistent with others⁴. Requirements vary nationally and internationally. Specifically, NP applicants in eight Canadian jurisdictions are required to have practised within the previous three years. Similarly, applicants in the UK and New Zealand are required to provide evidence of nursing practice within the past three years. However, licensed practical nurses (LPNs), RNs and NPs in three jurisdictions across Canada are required to demonstrate that they have maintained practice either within a two, four or five year period.

Requirements also vary nationally and internationally in relation to ongoing competency requirements⁵. NPs in eight Canadian jurisdictions are required to have practised within the previous three years. Likewise, nurses practicing in the UK, New Zealand and Australia are required to maintain practice in the last three years. Conversely, LPNs, RNs and NPs in three jurisdictions across Canada are required to demonstrate practice either every two, four or five years.

Summary of the Ontario Regulatory Body Review

Upon initial registration, the majority of Ontario regulatory bodies require their applicants to demonstrate practice within the last three years⁶. Similarly, the majority of Ontario regulatory bodies require their members to demonstrate practice within the last three years to demonstrate ongoing competency⁷.

Literature Review

Knowledge fades without practice^v and decreases over time with non-use^{vi}. In fact, knowledge retention generally falls by 75-89% of its original level in a very short period of time^{vii}. One study suggests that knowledge retention falls 85% after four months, another suggests 80% after 11 months, and a third study suggests 75% after 24 months^{viii}. Additionally, a number of studies suggest that humans lose knowledge quickly when knowledge gained is not utilized. Jarrell and colleagues (2009) reported that individuals

⁴ Requirements in the US varies – some have a three year requirement.

⁵ Requirements in the US varies – some have a three year requirement.

⁶ Nine Ontario regulatory bodies require practice either within two or five years. Eleven Ontario regulatory bodies require applicants to have practised within the last three years.

⁷ Three Ontario regulatory bodies require practice in either the previous two or five years. Four Ontario regulatory bodies require practice in the previous three years.

who used the knowledge they learned at a training session scored higher on a test compared with those who had not used the newly gained knowledge^{ix,8}. Similarly, a study by Madden (2006) demonstrates that participants' CPR knowledge retention decreased 10 weeks following the training^x. Also, McKenna and Glendon (1985, as cited in Jaber & Kher, 2004) found that a break of six months resulted in a 60% decay in performance and a total loss of learning after three years^{xi}.

A number of factors impact knowledge retention including experience and practice setting⁹. Farr (1987) determined that the amount of knowledge decay is based on a number of characteristics (e.g., degree of mastery)^{xii}. Jaber and Kher (2004) found that theories related to the loss of knowledge suggest that there are two factors that frequently impact the loss of knowledge: the amount of experience gained prior to the interruption of the learning process and the length of the interruption interval^{xiii}.

The literature suggests a range of time periods when continuing competency should be measured. Whelan (2006) suggested that validation of competency should be annual^{xiv}. The US Federal Aviation Administration (2006) suggests that after 24 months, no person may act as pilot in command of an aircraft unless that person has accomplished a satisfactorily flight review^{xv}. Landry and colleagues (2006) stated that the assessment should be conducted a minimum of once every three years^{xvi}. The Canadian Nurse Practitioner Initiative (2006) determined that competency should be assessed every two to five years^{xvii}. Finocchio and colleagues (1998) suggested that the period of time to assess continuing competency should not exceed seven years^{xviii}.

NEXT STEPS

- Have legal counsel draft corresponding regulations (by September 2010)¹⁰.
- Develop a comprehensive communication strategy for members and stakeholders.
- Once the revised registration regulations are passed, implement new registration policies that reflect the amended regulations.

Staff Resource:

Erin Tilley, Policy Analyst

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⁸ The test was administered four months after the training was complete.

⁹ A study conducted by Smith (2003) suggested that experience was the primary factor that contributed to the ability to practice, followed by initial professional education [Smith, J. (2003). *Report of Findings: Exploring the Value of Continuing Education Mandates*. Retrieved March 9, 2009 from https://www.ncsbn.org/RB6_CE_ESforWeb.pdf]

¹⁰ Proposed changes to the registration regulation are expected to be presented at September 2010 Council, after which they will be circulated to the membership for feedback. Council will consider the feedback at the December 2010 meeting, and the proposed regulatory amendments will be forwarded to the Ministry of Health and Long-Term Care.

END NOTES

- ⁱ College of Nurses of Ontario. (2009). *Am I Practising Nursing?* Retrieved October 27, 2009, from http://www.cno.org/docs/general/44007_fsAmipractising.pdf
- ⁱⁱ Government of Ontario. (2008). *O. Reg. 275/94*. Retrieved October 27, 2009, from http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_940275_e.htm
- ⁱⁱⁱ Ministry of Training, Colleges and Universities. (2008). *Guide to the AIT*.
- ^{iv} Government of Ontario. (2006). *Fair Access to Regulated Professions Act, 2006*. Retrieved October 27, 2009, from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06f31_e.htm
- ^v Philipsen, N., Lamm, N., & Reier, S. (2007). Continuing competency for nursing licensure. *The Journal for Nurse Practitioners*, 3(1), 41-45.
- ^{vi} Farr, M.J. (1987). *The Long-Term Retention of Knowledge and Skills*. New York: Springer-Verlag.
- ^{vii} Bruno, P., Ongaro, A., & Fraser, I. (2007). Long-term retention of material taught and examined in chiropractic curricula: its relevance to education and clinical practice. *Journal of the Canadian Chiropractic Association*, 51(1), 14-18.
- ^{viii} Bruno, P., Ongaro, A., & Fraser, I. (2007). Long-term retention of material taught and examined in chiropractic curricula: its relevance to education and clinical practice. *Journal of the Canadian Chiropractic Association*, 51(1), 14-18.
- ^{ix} Jarrell, J.L., O'Neill, D.G., & Hasse, L.A. (2009). A clinical research efficacy study with a comparison of subjects who did not use learning within 4 months of training. *Journal of Clinical Health & Safety*, 16(2), 5-11.
- ^x Madden, C. (2006). Undergraduate nursing students' acquisition and retention of CPR knowledge and skills. *Nursing Education Today*, 26, 218-227.
- ^{xi} Jaber, M.Y. & Kher, H.V. (2004). Variant versus invariant time to forgetting: the learn – forget curve model revisited. *Computer & Industrial Engineering*, 46, 697-705.
- ^{xii} Farr, M.J. (1987). *The Long-Term Retention of Knowledge and Skills*. New York: Springer-Verlag.
- ^{xiii} Jaber, M.Y. & Kher, H.V. (2004). Variant versus invariant time to forgetting: the learn – forget curve model revisited. *Computer & Industrial Engineering*, 46, 697-705.
- ^{xiv} Whelan, L. (2006). Competency assessment of nursing staff. *Orthopaedic Nursing*, 25(3), 198-202.
- ^{xv} Federal Aviation Administration. (2006). *Conducting an Effective Flight Review*. Retrieved April 23, 2009, from http://www.faa.gov/pilots/training/media/flight_review.pdf
- ^{xvi} Landry M., Oberleitner, M.G., Landry H., & Borazjani, J.G. (2006). Education and practice collaboration. *Journal for Nurses in Staff Development*, 22(4), 163-169.
- ^{xvii} Canadian Nurse Practitioner Initiative. (2006). *The Competency Assessment Framework for Nurse Practitioners in Canada*. Retrieved February 25, 2009, from http://206.191.29.104/documents/pdf/tech-report/section1/07_Report_Tool2.pdf
- ^{xviii} Finocchio LJ, Dower CM, Blick NT, Gragnola CM and the Taskforce on Health Care Workforce Regulation. *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*. San Francisco, CA: Pew Health Professions Commission. October 1998. Retrieved February 25, 2009, from http://74.125.95.132/search?q=cache:RqIW4lnq2egJ:www.futurehealth.ucsf.edu/pdf_files/RTF.PDF+Strengthening+Consumer+Protection:+Priorities+for+Health+Care+Workforce+Regulation&hl=en&ct=clnk&cd=1&gl=ca

Appendix H: Letter Submitted March 26, 2021, to CNO Council by IENs

March 26, 2021

The College of Nurses Ontario
101 Davenport Road Toronto, ON Canada M5R 3P1

Dear CNO,

Warm Greetings to all Esteemed Members of the Council!

It is indeed a welcome development to have received your decision on March 4, 2021 amending the approval process for evaluating Internationally Educated Nurses (IEN's) applicants for RN registration with the college. This is specific to considering the successful completion of the NCLEX-RN exams as an alternate process of recognizing demonstrated satisfactory evidence of entry level nursing knowledge, skill, and judgement for those otherwise evaluated by the NNAS as not meeting the above. We however would like to take issue on the caveat of only considering the NCLEX-RN exams taken on or after 01 January 2015.

As an informal collective, we as a group have come together to forward your attention to what we feel is a deleterious situation that is brought about by the council's decision to exclude us, successful NCLEX-RN passers prior to the set intake date of 01 January 2015. Please accept this letter as formal appeal on the decision.

To substantiate our request for an appeal, we want to point out the survey conducted by the CNO in collaboration with the National Council of State Boards of Nursing (NCSBN) in 2009. The study identified 142 entry-level RN nursing activities validated by the 2008 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice. The result strongly suggests similarities between nursing practice in the US and Ontario (*NCSBN - Report of Findings from the Comparison of Entry-level Registered Nurses in the U.S. and Ontario, 2010*). Concomitantly, a similar study was also initiated by the College of Registered Nurses of British Columbia (CRNBC) with the NCSBN utilizing the same variables. The survey determined the similarity between the entry level nursing practice

in British Columbia and United States (*NCSBN - Report of Findings from the Comparison of Entry-level Registered Nurses in the U.S. and British Columbia, Canada, 2010*).

The 2008 RN Practice Analysis which is heavily utilized in both surveys in Ontario and British Columbia was launched to develop a framework for entry-level nursing practice and processes fundamental to the nursing practice for the 2010 NCLEX – RN Test Plan (*Wendt, Kenny, & Schultz. NCSBN, 2010*). The findings in both surveys significantly proved the validity of the 2010 NCLEX – RN examination to be congruent with Ontario’s nursing standards. Thus, it is reasonable to conclude that the NCLEX – RN passers using the 2010 test plan meets Ontario’s required nursing competencies.

Further investigation between the nursing practice in Ontario and US explored the 145 RN competencies identified by the CNO and compared it to the 2008 RN Practice survey, 2008 Knowledge of Newly Licensed Registered Nurses Survey and the NCLEX–RN integrated Process in the 2010 test plan; this revealed a well-defined pattern described as 98.54% correlation. These results led to a conclusion that the NCLEX-RN can be used as a fair, valid, and psychometrically sound tool to measure the competency of entry-level nurses seeking licensure in Canada (*CCRNr - NCLEX Frequently Asked Questions for Canadian Educators & Students, 2013*).

The recognition of the the 2008 RN Practice Analysis and 2010 NCLEX–RN Test Plan in the decision to adapt the NCLEX–RN implies that earlier versions of the examination is congruent with the competencies required to meet the Canada’s standard of entry level nursing practice.

A further scrutiny of the NCLEX–RN test plan content distribution corroborate that the 2013, 2016, and 2019 are identical. When compared to the 2010 content distribution, a difference of 1 percent can be noted both on safety & infection control and management of care subcategory. The 2007 and 2004 content distribution also reflect these at 4 percent and 1 percent, respectively (*NCSBN NCLEX – RN Test Plan, 2004 – 2019*). The NCLEX–RN test plan content distribution from 2004 to 2019 further shows congruence in all areas of client needs with minor percentage

discrepancies. These discrepancies however maybe fulfilled by the individual applicant's nursing curriculum.

It is therefore our fervent prayer that the above justification would warrant the council to re-evaluate the decision to exclude us. We believe the reliability of the NCLEX–RN examination preceding 2015 cannot be dismissed. We do feel this is an inequitable exclusion of a group of professionals seeking acceptance into the college.

We believe the college is fully aware and sympathetic of all the enormous challenges IEN's face in pursuit of Canadian Nursing Registration. This is aggravated by the fact that we are excluded from this new policy is disheartening and we feel disenfranchised.

Consequently, we are also prohibited to re-take the NCLEX– RN and this puts us on a disadvantageous position compared to those who have not passed the NCLEX-RN. We are trapped in this predicament.

Once again, we would like to commend the council for considering the NCLEX–RN examination as an aid to meet educational requirements of IEN's. It is our hope though that this esteemed council re-consider our plight.

We are tremendously eager to be part of our health care system, especially in this trying times!

Yours in respect.

References:

National Council of State Boards of Nursing (NCSBN). [2010]. Citation: Report of Findings from the Comparison of Entry-level Registered Nurses in the U.S. and Ontario, Canada, 47, 2-3. Retrieved from: https://www.ncsbn.org/10_Ontario_Vol47_web.pdf.

National Council of State Boards of Nursing (NCSBN). [2010]. Citation: Report of Findings from the Comparison of Entry-level Registered Nurses in the U.S. and British Columbia, Canada, 48, 2-3. Retrieved from: https://www.ncsbn.org/10_BC_Vol48_web.pdf.

Wendt, A., Kenny, L., Schultz, L., [2010]. Citation: 2010 NCLEX-RN® Detailed Test Plan. 2.

Canadian Council of Registered Nurse Regulators (CCRNr). [2013]. Citation: NCLEX Frequently Asked Questions for Canadian Educators & Students, 5-6. Retrieved from: https://www.ccrnm.mb.ca/uploads/ck/files/NCLEXRN_FAQs_For_Canadians_August_2013.pdf.

National Council of State Boards of Nursing (NCSBN). [2005]. Citation: 2005 NCLEX Examination Candidate Bulletin, 14.

National Council of State Boards of Nursing (NCSBN). [2007]. Citation: NCLEX – RN Test Plan, 3.

National Council of State Boards of Nursing (NCSBN). [2010]. Citation: NCLEX – RN Test Plan, 3.

National Council of State Boards of Nursing (NCSBN). [2013]. Citation: NCLEX – RN Test Plan, 5. Retrieved from: https://www.ncsbn.org/2013_NCLEX_RN_Test_Plan.pdf.

National Council of State Boards of Nursing (NCSBN). [2016]. Citation: NCLEX – RN Test Plan, 5. Retrieved from: https://www.ncsbn.org/RN_Test_Plan_2016_Final.pdf.

National Council of State Boards of Nursing (NCSBN). [2019]. Citation: NCLEX – RN Test Plan, 11. Retrieved from: https://www.ncsbn.org/2019_RN_TestPlan-English.pdf.

Appendix I: SPEP Job Postings Examples

indeed [Home](#) [Company reviews](#) [Salary guide](#)

What Job title, keywords, or company **Where** ontario

Supervised Practice (Speg) Program - Part Time Temporary
 Markham Stouffville Hospital Corporation [📍](#) • 3.8 ★
 381 Church St, Markham, ON
 \$19.81 an hour - Temporary, Part-time
 You must create an Indeed account before continuing to the company website to apply

[Apply now](#) [🔖](#)

Job details
 Here's how the job details align with your profile [🔗](#).

Pay
 \$19.81 an hour

Job type
 Temporary Part-time

Shift and schedule
 Holidays

Location
 381 Church St, Markham, ON

Screenshot taken on October 2024 from Indeed.com

SimplyHired.



**Internationally Educated Nursing Intern
SPEP**

Unity Health Toronto - 4.0 ★
 Toronto, ON

[🔄](#) [Apply Now](#)

Job details
 Temporary | Full-time \$ \$25-\$30 an hour

Qualifications
 BLS Certification Communication skills Time management

Full job description
 The IEN Intern plays a key role in delivering on Unity Health Toronto (UHT)'s mission, vision & values and in advancing UHT's Professional Practice strategic directions.

Screenshot taken on October 2024 from SimplyHired.ca

SimplyHired.

Job Title, Skills or Company
unity health ontario RN

City, Province/Territory, Postal Code

Sort by

Relevance

Date

Distance

25 kilometers

Job Type

All Job Types

Minimum Salary

All salaries

Registered Nurse, Surgical Daycare Unit

Unity Health Toronto — Toronto, ON 4 ★

Provides health education to patients and their families using effective teaching strategies. Supports and participates in evidence based practice...

\$39.07–\$56.00 an hour

1d

Registered Nurse Trauma&Neurosurgery ICU

Unity Health Toronto — Toronto, ON 4 ★

Provides health education to patients and their families using effective teaching strategies. Supports and participates in evidence based practice...

\$39.07–\$56.00 an hour

1d

Registered Nurse, Preadmission Facility

Unity Health Toronto — Toronto, ON 4 ★

Perianesthesia nursing certificate or perianesthesia course an asset. Provides health education to patients and their families using effective teaching...

\$39.07–\$56.00 an hour

1d

RPN ENT Clinic

Unity Health Toronto — Toronto, ON 4 ★

Aligns behavior with Unity Health Toronto's vision, mission and values and code of conduct; promotes nursing as a knowledge-based profession; and, supports the...

\$34.82–\$38.16 an hour

1d

Screenshot taken on October 2024 from SimplyHired.ca