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The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia

Lesleyanne Hawthorne
Department of Psychiatry, The University of Melbourne, Melbourne, Victoria, Australia

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The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia
Recent decades have coincided with the rapid globalisation of the nursing profession. Within Australia there has been rising dependence on overseas qualified nurses (OQNs) to compensate for chronic nurse shortages related to the continued exodus of Australian nurses overseas and to emerging opportunities in other professions. Between 1983/4 and 1994/5, 30 544 OQNs entered Australia on either a permanent or temporary basis, counter-balancing the departure overseas of 23 613 locally trained and 6519 migrant nurses (producing a net gain of just 412 nurses in all). The period 1995/6–1999/2000 saw an additional 11 757 permanent or long-term OQN arrivals, with nursing currently ranked third target profession in Australia's skill migration program, in the context of continuing attrition among local nurses. This pattern of reliance on OQNs is a phenomenon simultaneously occurring in the UK, the US, Canada and the Middle East — the globalisation of nursing reflecting not merely Western demand but the growing agency and participation of women in skilled migration, their desire for improved quality of life, enhanced professional opportunity and remuneration, family reunion and adventure.

Throughout the period 1995/6 to 1999/2000 sustained migration of overseas qualified nurses (OQNs) has resulted in a dramatic ethnic diversification of the Australian nursing profession, with unprecedented numbers of arrivals from non-English speaking background source countries (NESB) — particularly Asia — alongside continued substantial intakes from English-speaking background (ESB) source countries such as the UK, Ireland and New Zealand. In consequence of this diversification, the Australian profession and individual OQNs have been obliged to grapple with major labour market adjustment issues: ESB nurses passing seamlessly into employment, in marked contrast with NESB nurses who frequently have to overcome three major hurdles: mandatory English language testing, qualifications accreditation, and access to full mobility within employment. This paper analyses each of these barriers in turn, exploring their impact together with the introduction by the Australian Nursing Council Incorporated (ANCI) of competency-based assessment of OQN skills. Four major databases are utilised for this purpose: a detailed study of 719 OQNs, 1991 and 1996 Census nursing employment data, Department of Immigration and Multicultural Affairs statistics, and pre-migration and postarrival OQN qualifications assessment outcomes provided by the ANCI together with a range of state bodies.

Correspondence: Lesleyanne Hawthorne, Department of Psychiatry, The University of Melbourne, Victoria 3010, Australia.
E-mail: <lhawt@unimelb.edu.au>

GLOBAL MOBILITY IN NURSING

Nurses exemplify the rising participation of women in skilled migration. According to Lee (1996), until the 1980s the 'role of women in international migration was largely unrecognised ... [Their] economic and social contributions were considered trivial or nonexistent because when women migrated, they were routinely viewed as dependents of male migrants or as passive participants in migration' (6–7). In the view of Fincher and colleagues, there was a 'taken-for-granted view that women are the appendages of either protective males or the patriarchal state' (Fincher et al. 1994, 150).

In recent years, contesting this view, a range of analysts have demanded a proper respect for and attention to the status of women within global labour movements (e.g. Hartman and Hartman 1983; Zlotnik 1995; Hawthorne 1996; Yeoh and Khoo 1998). Historically significant shifts have been underway since the 1970s — a result of women's increasing capacity to access education, employment, and contraception. In 1976 fewer than 15% of the 146 400 Asian workers who left their countries to work overseas were female. By the early 1990s however, the 'feminisation' of Asian labour movements was pronounced, with the majority of Asian temporary migrants female — particularly those from the Philippines, Indonesia, Sri Lanka and Thailand (Hugo 1990; Stahl and Appleyard 1992; Lim and Oishi 1996). An increasing proportion of women have sought employment throughout Asia, the Middle East, and a select range of Western countries as 'nurses, doctors, teachers and secretaries — the feminized occupations' — despite the persistent image of women as unskilled workers or 'trailing spouses' (Lim and Oishi 1996, 26; Yeoh and Khoo 1998, 159).

While Filipino nurses will be examined briefly first below, it is essential to note that nurses have reached Australia and comparable countries from a wide range of regions. Substantial numbers have moved from Eastern to Western Europe and then beyond — part of the more than 1.3 million people by the late 1980s quitting the COMECON bloc in search of political freedom and economic opportunity (Grecic 1991, 245). This East–West population movement accelerated in the 1990s, with the outbreak of war in the Balkans and consequent large-scale refugee movements. Within the European Community (EC), nurse mobility has also risen over the past decades (Seccombe et al. 1993; Buchan and O'May 1999; Buchan 2001a,b) — part of a trend to increased geographical mobility among professionals, compared to declining mobility among minimally skilled workers. In the EC these trends for nurses have been facilitated by the fact that formal barriers in the way of qualifications recognition and issue of work permits have been progressively dismantled, with proof of good character, certification of mental and physical health, and verification of professional registration the prime determinants for accessing European employment.[1]

Throughout the 1980s there was also a rising outflow of nurses from the UK — not merely to Europe, but to Australia (the primary destination), followed by Canada, the US and the Middle East. In 1992 a national survey of nurses showed 10% had been employed outside Britain (Seccombe et al. 1993) — many no doubt originally trained in Commonwealth countries (Buchan and O'May 1999; Buchan 2001a,b).

FILIPINO NURSES: A CASE STUDY IN GLOBAL MOBILITY

Perhaps nowhere have female workers been more actively sought than in the Philippines, where by 1996 some 700 labour recruitment agencies were operating (Ortin 1994; Lim and Oishi 1996). To seize the available international opportunities, skilled Filipinas have frequently taken low-skilled work, e.g. as maids in Singapore and Hong Kong (Zlotnik 1995). By 1987 some 83% of Asia-bound Filipino workers were female,[2] contributing to the US$800+ million returned in remittances per year, on which the Filipino economy had become highly dependent (Lindquist 1993). Permanent migration frequently followed temporary worker flows — particularly for women with good education. As Stahl and Appleyard state, the increased mobility of many Asian workers 'has been enhanced by the internationalization of education systems through which the more highly educated in Third World countries are acquiring qualifications which facilitate their entry into what is becoming a global labor market for the highly skilled' (Stahl and Appleyard 1992, 471).

While many Asian nations are keen to export skilled females,[3] within the Philippines the production of nurses has deliberately been geared to the export industry. The country has long exported female labour — with women by 1987 constituting some 83% of all Asia-bound Filipino migrants (Stahl and Appleyard 1992, 449). According to De Perelta (1994) and Teschendorff (1993), the Filipino education system is dictated by market forces in other countries, with the most sought-after courses corresponding to demand in the US and the Middle East. Between 1986 and 1990 2.3 million local jobs were created in the Philippines, in a period when 3.5 million Filipinos entered the workforce, and local salaries continued to deteriorate. In 1986, at

[1] *The Treaty of Rome specifically precludes discrimination in the EC on the basis of language.*

[2] *By 1989 Filipino remittances amounted to $973 million, or 12.5% of Filipino 'merchandise exports' (Stahl and Appleyard 1992, 452).*

[3] *In August 1997, in the course of interviewing a wide range of senior bureaucrats in the Ministry of Health in Jakarta, the researcher was informed a primary government aim was to produce highly skilled nurses to work overseas (e.g. in the Muslim countries of the Middle East), rather than to upgrade health service provision in Indonesia. The goal in this was clearly to secure remittance flows, as achieved by the Philippines.*

a time of recession, 277 000 college graduates were unemployed, alongside 284 000 with some college education (Abella 1993). In 1990 alone, some 700 000 Filipinos left to work overseas as documented workers, 'to join the stock of an estimated 5.7 million Filipinos in some 160 countries' (Asis 1995, 328).

Paredes (1990) provides a detailed gendered analysis of Filipino emigration, including the prominent representation within it of nurses. By 1991/2 some 152 741 students were enrolled in Filipino nursing schools (the second most popular field after engineering). The consequence of this was a country reportedly 'awash with unemployed and underemployed nurses waiting for a ticket abroad', given paid positions were almost impossible to find for those lacking contacts, or trained in the less prestigious institutions (De Perelta 1994, 79). Many of these nurses would depart for Western immigrant-receiving nations — among the 522 105 Filipinos leaving for the US, 72 178 for Canada and 54 141 for Australia between 1975 and 1989 (Paredes 1990).

Between 1985 and 1987 alone, 65 940 Filipino nurses were employed overseas — a conservative estimate, since this excluded nurses leaving the Philippines under family preference, business and other emigration categories. For those in employment the goal was improved work conditions and rewards, compared to chronic overwork, poor security in remote hardship posts, and lack of opportunity for growth and development. This process was facilitated by the nation's labour export policy, the aggressive recruitment strategies of labour agencies, and 'the Western orientation of nursing education which makes Filipino graduates marketable to foreign countries' (Ortin 1994, 126). So great was this nurse exodus that by 1989 some 11% of Filipino hospital and public health positions were vacant, with the quality of nurse education compromised by the number of nurse academics and deans leaving. According to Ortin, by 1994 there were severe consequences for the quality of health service provision in the Philippines:

> Despite the lack of qualified nursing deans and faculties, more nursing colleges are opening due to increased demand. Nursing schools have become such a lucrative business that politicians, businessmen and even parents pressured the Department of Education, Culture and Sports to lift the moratorium on opening new schools of nursing. Thus, the conditions prevailing in nursing schools remain deplorable. In 1988, about half of the schools did not meet the standards set by DECS. Students graduate with little clinical exposure or experience (Ortin 1994, 127).

Comparable trends related to Filipino nurses and migration were evident in the US, UK and Canada (Buchan and O'May 1999; Butler 2000; Buchan 2001a,b). By 1994, for instance, Filipino nurses were 'the most highly visible foreign-trained nurses in the United States', with some 25 000 arriving on a permanent basis between 1966 and 1985, supplemented by a further 75% of all temporary registrant arrivals by the late 1980s. Such nurses were responding not merely to 'push' factors in country of origin, but to chronic Western nursing shortages driven by:

- growth in healthcare demand;
- the absence of economic incentives to attract and keep sufficient local nurses (an issue reflecting 'sex-based wage discrimination at the occupational level';
- ongoing depression of hospital-based terms and conditions (related to downsizing, mergers and the implementation of managed care systems); and
- chronic wastage rates in the profession (related to professional burnout, perceived powerlessness, and growing labour market choices for women).

AUSTRALIA'S RELIANCE ON MIGRANT NURSES

In Australia, this growing participation of nurses in skilled migration has had a profound impact on the profession, in a period characterised by the increasing feminisation of migrant intakes in key health professions (see Table 1; Hawthorne 1996). To date, however, the trend has received minimal research attention.

As Table 2 demonstrates, over past decades Australia has become increasingly reliant on migrant nurses to counterbalance the steady departure overseas of Australia-born nurses, on both a permanent and long-term basis — despite the nursing literature taking time to recognise this trend. In 1979, for instance, *Nursing personnel: A national survey* barely acknowledged the contribution of overseas qualified nurses (OQNs) — a lack of interest that seems startling now, given

Table 1 Medical, dental and nurse migrants to Australia by female gender 1982/3–1992/3

Year	Medical doctors and specialists (%)	Nurses and matrons (%)	Dentists and orthodontists (%)
1982/3	22	89	2
1984/5	27	92	4
1986/7	21	90	32
1988/9	27	88	24
1990/1	41	91	37
1992/3	41	94	51

Source: Hawthorne 1996, 45, Table 2.

Table 2 Permanent and long-term arrivals and departures of registered nurses, including matrons and directors of nursing (Australia): 1983/4–1994/5

Year	Arriving settlers	Short-long-term arrivals	Departing settlers	Permanent and long-term departures	Net nurse gain/loss
1983/4	484	465	453	1 653	−1157
1984/5	523	845	362	1 732	−726
1985/6	1 398	1 103	383	1 741	+377
1986/7	2 660	1 066	475	1 679	+1572
1987/8	2 636	1 040	453	1 841	+1382
1988/9	2 249	1 423	486	1 948	+1238
1989/90	1 910	2 154	666	2 248	+1150
1990/1	1 927	1 900	703	2 263	+861
1991/2	1 452	916	677	2 291	−600
1992/3	854	448	640	2 191	−1529
1993/4	790	526	654	2 032	−1370
1994/5	991	784	567	1 994	−786
Total	17 874	12 670	6519	23 613	+412

Source: 1983/4–1994/5 data derived from unpublished statistics provided by the Bureau of Immigration, Multicultural and Population Research (BIMPR).

some 11% of surveyed RNs had already gained their qualifications overseas (Committee on Nursing Personnel (CNP) 1979). This trend, moreover, was in the process of accelerating, with the arrival of 7018 permanent resident and 20 478. long-term temporary entrant nurses underway in the 1977–82 period.

By the time the *National nurse labour market study* was published 12 years later, Australia's indifference to overseas qualified nurses had begun to transform. In 1986 the regular exodus of local nurses had been exacerbated by the serious nurse shortages accompanying the transfer of New South Wales (NSW) nurse training from hospital to tertiary-based settings — a crisis immediately addressed through aggressive international government and institutional recruitment (Hawthorne 2000, 113). By 1991, moreover, major uncertainties were acknowledged to exist in relation to 'graduation rates, workforce participation rates and immigration rates'. While 'the outlook for the 1990s is for an underlying balance of supply and demand for nurses', this was perceived as something which could 'easily be upset' (Department of Employment, Education and Training 1991a, ix, 1991b).

CHANGING SOURCE COUNTRIES

Australia's reliance on OQNs was in fact rising at a time when their labour market absorption was becoming more problematic — a consequence of the growing proportion of NESB compared with English-speaking background (ESB) nurse arrivals, in line with trends evident in other key Australian professions (Hawthorne 1994, 1997a; see Table 3).

While the majority of OQNs reaching Australia continued to be from English-speaking background countries such as the UK/Ireland and New Zealand (around 65% of all permanent arrivals), *net* migration was increasingly favouring NESB nurses, much higher proportions of whom stayed (Toth 1995, 4; Hawthorne 2000). In 1987/8, at the height of the NSW nurse crisis, 543 Asia-born and 88 Europe-born nurses migrated to Australia, including 251 from Malaysia, 111 from Hong Kong, 58 from the Philippines and 30 from India/Sri Lanka.

By the time of the 1991 census, Australia possessed 260 203 nurses (not all in the workforce): 192 564 born in Australia and 67 639 overseas (26%) (Birrell and Hawthorne 1997, 19). Identical proportions of each group were degree and diploma-qualified (respectively 18 and 82%), and these nurses were becoming of increasing interest to Australian researchers (e.g. Iredale 1987; Pittman and Rogers 1990; D'Cruz and Tham 1991). A number of these researchers were now paying systematic attention not merely to Australia attracting OQNs but to more adequate utilisation of their skills (e.g. Iredale 1987) — a significant issue in terms of supply and demand, and arguably vital for a country deriving its patient base from more than 200 countries with multiple linguistic, cultural and religious affiliations (Kanitsaki 1983, 1988, 1992; Garrett and Lin 1990; Parsons 1990; McKay 1999). See Hawthorne et al. (2000) for a detailed separate

Table 3 Source of migrant nurses (excluding matrons) by region of origin by year 1982/3–1993/4

Year	UK/Ireland	Europe	Middle East	US/Canada	S and C America	Africa	Asia	NZ/Ocean	Other
82/3	246	29	3	39	1	44	227	125	6
83/4	191	17	4	19	3	25	112	110	3
84/5	197	23	9	29	5	17	77	164	2
85/6	764	57	11	46	10	49	231	229	1
86/7	1608	60	19	80	14	135	501	234	9
87/8	1460	88	19	90	12	142	543	276	6
88/9	1167	58	14	85	12	100	502	311	0
89/90	964	94	12	70	17	63	494	196	0
90/1	795	72	15	56	11	56	775	142	5
91/2	552	106	14	63	8	25	556	122	6
92/3	260	109	8	36	6	13	282	136	4
93/4	304	84	15	33	4	23	179	142	6
Total	8508	797	143	646	58	103	4479	2187	48
%	48	5	0.8	4	0.3	0.6	25	12	0.3

Source: Hawthorne 2000, 111.

analysis of the degree of Australian patient demand for bilingual bicultural nursing professionals.

The great majority of OQNs entered Australia as skilled migrants between 1982/3 and 1993/4 (73%), with significant numbers also coming via New Zealand visas (13%) or the family reunion program (12%). In line with Australia's overall population trends, such nurse arrivals would be extremely unevenly dispersed: 38% and 26%, respectively, locating in New South Wales and Victoria, compared to 18% in Western Australia, 11% in Queensland and a mere 4% in South Australia (Hawthorne 2000, 112). This dispersal would have significant ramifications for OQNs' access to professional accreditation — strong support programs developing in both NSW and Victoria, compared to minimal and/or sporadic specialist assistance in the 'smaller' immigration states.

THE LABOUR MARKET INTEGRATION OF MIGRANT NURSES IN AUSTRALIA

According to the *National nurse labour market survey*, by 1991 a mere 600 OQNs in Australia 'have not been registered or enrolled because of language difficulties or because their qualification is not recognised' (Department of Employment, Education and Training 1991a, 6). Addressing such trends, the report stated that 'nothing is known as to how far [many nurses'] qualifications fall short of the registrable standard' (DEET 1991a, 6). The study defined a need for state registration boards to analyse outcomes by country of origin, to identify groups at particular risk of unemployment. Bridging programs were seen as the key to skills' recognition, particularly for OQNs whose qualifications 'fall only a little way short of Australian registration standards' (DEET 1991a, 24). Nurses with more 'deficient' qualifications, by contrast, were viewed as requiring 'credits ... awarded towards an Australian qualification' (DEET 1991a, 24).

Regrettably, the *National nurse labour market study* seriously underestimated the scale of OQNs' labour market integration problem. Birrell and Hawthorne's subsequent analysis of 1991 census data demonstrated 3% of all migrant nurses to be unemployed at this time, but with a further 28% not in the labour force (many presumably learning English), and 17% securing only subprofessional work (Birrell and Hawthorne 1997). Dramatic labour market exclusion rates were evident for recent NESB nurse arrivals (1986–91), large numbers of whom had already been resident 4 to 5 years. Of OQNs reaching Australia between 1986 and 1991, nursing employment rates for degree-holders ranged from a high of 69% (Malaysia), 62% (UK and Ireland) and 49% (New Zealand), to a low of nil per cent for nurses from Yugoslavia, Vietnam and Poland. (Employment outcomes for diploma-holders were similarly variable.) The great majority of nurses failing to secure professional work were categorised as 'unemployed' or 'not in the labour force' — in the case of Vietnamese diploma-qualified nurses, for instance, representing some 48% (unemployed) and 37% (not in labour force) of potential workers. This contrasted markedly with

the experience of recent Australian nursing graduates, of whom 78% with degrees and 71% with diplomas had been successful in gaining nursing work. Analysis of data for pre-1981 arrivals confirmed NESB OQNs could require a very substantial period of time to improve their English, pass the compulsory ESL test and secure qualifications' recognition — taking years to catch up to the relatively advantaged English-speaking background (ESB) and Commonwealth-Asian nurses (Birrell and Hawthorne 1997, 22–3).

Five years later, by the time of the 1996 census, identical differences in employment outcome by country of origin prevailed, including for OQNs established in Australia a minimum of 3–5 years prior to collection of data. Table 4 demonstrates the degree to which ESB nurses achieved high professional penetration, followed by mainly English-speaking background (MESB) nurses from Commonwealth countries, with nurses from NESB nations still lagging very seriously behind. Provision of accreditation bridging programs could be critical to this process. For example, in Western Australia the establishment of a bridging course in the late 1980s converted a failure rate of 74% for NESB nurses (averaged across 10 years) to a pass rate of 89%, based on a preliminary pilot project (Scott 1989; International Institute for Policy and Administrative Studies). This course however, was subsequently abolished.

Despite the recent period of qualifications recognition reform (Hawthorne 2000), this remains a significant labour force issue for Australia, in the context of the sustained global movement of nurses, and the comparative attractiveness to date of Australia. Indeed, following a slump in permanent and long-term migration during the early 1990s, nurse migration once again is steadily expanding: the latest Department of Immigration and Multicultural Affairs figures showing 11 757 new permanent and long-term nurse arrivals over the past 5 years (Department of Immigration and Multicultural Affairs; see Table 5). Their arrival represented a vital offset to the net 'brain-drain' still being experienced in nursing, with the latest figures confirming the departure of a further 2604 nurses from 1997/8 to 1999/2000 from Australia (Birrell et al. 2001, 18).

As indicated by the Western Australian example above, many NESB nurses relocating to Australia are in fact consigned to *subprofessional employment*, or temporary labour market withdrawal, often due to problems related to professional accreditation. The following comments highlight the difference in experience typically reported by ESB compared to select NESB nurses, derived from a recent detailed study of the labour market integration of 719 OQNs

Table 5 Permanent and long-term nurse arrivals (all registered categories) 1995/96–1999/2000

Year	Permanent nurse arrivals	Long-term nurse arrivals	Total nurse arrivals
1995/6	1064	1142	2 206
1996/7	881	1185	2 066
1997/8	933	1319	2 252
1998/9	1032	1461	2 493
1999/2000	1102	1638	2 740
Total	5012	6745	11 757

Source: Unpublished figures provided to the researcher by the Statistics Section, Department of Immigration & Multicultural Affairs (2001).

Table 4 Employment outcomes for overseas-qualified nurses (1991–93 arrivals) by degree by select country of origin — 1996 census

Country of birth	Nursing (%)	Other professions (%)	Administration (%)	Subprofessional (%)	Unemployed (%)	Not in labour force (%)	Number
ESB countries							
UK and Ireland	72	1	—	13	—	14	222
South Africa	83	—	—	—	—	17	18
MESB countries							
Hong Kong	57	8	—	8	3	23	107
India	62	15	—	8	—	15	39
NESB countries							
China	28	—	—	31	10	31	29
Philippines	37	2	—	33	4	26	289

Source: Birrell and Hawthorne 1999, Appendix, adapted from Table 3.

(Hawthorne 2000, 294–311). The first comes from a UK nurse:

> [Employment] all happened extremely quickly. We arrived here on the Sunday. On the Monday morning I rang ... a list of hospitals in Victoria ... I just happened to be the person who called [a local hospital] at the right moment ... so on the Tuesday morning I actually went for an interview with them and ended up working most of the day ... They took me on casual initially, but within a month I was offered a full time post ... I was asked to look after the midwifery department ... Whenever I've had interviews for work ... it's almost like senior managers in Australian hospitals snap up the English trained nurses — 'Oh she'll be good!' you know, because they know the background.

For NESB nurses this instancy of professional acceptance was rare. For most, the preliminary postarrival period was devoted to learning English and/or securing professional registration. For many, like the following Polish nurse, the professional transition was associated with doubt and penury:

> We arrived ... with the depression, that was the worst time, and we hear on the TV all the time they are closing [this and that], and suddenly my husband was feeling 'Oh my God, what's going on, we are going to have the unemployment benefit'. He said 'I don't want this money!', and he became so upset ... [Our relatives said] 'Don't be upset — half a year it will be everything OK, go and learn language'. All right. We learn this language. We start our education ... (Finding adequate rental accommodation was a terrible dilemma). I become very stressed, my husband too, we started fighting ... you fight all the time ... [Very] often I didn't move out of home without the dictionary ... and I was hopeless. There was some days when I was feeling very sad, you know, crying during the night and said 'Why I came?'. I don't know what they were saying on the TV, I don't know what the people talking to me on the street, but slowly, slowly, then you started picking up the language.

In the first 2 years following her arrival in Melbourne, this nurse and her family lived off unemployment benefits, while scraping together $700 for a car and reimbursing relatives for fares and removal expenses. Her first step to professional reintegration was cleaning a nursing home: de-skilled unappealing work, which nevertheless provided a degree of professional orientation. The next years were consumed by securing professional registration.

Many described the turmoil of their first labour market rejection, such as the following Filipino nurse who sought work at a Melbourne hospital:

> (The Director Nursing didn't state what was expected.) The first thing she did was (say) 'Look ... let's say you're in a situation where you're in the ward and then you answer the phone ... [she pretended to call]. You pick up the phone, and then write down what I tell you!' So that's what she did, first thing. So I was so scared ... and instead of writing down 'hypertension' I wrote down 'hypotension' ... and (later) she said 'Well, you're just above the pass mark', but she ... asked me (about) those mistakes I did (like) when do you say a patient (has) hyperglycaemic and hypoglycaemic ... signs and symptoms ... [I]t was a terrible interview, then she was saying, 'Look, can you come back in three months time ... because you have to acclimatise yourself!'

For a substantial number of NESB OQNs relocating to Australia the path to labour market integration takes years. The steps underlying the process are briefly defined in the section that follows, given the issues they pose for OQNs in the context of the growing global mobility of nurses.

LABOUR MARKET BARRIERS FOR NESB NURSES IN AUSTRALIA: KEY ISSUES

In 1996, when Research Manager (Social & Demographic Research) at the Bureau of Immigration, Multicultural and Population Research, the author and a colleague (Toth 1996) secured extensive data from 719 overseas qualified fully registered nurses who had settled in Australia between 1980 and 1996 (93% of them female). In terms of accessing these informants, significant administrative assistance was provided by the Nurses Board of Victoria and the Queensland Nursing Council, including (with the Australian Nursing Council Incorporated) provision of valuable feedback on the survey instrument design. The surveys were subsequently analysed in detail by the author as part of her doctoral thesis (Hawthorne 2000). To supplement this process, the author conducted extended individual interviews with 29 OQNs (supplemented by four Toth interviews), analysed 231 OQN interviews completed as part of the mandatory 1995 Occupational English Test for nurses, and interviewed 71 Australian and international key informants with expertise related to the migration, English language testing, qualifications assessment and employment of OQNs. A wide range of databases related to migrant nurses were also analysed (in select cases by Toth). As far as possible, ESB and NESB nurses were chosen for comparable demographic and professional characteristics, despite significant variations in level of English and the number of qualifications evident between select NESB groups (Hawthorne 2000, 145). The following summary of labour market barriers for NESB nurses in Australia is derived from the totality of these data (see Table 6).

Barrier 1: premigration qualifications screening

For many OQNs, qualifications' recognition presents an intractable barrier to employment. This issue is the subject of a forthcoming paper by the author, with only key issues highlighted here.

First, it is important to acknowledge the difficulty NESB nurses frequently encounter in gaining qualifications' recognition at the *point of entry* to Australia, at the time

Table 6 Demographic characteristics of ESB and NESB OQN survey respondents

Variable	All informants (%)	ESB nurse informants (%)	NESB nurse informants (%)
Proportion of respondents	100	48	52
Date of arrival			
1980–89	73	71	74
1990–96	27	29	26
Region of origin	100	UK/Ireland: 31	*Comm-Asia: 25
		NZ: 10	Non-Comm Asia: 10
		S Africa: 3	W Europe: 7
		US: 2	E Europe: 7
		Canada: 1	Middle East: 2
		Other: 1	Africa (Non-SA): 3
Visa category			
Aust/NZ	13	27	1
Independent	39	33	48
ENS	11	15	8
Spouse/fiance	15	10	19
Family reunion	7	3	11
Study	2	1	3
Working holiday-maker	6	10	2
Other (inc. Ref/SHP)	5	1	5
Principal applicant (PA)	Aust/NZ: 13	Aust/NZ: 26	Aust/NZ: 1
	Yes: 66	Yes: 60	Yes: 75
	No: 19	No: 14	No: 24
Gender	M: 7	M: 7	M: 8
	F: 93	F: 93	F: 92
Age			
Low-39	54	64	45
40–49	38	29	45
50-High	8	7	10
Marital status			
Never married	18	18	17
Married/de facto	75	74	76
Divorced/separated	7	7	7
Widowed	1	1	1
Children			
Yes	66	63	68
No	34	37	32
Current residential status			
Citizen	59	53	64
Permanent resident	37	40	35
Temporary/visitor	4	7	2
Location			
Capital city	77	6	986
Regional/rural	22	31	14

Table 6 *continued*

Variable	All informants (%)	ESB nurse informants (%)	NESB nurse informants (%)
First language	English: 76 Other: 24	English: 99 Other: 1	W Europe: 11 E Europe: 22 NC Asia: 23 C Asia: 35 Other: 10
Level of ESL premigration	Perfect/native speaker: 60 Very good: 22 Good: 12 Poor / none: 6	Native speakers: 99	Perfect: 26 Very good: 40 Good: 22 Poor / none: 11
Number of qualifications			
One	29	25	34
Two	34	39	29
Three–four	36	37	36

*All percentages in chart rounded to the nearest whole number. This process 'inflates' the percentage of NESB informants to 54%, where in practice it totals 52.2%.

where those defined as 'principal applicants' are required to submit their papers to the Australian Nursing Council Incorporated (ANCI) as part of skilled migration assessment. When Toth analysed Australian Nursing Assessment Council (ANAC) and ANCI assessments from 1988 / 9 to 1994 / 5 for the study, she discovered exceedingly low immediate recognition rates for NESB nurses, in marked contrast to the average of 97% awarded ESB nurses (Toth 1995).

While this issue had been explored in detail in a range of reports in terms of the medical profession (e.g. Kunz 1975, 1988; CIROQ 1983; Iredale 1987; Human Rights and Equal Opportunity Commission 1992, 1995; Ethnic Affairs Commission of New South Wales 1998), few studies to date had examined ESB/NESB comparative outcomes in relation to nursing (Iredale 1987; Hawthorne 2000). Indeed, Toth's analysis demonstrated that ANAC/ANCI premigration qualifications assessments had become *harsher* rather than more lenient in the previous decade: plunging from an average of 48% recognition for NESB nurses in 1982 / 3 to an average of 29% between 1988/9 and 1994/5 — an exceptionally low recognition rate for a theoretically 'liberal' regulated profession. This contrasted to an Australian average of 50% qualification recognition rates for NESB migrants across all professions by 1988, compared with 90% recognition for ESB qualifications — a differential outcome identified by decades of researchers as a national scandal (see e.g. CIROQ 1983; Iredale 1987; Committee to Advise on Australia's Immigration Policy 1988; NSW CIROQ 1989).

These exceedingly low assessment rates in nursing did not appear to reflect more 'questionable' sources of nurse migration (e.g. from the Philippines) (Teschendorff 1993, 1994). West German nurses, for example, secured extremely low recognition rates — despite the calibre of their health system and their immediate entitlement to work in UK nursing settings on the basis of European Union membership (Seccombe et al. 1993). From 1988/9 to 1994/5, no nurses from the former Yugoslavia, 3% from Poland, 4% from Fiji, 10% from West Germany and India, 15% from the Philippines, 25% from Malaysia, 31% from Singapore, 40% from Denmark and 53% from Hong Kong were awarded full premigration recognition. When ANCI staff members were at last resourced to research nurse qualifications in Hong Kong and Scandinavia in the mid 1990s, this led to an immediate recommendation to council for extension of recognition to nurses from these countries. By definition, a number of NESB nurses had thus received inferior outcomes in the past — *not* because of the inadequacy of their training, but due to lack of Australian research on the actual calibre of their courses. (It is important to note in relation to this that a range of regional mutual recognition initiatives are currently underway (Raven 2000).)

Barrier 2: English language testing

Nurse principal applicants who failed to secure recognition were at risk of being barred from migration to Australia.

Many, however, still arrived as spouses or fiancees. Others came through family reunion or refugee programs, for which advance qualification recognition was not mandatory. These nurses then confronted the next set of barriers, the first being assessment of level of English (the same test as applied overseas to principal applicants, for those seeking skilled migration).

In nursing, as in other regulated health professions such as medicine, the first stage in securing Australian registration is passing a specialist test of English: the primary instrument used (since 1988) being the Occupational English Test (OET). In 1996, Hawthorne and Toth analysed the impact of this test on overseas qualified nurses (Hawthorne and Toth 1996). Stated briefly, the OET was shown to have a powerful capacity to:

- *exclude* NESB nurse principal applicants at point of entry to Australia (67% of overseas candidates failing compared with 33% of doctors);
- *bar* OQNs from proceeding to preregistration courses in Australia (41% of nurses failing compared with 19% of doctors); and
- *selectively delay* NESB nurses from professional re-entry (despite a significant number of those categorised as 'NESB' by State Registration Boards actually possessing exceptionally competent levels of English) (Hawthorne 2000, 185–217).

By any criteria this test has dramatic results — exemplifying the degree to which mandatory English language testing has a potential to *disqualify* NESB nurse applicants from both the migration and the qualifications' recognition process. Moreover, as with doctors, highly differential impacts were identified by country of origin, with a mere 35% and 41%, respectively, of Filipino and former Yugoslav Republic candidates passing, and select regions achieving exceedingly low overall pass rates. Many such nurses would subsequently study for months or even years to overcome this hurdle — a process often further complicated by family responsibilities (Hawthorne 1997b, Hawthorne 2000, 202).

Barrier 3: qualifications' recognition

Despite the abysmal premigration qualifications' recognition rates noted above, nursing was, in fact, one of the few Australian professions to *improve* qualifications' recognition procedures within Australia in the period 1990–96. Arguably, this was because of the profession's longstanding experimentation with competency-based assessment (CBA), its formal adoption of CBA as policy in 1986, and its relatively benign attitude toward NESB nurses, particularly in the context of labour market shortages. There is no scope here to describe the complicated evolution and application of CBA in various states. In sum, however, CBA bridging programs provided an excellent alternative to the 'hit or miss' assessment that had prevailed for OQNs to the late 1980s (Iredale 1987). In particular, CBA could offer:

- a clearly defined pathway into professional registration;
- ease of clinical access (with host institutions locating essential hospital placements rather than individual nurses);
- preliminary and concurrent training in equipment use, orientation to Australian nursing practice, terminology, the health system, jargon, etc.
- systematic revision of core nursing content, including anatomy, physiology and pharmaceuticals;
- information on initially 'alien' concepts such as duty of care, informed consent, the nature and style of Australian hospital hierarchies, etc., and
- formally structured and defined skills assessment procedures (Hawthorne 2000, 250–1).

In Victoria by the mid 1990s, pass rates of 90–95% following completion of three-month CBA courses would be fairly typical for course participants. In NSW (where entry-level English was more flexibly assessed) pass rates varied from 55 to 71 per cent, with the growing participation of Filipino and Fijian-trained nurses reportedly 'dragging down' averages. According to the 1996 survey data (719 nurses), region of origin had major impact on the length of time taken to secure registration, with ESB and Commonwealth-Asian nurses securing it in a couple of months, and West and East European nurses experiencing very long timelags (typically 1 to 2 years; see Table 7).

By 1995, according to Sue Hendry of the ANCI, ESL testing and CBA-based bridging programs were offered in virtually every Australian state. Yet, the funding of CBA courses remained unstable, particularly in states with small numbers of NESB nurses. Moreover, the degree to which the tested competencies were actually based on the recommended

Table 7 Time taken to secure professional registration postarrival in Australia by region of origin (OQN survey sample)

Region of origin	Time taken post-arrival to secure registration (years)
ESB	0.19
Commonwealth-Asian	0.22
Other	0.60
Non-Commonwealth Asia	1.10
West European	1.90
East European	2.50

Source: Hawthorne 2000.

national ANAC/ANCI model remained highly variable. Overviewing CBA nursing reforms from 1991 to 1995, Hendry concluded with some frustration:

> In general all the nurse regulatory authorities have made attempts to provide migrant bridging programs one way or another ... however, these processes and programs lack national consistency and this very issue needs serious consideration. Whilst all nurse regulatory authorities acknowledge acceptance and use of the ANCI competencies, where and when these competencies are demonstrated or utilised is not always clear. In Queensland NESB nurses have to pass the Queensland Nursing Council's examination before undertaking supervised practice or the bridging program, a requirement that seems out of line with the philosophy behind the ANCI competencies. Very few programs and processes are used for re-entry and even fewer are part of the mainstream educative processes. What is now urgently required is more specific information about the migrant bridging programs and processes so that the required changes can take place. Specific information such as:
>
> 1 what are the real numbers of migrant nurses requiring access to bridging programs and processes;
> 2 do these programs/processes produce safe and competent practitioners;
> 3 exactly how and when are the ANCI competencies utilised and are they fair and non-discriminatory to NESB nurses and do they ensure (sic) someone with the competence to practise on Australians?
> 4 are these programs/processes cost-effective; and
> 5 what quality assurance review/assessment systems are in place for these processes (Hendry 1995, 5).

According to a senior informant from the National Office of Overseas Skills Recognition (NOOSR), a total of 386 individual training places for OQNs were federally funded in Australia from 1994 to May 2001 — a pitiful number, in the context of over 11 000 new arrivals. By July 2001, bridging courses were offered in seven states or territories, with all now claiming to use ANCI competencies (ANCI 2000).

Barrier 4: recruitment patterns

Given sustained Australian labour market demand, once OQNs have passed the mandatory English language test and secured professional recognition, the majority pass seamlessly into employment. By the time of the 1996 survey 47% of NESB nurses were in full-time work, compared with 40% of ESB nurses (see Table 8). ESB nurses were in fact more likely to be working part-time (41%, compared with 33% NESB), or to report full-time dedication to home duties (7%, compared with 3% NESB nurses) ($Chi^2 = 14.72$, $P < 0.01$). While this could have reflected comparative wealth, it could also reasonably be inferred that female NESB nurses showed a greater career attachment than ESB nurses — an issue with the potential to result in comparatively favourable professional outcomes.

Despite this, when *current work status* was analysed by region of origin, NESB nurses proved to be significantly less likely than ESB nurses to have progressed beyond baseline registered nursing employment. Sixty-seven per cent of NESB females were employed as 'just' RNs, compared to 56% of NESB males and ESB females, and a low 30% of the relatively elite ESB males ($Chi^2 = 27.97$, $P = 0.02$). Though 16% of NESB males and 20% of NESB females had found specialist or charge nurse positions, they had achieved minimal representation in higher managerial or nurse supervisor positions — despite the reasonable qualifications and relative seniority of Commonwealth-Asian nurses. The most senior nursing roles in the survey were, in fact, dominated by West European and African nurses (the latter derived from former Commonwealth countries and Mauritius) — with the representation of ESB nurses almost certainly reduced by ESB females' preference for part-time employment (see Table 9). In line with classic immigration research, length of residence was shown to be a critical determinant here — with recent arrivals (1990–96) significantly more likely to

Table 8 Nursing employment outcomes in Australia by 1996 by region of origin: migrant nurse survey data

Region of origin	Registered nurse (%)	Specialist/charge nurse (%)	Manager/nurse supervisor (%)
ESB*	54	22	9
Africa	47	20	13
Comm-Asia	56	27	3
W Europe	64	9	14
E Europe	80	18	2
Middle East	85	8	0
Non Comm-Asia	86	9	2

Source: Hawthorne 2000, Table 10.3, p. 298.

*UK, US, Canadian, South African, Irish and New Zealand nurses.

Table 9 Nursing employment outcomes in Australia by 1996 by region of origin: migrant nurse survey data

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Source: Hawthorne 2000, Table 10.3, p. 298.
*UK, US, Canadian, South African, Irish and New Zealand nurses.

Table 10 Nursing employment by major sector in Australia by 1996 by region of origin: migrant nurse survey data

Region of origin	Private hospital (%)	Public hospital (%)	Nursing home sector (%)
ESB	21	49	10
Africa	20	47	13
Comm-Asia	10	63	10
W Europe	25	48	11
E Europe	7	64	29
Middle East	15	39	23
Non Comm-Asia	16	59	19

Source: Hawthorne 2000, Table 10.5, p. 300.

be employed as RNs (75%) than those reaching Australia earlier (55%) ($Chi^2 = 25.35$, $P < 0.01$).

Table 10 explores a second critical indicator of professional 'success' — the degree of *labour market segmentation* in nursing employment by sector. The 1990s coincided with the contraction of the Australian public hospital system, alongside ongoing diminution of public sector resources and employment conditions (Department of Human Services 1999, 5–6; Carson 1999, 11; Webb 1999, 8). Simultaneously, a rapid expansion in the private sector was occurring. Employment in acute-care private hospitals was increasingly congenial and professionally prized. Employment in the nursing home sector, by contrast, was shunned by many informants — stigmatised by limited career opportunity and repetitive 'maintenance' nursing.

As Table 10 shows, ESB males and females proved significantly more likely to be employed in private sector hospitals than NESB nurses ($Chi^2 = 19.01$, $P < 0.01$). Moreover, West European nurses had *exceeded* ESB levels, once overcoming their major disadvantage (access to professional registration). NESB nurses, by contrast, were found to be disproportionately clustered in public hospital positions (Commonwealth-Asian and East European nurses), or to be based in the nursing home sector (East European, Middle Eastern and non-Commonwealth Asian nurses) ($Chi^2 = 51.45$, $P < 0.01$). When reanalysed by gender as well as region of origin, women from these latter regions were found to be most at risk of nursing home sector employment, almost certainly reflecting their initially poor ESL and low qualifications level ($Chi^2 = 29.15$, $P < 0.01$). While virtually all those OQNs who had wanted to had found professional work, it was largely ESB and West European nurses who were taking up employment opportunities in the rapidly expanding private sector. According to informants, applicants' preference for part- or full-time work would not be decisive here, since shift-work was readily available across all hospital sectors.

Interestingly, the survey elicited a torrent of spontaneous comments from Asia-born nurses, defining their perception of inferior workplace treatment — a potentially critical issue, in the context of the increasing globalisation of the nursing workforce. The following comments were fairly typical:

> I have been told at an interview for an Assistant Charge Nurse position, 'We don't know what sort of bush nursing you've done in India', when I had a clear CV and syllabus and referrals (India).

> With my background, and coming from England, I find the nurses in Australia bossy, assertive and power-hungry. I encounter some prejudice too (Malaysia).

> Management / colleagues / patients believe that Asian nurses work harder but not smarter. There is awareness of racial differences subconsciously, which often reveals itself when conflict arises (Malaysia).

> Being Asian, promotion is rather difficult if you do not get on well or agree with the higher authority, especially those who conduct the interview (Malaysia).

> (We encountered) some racism, treated as inferior, ignorant beings. (Australian nurses) can't believe that our former country can have sophisticated machines/equipment too. Very condescending attitudes (Singapore).
>
> If I had wanted to go up the ladder, cultural differences with colleagues and discrimination would have been obstructions (Sri Lanka).
>
> Dark skin. Many think we are dumb (India).

Frustrations such as these were by no means limited to Commonwealth-Asian nurses. A Filipino nurse believed rejection resulted from 'only my colour and the way I pronounced words (so) that you are always laughed at, degraded'. Middle Eastern nurses outlined 'hidden and clear discrimination' as well as outright 'racism by Anglo-Saxon nurses'. Over the years, this pattern reportedly robbed many non-European nurses of confidence. An Indonesian nurse perceived her nursing skills to be compromised by exclusion from teams. ('We were allowed to do more overseas than here ... (It's) really hard here, feeling not worthy of the job, not listened to'.) Though less common, East and West European nurses also reported some degree of personal rejection. An Italian stated 'The only disadvantage has been the perception of Australian-trained nurses towards overseas one'. A Czech nurse said, 'I remained always a foreigner not accepted among Australian colleagues, racial discrimination', while another described being the constant target of 'discrimination and prejudice and backstabbing' from colleagues and administration. Such comments were legion — despite NESB nurses' pride in their skills, and their intense sense of advantage in terms of linguistic and cross-cultural experience.

In order to assess whether such perception of prejudice in professional employment was reasonably based, a logistic regression was undertaken to check the relationship between a range of background variables and the level of seniority attained. Employment outcomes for the research sample were dichotomised between OQNs employed as registered nurses ($n = 425$), and those occupying positions of responsibility (PORs: defined as working as a nurse educator, nurse supervisor or manager; $n = 200$). Nurses not working within the profession were excluded from this analysis ($n = 87$). The variables potentially thought to be associated with PORs were length of time in Australia, gender, age, children, the number of qualifications held, visa status, and region of origin.

The analysis revealed that the significant predictors of working in a POR were:

- *Holding 3–4 qualifications.* These people were 370% more likely to hold a POR when compared with those holding just one qualification (OR: 4.7; 95% Cl: 2.8–8.0).
- *Holding 2 qualifications.* These people were 90% more likely to be in a POR when compared with those holding just one qualifications (OR: 1.9; 95% CI: 1.1–3.2).
- *Region of origin.* Nurses of non-Commonwealth Asian origin were 70% less likely to hold a POR when compared with ESB nurses (OR: 0.3; 95% CI: 0.1–0.6). No other region of origin group was found to have a significant employment difference.
- *Length of time in Australia.* 1990–96 arrivals were 60% less likely than those arriving 1980–89 to be in a POR (OR: 0.4; 95% CI: 0.2–0.6).

After adjustment (i.e. when all putative factors were entered simultaneously in the logistic regression model), *no* significant associations were found between holding a POR and any of the other predictors, i.e. gender, whether a nurse had children or not, age or visa status. In terms of mobility, non-Commonwealth Asian nurses were the sole group shown to be at significant disadvantage. While nurses from Commonwealth-Asian countries were 40% less likely to be employed in a POR when compared with ESB nurses, this proved to be a non-significant finding (95% CI: 0.4–1.1). The prejudicial behaviour many Commonwealth-Asian nurses believed they had received in Australia had thus *not* resulted in significant barriers to advancement. At the same time, their degree of workplace discomfort should not be dismissed — clearly reflective of a significant level of social (if not professional) rejection.

A nominal regression analysis was undertaken next to assess the key criteria for nursing employment by *sector*, in the context of the comparative advantage of acute medical care versus nursing home sector employment, previously noted. In particular, any evidence of labour market segmentation in nursing was sought.

This table proved far more complex to construct, given the restricted number of cases in the study. In order to overcome this, the three critical variables thought to be relevant (length of residence in Australia, number of qualifications and region of origin) were used. A preliminary analysis was first undertaken of the two critical variables: number of qualifications and region of origin. The former revealed highly comparable characteristics shared by non-Commonwealth Asian and East European nurses with respect to employment location. These two categories were thus combined. The second showed that 'elite' nurses with three to four qualifications were significantly more likely to be employed *outside* the hospital sector ($Chi^2 = 34.70$, d.f. = 6, $P < 0.01$). They were therefore used as the base group for comparative purposes.

The nominal regression, which simultaneously adjusted for the three hospital employment sectors (public, private

and nursing home), revealed that the significant predictors of public hospital employment were:

- *Holding 1 qualification.* These people were 81% more likely to work in this sector when compared with those holding 3–4 qualifications (OR: 1.8; 95% CI: 1–3.3).
- *Holding 2 qualifications.* These people were 155% more likely to work in this sector when compared with those holding 3–4 qualifications (OR: 2.6; 95% CI: 1.5–4.4).
- *Region of origin.* East European and non-Commonwealth Asian nurses were 540% more likely to work in this sector when compared with ESB nurses (OR: 6.4; 95% CI: 2.2–18.8). Commonwealth-Asian nurses were 82% more likely to work in public hospitals (OR: 1.8; 95% CI: 1.1–3.1).

Those people working in private hospitals were:

- *Holding 1 qualification.* These people were 136% more likely to work in this sector when compared with those holding 3–4 qualifications (OR: 2.4; 95% CI: 1.1–4.9).
- *Holding 2 qualifications.* These people were 283% more likely to work in this sector when compared with those holding 3–4 qualifications (OR: 3.8; 95% CI: 2.0–7.4).
- No other significant predictors (including region of origin) were found.

Those people working in nursing homes were:

- *Holding 1 qualification.* These people were 210% more likely to work in this sector when compared with those holding 3–4 qualifications (OR: 3.1; 95% CI: 1.5–6.6).
- *Holding 2 qualifications.* These people were 117% more likely to work in this sector when compared with those holding 3–4 qualifications (OR: 2.2; 95% CI: 1.0–4.7).
- *Region of origin.* East European and non-Commonwealth Asian nurses were 840% more likely to work in this sector when compared with ESB nurses (OR: 9.4; 95% CI: 2.9–30.2).
- No significant differences were found for any other predictor in the model.

It should be noted that the above findings are based on a limited analysis which was restricted by the small number of cases in the study. Subject to the limitations imposed by this, the findings are striking. Clear evidence of labour market segmentation in nursing emerged, with East European and non-Commonwealth Asian nurses at disproportionate risk of concentration in the least prestigious nursing home sector — a sector in the process of redefinition as for 'foreign labour' (in line with Gordon et al. 1982, 192–209; Castles and Miller 1993, 189). No comparable disadvantage was found for any other group studied, even those with similarly few qualifications. Length of residence in Australia, while included in the model, was found to have no significant impact on employment sector. This is a matter for serious concern, suggesting the potential of initial employment disadvantage for select OQNs to persist in Australia over time. Non-Commonwealth Asian nurses were particularly disadvantaged — the group also least likely to be appointed to positions of responsibility (as previously demonstrated).

These findings are briefly compared in the section below with those reported by Birrell and Hawthorne (1997) for all Australia-based nurses. Census data for 1991 confirmed OQNs' ready access to Australian nursing employment — with virtually no overall employment disparities found between Australian and overseas-born nurses (45–47% and 44–45%, respectively, for degree and diploma-qualified nurses). The relatively elite status of Commonwealth-Asian nurses was strongly confirmed. Despite NESB nurses' deferred labour market entry, employment rates for degree holders reaching Australia between 1986 and 1991 ranged from a high 69% (Malaysia), 62% (UK and Ireland) and 49% (New Zealand) to nil for nurses from Yugoslavia, Vietnam and Poland (for whom the profession was initially inaccessible). Similar findings emerged from the 1996 Census: with 62% of Australian degree-qualified nurses in nursing employment, compared to 60% of the total overseas-born and peak rates of 76% for the Malaysia-born and 62% for the Hong Kong-born (Birrell and Hawthorne 1999). Once again, in terms of recent arrivals (1994–96), NESB nurses from Eastern Europe and non-Commonwealth Asia proved to be among the most disadvantaged.

As noted earlier, one further indicator of professional success is the degree to which migrant nurses move into Australian management positions (though — unlike the OQN survey — the census data do not allow analysis of whether this has occurred within *nursing* positions). Despite NESB nurses' initial difficulties, the 1991 census confirmed the majority of OQNs to have experienced significant professional mobility over time. OQNs arriving before 1981 from the UK/Ireland, New Zealand and Commonwealth-Asian countries had secured the highest level of managerial work — once again despite Commonwealth-Asian nurses' acutely felt disadvantage. This pattern held more strongly for degree than diploma-qualified nurses, almost certainly reflecting the increased professionalisation of nursing which had occurred in the recent period. Eleven per cent of Egyptian nurses and 6% of China-born nurses had also secured some form of management work. Their achievement compared favourably with the average of 7% of Australian nurse degree holders and 6% of diploma holders working in management positions. Degree-holders resident in Australia 10 years or less (1981–85 arrivals) were also making steady inroads into management positions: 7% of

UK/Ireland nurses and 5% of New Zealanders, compared to an extraordinary 17% from Hong Kong, 11% from Vietnam and 3% from Malaysia.

CONCLUSION

As should be clear from the above, the globalisation of the nursing profession represents a two-edged sword for Australia — attracting unprecedented numbers of nurses to migrate, while simultaneously facilitating the constant exit of Australian nurses to work overseas. In consequence, OQNs have become an increasingly vital component of the Australian nursing workforce. Yet the study reveals major labour market barriers to be experienced by NESB OQNs, in marked contrast to the ESB nurses who pass seamlessly into initial and then more senior employment.

To begin with, mandatory English language testing was shown to have barred up to 67% of NESB nurse principal applicants from eligibility for skill migration, in addition to barring 41% of those reaching Australia from proceeding to preregistration courses. Second, premigration qualifications' screening was shown to have resulted in immediate recognition for 97% of ESB nurses, compared to a mere 29% of those of NESB origin — a process harsher in the mid-1990s than a decade earlier, with results which could not reasonably be accounted for by the inferiority of overseas qualifications (e.g. for nurses from West Germany). Third, while the introduction of competency-based assessment courses represented a very significant Australian reform (producing 90–95% pass rates in Victoria and 55–71% rates in NSW), funding for these courses was shown to be both unstable and inadequate, with courses by definition restricted to OQNs in Australia. Fourth, while both ESB and NESB nurses secured professional employment once registration had been gained, significant and persistent labour market segmentation was evident for select NESB nurses over time, with East European and non-Commonwealth Asian nurses disproportionately concentrated in the stigmatised geriatric care sector. Finally (and just as importantly), many NESB OQNs, particularly those from Commonwealth Asia, spontaneously reported a serious and discomforting level of Australian nurse peer rejection.

Such OQN adjustment issues have received insufficient policy attention to date, despite their potentially profound impact on workforce cohesion and supply. In a context of accelerating globalisation (with 26% of Australia's registered nurse workforce born overseas), they have unmistakable significance for the Australian nursing profession.

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