

REVIEW ARTICLE

Overseas trained nurses working in regional and rural practice settings: do we understand the issues?

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ABSTRACT

Introduction: Issues associated with the employment of overseas trained nurses (OTNs) in regional and rural practice settings have received little professional attention in Australia. The global nursing workforce crisis has dominated discussion about the migration of nurses. This review explored the contemporary understandings of the employment of OTNs in Australian regional and rural practice settings.

Methods: An integrative literature review was undertaken to incorporate a range of literature types related to OTN employment. A search of electronic databases and relevant web pages was undertaken for the publication period 1995–2008. Integrative literature reviews incorporate assessment of empirical research as well as theoretical and opinion-based literature to present a broad synthesis of the topic of interest. Following identification of relevant literature, thematic analysis was undertaken to reveal patterns and relationships among concepts facilitating synthesis of findings across the range of literature.

Results: There is an abundance of literature exploring the international migration of nurses that demonstrates an imbalance of migration from poorer countries to more affluent countries. This review identified a number of economic and ethical issues, together with risks for potential exploitation of migrant nurses. There was minimal literature specific to the experiences of OTNs working in regional and rural areas. However, there has been some exploration of issues associated with medical recruitment to rural areas.

Conclusions: The employment of OTNs is accompanied by complex and varied issues which require resourceful and proactive responses by healthcare employers. Further research is needed to understand the challenges OTNs have in working in rural



settings, particularly in Australia. Increased understanding in clinical settings of factors that influence nurses to migrate, as well as the range of barriers they face in working and living in host countries, may assist in the retention of these nurses.

Key words: Australia, international personnel recruitment, overseas qualified nurses, overseas trained nurses, rural workforce, worker retention.

Introduction

Over the past decade, the global nursing workforce shortage has threatened the quality of health services. Australia is not isolated from this crisis and is experiencing a severe but unevenly distributed shortage of nurses¹. The greater shortage of nurses in non-metropolitan health services, especially rural and remote areas, is of particular concern and has contributed to poorer access to health services². It is increasingly difficult for Australians living in isolated areas to obtain acceptable and affordable health care³.

In regional and rural areas, nurses form the largest part of the health workforce and are often the patient's first point of contact. In more remote areas, registered nurses (RNs), along with Indigenous health workers, comprise 95% of all healthcare professionals⁴. Health services in smaller rural communities experience ongoing problems in attracting nurses to fill generalist, aged care and midwifery positions, with some services now actively recruiting overseas trained nurses (OTNs)^{5,6}. Although international recruitment of nurses is not a new idea, and in countries such as the USA, Canada and the UK this has been the case for many years, the recruitment of OTNs into rural health settings is vastly different from recruiting into metropolitan settings. Arguably nurses have a unique role and status in regional and rural communities; they contribute significantly to the social capital of their communities through their immersion in the social networks that are integral to rural life⁷. Therefore, the aim of this review was to develop a contemporary understanding of OTNs who are specifically employed in regional and rural health practice settings.

There were two challenges in the review. First, the literature of immigration and health workforce is broad but has minimal specific exploration of regional or rural practice contexts^{8,9}. Second, where there is interest in rural workforce, it is predominantly focused on issues associated with medical international graduates. Therefore, the strategy adopted was to undertake an integrative literature review with the goal of critically analysing trends in the field and identifying areas of research need.

Methods

Integrative literature reviews incorporate assessment of empirical research from diverse methodologies as well as from theoretical and opinion-based literature to develop a greater understanding of a particular topic¹⁰⁻¹². Following the careful collection of relevant literature, interpretation is based on thematic analysis where patterns are identified, relationships between concepts noted and, finally, a synthesis of findings across the range of literature is achieved. Integrative reviews provide a broad thematic overview of literature and are different from reviews concerned with the detailed critique of a limited range of studies¹¹.

The initial search revealed only one specific article related to the OTNs in regional and rural employment so a search strategy with broader parameters was instigated. Google scholar, CINAHL Plus with Full Text (using EBSCOhost) and the MEDLINE database (via PubMed) were searched to identify the range of literature published between 1995 and 2008. Due to the diversity and volume of the literature relating to the broad topic of nurse workforce and migration, more than 8000 citations were initially found. Following



refinement of the search to works in the English language, the main search terms used were: 'nurse migration', 'overseas trained nurses', 'health workforce', 'nurse workforce', 'regional', 'rural'.

Highly cited articles were located and the analysis of these assisted in the initial formation of the thematic structure of the integrative review, and subsequent identification of relevant articles¹². These themes were: macro view of international nurse workforce and migration; recruitment of OTNs in Australia; and international recruitment specifically for developing the rural health workforce. Additionally, a search of the World Health Organisation (WHO) (<http://www.who.int/en/>) and International Council of Nurses (ICN) (<http://www.icn.ch/>) web sites revealed relevant reports and links. References in recently published work were scrutinised, and textbooks were hand searched.

Overall, the search revealed little specific literature related to OTNs working in regional or rural healthcare services. One problem in finding relevant articles was the variety of terms used to describe nurses who migrate to other countries after initial nurse registration; however, these terms were inconsistently defined and applied. Overseas trained nurses, overseas qualified nurses, internationally educated nurses and overseas nurses are terms used in similar ways, and denote RNs who undertake their pre-registration nurse education in a country other than their current country of employment. Similarly, several authors used the terms international nurse graduates¹³ and internationally recruited nurses (IRN)¹⁴. Another term was identified in a single article⁹: 'non-traditional RNs', where it was used interchangeably with OTN, and appears to differentiate between nurses trained in Australia and others. The lack of common nomenclature made it difficult to ensure access to relevant work in the field.

A second problem was the terminology related to regional and rural settings, which are also used widely with little clarity of definition. In the Australian context, there is debate about the meaning of rural. Traditionally 'rural' referred to areas of low housing density, largely agricultural in activity

but this has been confounded in recent years by shifting patterns in urban settlement and changes in agricultural practices. The Australian Standard Geographical Classification Remoteness Areas was identified as useful in this review for differentiating the various contexts in which nurses might work¹⁵. This classification defines five remoteness categories related to both distance from population centres and size of population and include: major cities; inner regional; outer regional; remote; and very remote¹⁵. This review was interested in nursing workforce and international migration to the latter three classifications where there is relatively low access to population centres with populations over 5000 persons¹⁵.

Results and Discussion

The analysis of the identified literature revealed three broad themes of knowledge that inform the topic of OTNs in regional and rural settings. The following is a brief summary of contemporary understandings of international nurse workforce and migration, including explanations of uneven flow in migration, ethical issues in the international recruitment of nurses and the impact of migration on the nurses who migrate. Subsequently, with a focus on Australia as a major provider of regional and rural health services, the recruitment of OTNs will be explored. Finally, issues associated with international recruitment, specifically for the development of the rural health workforce, are discussed. The major research in this area relates to the recruitment of overseas doctors to rural settings, and highlights the emphasis and investment in medical workforce shortages, with little published evidence of comparable investment in nursing and allied health workforce.

International trends in nurse migration

There is a large body of work related to issues in the international nursing workforce; the following section discusses the dominant themes in this literature. Some difficulty in gaining a detailed understanding of the flow of the nurse workforce internationally was due to limitations in



the quality of data¹⁶. However, there is clearly an uneven flow of nurses from developing to developed countries. A complex array of factors influence the migration of nurses. Central to this discussion are arguments about the ethics of international recruitment practices. What is less visible, but is slowly emerging, is an interest in the 'micro' aspects of the flow in global nursing workforce, that is, what the outcomes of migration are for the nurses themselves.

Uneven flow of nurses with underlying problems unresolved: There is broad consensus that a disparity exists in the international movement of nurses, with more developed countries attracting increasing numbers of nurses from less developed economies¹⁷⁻¹⁹. Rather than the commonly used simple explanation that nurses leave poorer countries to seek better lives, more recent authors suggest a number of complex and interrelated factors as influential in the current international flow of nurses. Sparacio argued that these encompass the economic, social, political and professional domains²⁰.

Economic and political changes have resulted in considerable deregulation of the international movement of labour in recent years. This has meant a reduction in some of the previous barriers to immigration (eg in the European Union), and consequent greater mobility of women than previously²¹. Some countries have been opportunistic in developing new markets through the production of 'nurses to send offshore'²¹, most notably the Philippines^{19,20} and more recently India^{18,22}.

Although there is now significant freedom in the international movement of nurses, Kline notes that immigration strategies to fill workforce vacancies fail to address the underlying issues associated with retention²³. She contends that the working conditions in host countries are problematic and require long-term solutions. In part, these conditions are a product of an increasing focus on 'productivity' management²³ at the expense of supportive environments that would assist international nurses' retention. The literature suggests that there is a need for greater investment in both educational and workplace

environments by providing opportunities for career advancement, flexibility in working conditions and greater access to supportive technologies^{19,23}.

Push-pull thesis: Several authors refer to the 'push-pull thesis' to explain the uni-directional flow of nurse migration: nurses experience a 'push' from their home country and a simultaneous 'pull' to the host country^{19,20}. There are a number of motivators influencing this push-pull, which Kline argued can be grouped into three categories: professional and career advancement; improved pay and work conditions; and greater personal safety and security²¹.

Substantially better conditions, for both personal and work life, are strong pull factors for nurses to developing countries¹⁶. Wages are significantly higher in host countries than in their home country²¹ and provide migrants with much higher standards of living²³. In many nations nurses experience political and social conditions that present significant personal risks to health and safety; these are strong push factors in migration. In Africa, for example, there are high rates HIV/AIDS-related illnesses that affect the health workforce both directly and indirectly. It is estimated that between 15 and 20% of health workers in South Africa are HIV positive²⁴ and this is likely to rise due to inadequate resources to reduce occupational risks. Additionally, the HIV/AIDS pandemic has a broader impact with developing nations in Africa experiencing diminishing capacity to retain their current level of economic development. Consequently, there is an increasingly heavy burden of work, both physically and emotionally, for current health workers in these countries.

Ethical recruitment: There has been considerable debate about the ethics of active recruitment of nurses from developing countries where there is a great need to retain the nursing workforce. In 2001 the International Council of Nurses adopted a position statement on the ethical recruitment of nurses that acknowledged the right of nurses individually to migrate²⁵. In spite of this type of public policy, large scale recruitment continues and migration puts the quality of health care in donor countries at risk^{16,23}. As



Aiken et al indicated, enforcement of ethical guidelines in recruitment is difficult in an increasingly privatised, entrepreneurial market¹⁹. The ICN also advocated the benefits of ‘circular migration’ where nurses return to their home countries. Yet very few nurses return to their home country after migration, therefore continuing the significant depletion of donor countries with an already limited workforce¹⁹.

The ICN condemned recruitment practices where nurses were exploited or misled about the work and conditions of the jobs they accepted. However, as Smith and Mackintosh²⁶ report, this remains a problem:

...there is comparable evidence from across the world of exploitation and racialized hierarchies of employment rights faced by migrant nurses in countries of destination, that build on international hierarchies of disadvantage often with strong historical roots in colonialism and empire (p.2217).

Xu and Zhang acknowledged the ICN attempt to support the ethical recruitment of nurses internationally but highlighted that the ICN position’s focus on individual nurses meant insufficient attention to other stakeholder interests²⁷. They suggest that consideration of the competing and overlapping interests of individuals, institutions, and national and international organisations in international nurse migration may mean different conclusions are drawn about what ethical recruitment means. For example, the movement from developing countries to developed countries, while presenting a potential ‘brain drain’, may also force national policy shifts in donor countries to improve the working conditions and the status of nurses. Dwyer, however, returns responsibility to the destination countries²⁸. He argues that developed, compared with developing countries, do not have a shortage of health personnel. While agreeing that nurses have the right to migrate, he suggests that further investment in nurse education and increasing the attractiveness of nursing as a career through improved work conditions would address the causes of workforce shortages in developed countries.

Micro implications of migration: There is limited research reporting on the impact of migration regarding the predominately female influx of nurses to developed countries. Cutcliffe and Yarbrough identified two major areas of impact for OTNs: one is related to clinical work, and the other to the non-work aspects of migration¹⁷. A further area identified in the literature is the role and influence of recruitment agents, who are said to have a significant effect on both the clinical and non-clinical aspects of OTNs’ lives²¹.

Whatever the destination of nurses, English has become the dominant language of migration and there has been a growth in services offering ‘cultural grooming’ (accent modification) to assist in ‘fit’ with the host country workplace²¹. One outcome associated with cultural grooming is ‘cultural displacement’, where migrant nurses feel that they neither belong at home nor in the host country. Other services offered by a growing number of recruitment agents include assisting prospective immigrants with their applications for entry into the host country, processing applications for registration and locating employment. The agents profit from brokering employment and, in some source countries, the relationship between the nurse and agency is highly dependent, leaving the nurses ‘vulnerable to exploitation’²². Smith and Mackintosh reported that agencies can charge nurses high fees and often retain the nurses’ documents, which creates a dependent relationship in terms of employment and access to registration²⁶.

In examining immigration in the UK, O’Brien argues that the nursing workforce is segmented and that OTNs are over represented in the lower grades of nursing¹⁴. She notes that OTNs have higher levels of technical skills than the local nurses but less experience with practical care. Furthermore, OTNs become de-skilled¹⁴ as part of the slow and protracted competency recognition processes. Another complexity relates to the different nomenclature of nursing practice among countries, and the cultural construction of nursing practice in any given context. Allan noted that OTNs found practice in the UK was less autonomous than expected, and they experienced a lack of valuing of the skills they bought



to the work place²⁷. Although the English language of an OTN may be of a high level, the language variations of practice in any new setting can present a barrier to integration¹⁷. Racial discrimination from co-workers and patients has also been noted in a number of reports of OTNs^{14,17,29,30}. There are clearly unequal opportunities in career advancement and professional development³¹. For example, Henry reported that Ghanian OTNs in the UK experienced informal management systems for promotion that lacked transparency, were subjective and included discriminatory practices³².

The non-work-related aspects of migration have received less attention in the literature. Several articles have reported on the key role income plays in the life of OTNs, with many regularly sending some of their salary to their country of origin for the support of family^{33,34}. Buchan et al identified that most of their sample of OTNs in London were married with dependent children³³. A significant proportion of these families had members living in different countries, with more than a quarter of spouses and/or children remaining in the country of origin. Kingma argues that the separation from family and community that occurs with migration is perhaps the greatest challenge OTNs face³⁵. These factors contribute to experiences of isolation and difficulty in adapting to the new environment, particularly if discrimination is experienced in the work place.

Recruitment of overseas trained nurses in Australia

In Australia, immigration policy encourages the migration of OTNs because nursing is listed on the Occupations in Demand List for potential immigrants³⁶. The diversification of the Australia nursing workforce has been rapid as increasing numbers of OTNs migrate to Australia; this is part of the global trend to high mobility in nursing workforces. Australia has sourced significant numbers of OTNs through migration, initially drawing from English-speaking countries (eg New Zealand and the UK). Over the past two decades an increased diversity in country of origin has meant a significant proportion of OTNs have come from non-

English-speaking countries³⁷, increasing the cultural and linguistic diversity in the Australian nursing workforce³⁸. Currently, the OTNs entering Australia come from Africa, India and the Philippines, as well as the UK and New Zealand^{36,39}.

Over the last few years there has been a significant increase in registration of OTNs in Australia. For example, in the 2006/2007 reporting period, the state of Queensland experienced an 141% increase in approved registration applications from OTNs ($n=1006$)³⁸. In 2005, OTNs comprised almost 25% of nurses obtaining initial registration with the Nurses Board of Victoria, increasing to 40% in 2009, with more than two-thirds of these from India⁴⁰.

In the western areas of Victoria, a number of health services are targeting the recruitment of OTNs as an approach to address nursing workforce shortages⁶. As an example, several health services have employed nurses from Zimbabwe, South Africa, China and India. It is likely that the recruitment of OTNs will increase in Australia as a strategy to address nursing workforce shortfalls and, therefore, OTNs will form an integral and essential part of the Australian nursing workforce. Because of this, it is important to understand the experiences of OTNs working in Australia, particularly those in regional and rural health care.

Hawthorne³⁷ summarised the specific barriers OTNs from non-English speaking backgrounds have encountered in accessing the labour market in Australia. She reported difficulty with initial pre-migration screening for the recognition of nursing qualifications, stating that the assessment of qualifications has become harsher with poorer outcomes for these nurses. Difficulties are also experienced in English-language testing, with occupational English testing identified as an effective tool for excluding applicants from entry to Australia, or barring or delaying OTNs' initial registration or access to pre-registration courses. These have also been identified as issues for international medical graduates, although the language failure rate for nurses is much higher.



Konno presented a meta synthesis of two qualitative studies about support for OTNs adjusting to practice in Australia and identified two major areas of impact⁴¹. First, OTNs were often lonely and isolated, and this was associated partly with difficulties in both written and oral English language. Their loneliness and isolation was related to dislocation from families and friends and created a need for support networks. The second area related to experiences of cultural incongruity. The OTNs experienced tensions between workplace roles and their own cultural values. This was exemplified by the way Australian nurses engaged in animated discussion with males in the workplace, which was not acceptable social practice for some OTNs. Another example of cultural incongruity was the difficulty OTNs experienced in establishing collegial relationships, at times being treated differently from peers due to poor institutional understandings of and/or support for diversity.

Only one recent publication specifically focused on OTNs recruited to rural settings⁹. This article examined both employer and OTN perspectives of employment in rural eastern Victoria. Issues that employers associated with employment of OTNs included the bureaucratic demands connected with immigration, providing sponsorship, and support for visas. Employers and members of rural communities reported successful organisation of accommodation and support to assist OTNs to become part of the community. There were a number of issues both employers and OTNs experienced as difficult. Cultural differences identified included specific nursing activities that were not part of the scope of practice in country of origin (eg washing patients). The OTNs experienced difficulty when working with others from their country of origin if they were of differing caste or class. Language was often problematic for both the locals and immigrants, with accent and idiom contributing to poor understanding/comprehension.

Australian rural health workforce and immigration

With the exception of an article by Francis et al⁹, the Australian literature relating to immigration and rural

workforce focused predominantly on medical practice. For example, a search of the Australian National Rural Health Alliance repository of National Rural Health Conferences proceedings, policy documents and *Australian Journal of Rural Health* articles published in the period 1991–2007 identified no nursing citations. However 79 separate items relating to overseas trained doctors (OTDs) were found. However, in the absence of specific nursing studies, medical studies may provide insight into potential issues for OTNs in rural employment.

There are increasing numbers of overseas trained doctors employed in rural practice in Australia. Similar to the overall nursing migration patterns, the Australian medical workforce in the past was largely drawn from the UK and Ireland. However, there is now a greater mix of countries of origin, with 55 nationalities identified in the Victorian state medical workforce in 2003⁴². Overseas trained doctors employed in Australian rural settings have been characterised as: younger, less experienced, working more sessions, and having a higher representation in remote general practices than other GPs⁴³. Overseas doctors in rural settings are also more mobile than their Australian counterparts, moving from different communities to seek better opportunities for their families and their careers^{42,43}.

Several studies into OTDs in regional and rural communities indicate levels of satisfaction with work and lifestyle factors are closely linked to retention, and therefore recommend a range of supports needed to retain OTDs in rural practice. Kosima et al proposed that OTDs needed increased orientation to the Australian systems for the delivery of medical and healthcare services, as well as training and up-skilling in women's health, emergency care and cultural sensitivity to Indigenous people, in particular⁴². Arvier et al reported that most emergency departments (EDs) outside larger metropolitan centres are staffed by non-specialist doctors, and increasingly OTDs fill these positions⁴⁴. They reported concerns at the lack of educational standards for doctors working in small EDs and the potential impact on the quality of rural emergency services. From the viewpoint of OTDs, the pathway to registration has been described as



'tortuous' and is compounded by professional isolation, limited experience in rural practice and the heavy workloads typical of rural practice⁴⁵.

Other factors that influence the retention of OTDs include both family and personal settlement. The first place of settlement is important because OTDs and their families form friendships that increase their reluctance to move to other places⁴⁵. Other issues related to family include access to quality education for their children and opportunities for spousal employment. Additionally, having contact with their own ethnic community is identified as important. Many communities have developed active social integration programs to assist OTDs to find accommodation and social 'fit' in the community. Similarly, Kearns et al reported that OTDs leave rural practice in New Zealand for three main reasons: access to schooling, spouse access to employment, and limited cultural life⁴⁶.

Conclusions

In the past two decades there has been considerable growth in identification of the major challenges associated with the internationalization of the nursing workforce. The complex interplay between individual rights to seek opportunities for improving personal life, and community needs to maintain and retain competent workforces in the countries of training have been debated. The international recruitment of nurses is discussed in terms of economic, political and ethical arguments, which focus a 'macro' view of recruitment and its implications. While there has been considerable work undertaken in the area of nurse migration, this is complicated by a lack of consensus about or precision in terminology, making comparison difficult. There is thus an urgent need for international consensus about the terminology used.

A major emphasis to date has been the discussion of OTNs as a workforce solution and the professional issues they experience. A smaller number of studies explore the impact of migration on OTNs' personal lives, and their significant economic and social stress. Further work is needed to

understand these issues, in order to assist the establishment of targeted support systems for the retention of OTNs.

The present review identified a lack of attention to the experience of OTNs in regional and rural employment. While some work has explored the experience of IMGs, it is unclear how applicable these findings are to OTNs. Further research is needed to understand the facilitators and challenges OTNs meet in regional and rural contexts, particularly in Australia. Such research should examine the experiences of OTNs in a range of communities, and also explore community attitudes to and experiences of hosting OTNs. This will enable healthcare services to identify issues and adapt, so OTNs are able to use their skills and expertise with regional and rural populations. Increased understanding in clinical settings of factors that influence nurses to migrate, as well as the range of barriers they face in working and living in host countries will assist in retention of these nurses. Finally, all nurses should be aware of the potential discrimination OTNs experience from peers and patients, so they can work positively with OTNs to develop supportive work environments.

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