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Faculty of Health Sciences

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**A CRITICAL ANALYSIS OF THE ASSESSMENT OF
OVERSEAS-QUALIFIED NURSES**

DIANE WICKETT

RN, CM, Dip.App.Sc, BN (Ed), MN (Advanced Practice)

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ABSTRACT

Policies underpinning the processes used by nurse regulatory authorities to assess overseas-qualified nurses (OQNs) vary from country to country. Some countries' policies are to undertake paper-based assessments of nurses' initial and post registration education and experience, while others require all nurses to undertake a generic examination. How these policies were developed and why, were pivotal questions in this study. The aim of the study was, to critically analyse the policy development and policies relating to assessment of overseas-qualified nurses in thirteen nurse regulatory authorities from Australia and overseas. Using Critical Social Theory as the theoretical underpinning a critical policy analysis was undertaken. Data was obtained from policies and procedures, interviews, organisational websites, annual reports and Nurses Acts. The process of development of these policies and procedures was analysed using Bridgman and Davis' policy cycle. The study revealed that only one organisation used a framework to develop policies on the assessment of OQNs. Policy analysis in most organisations was based on anecdotal evidence and experiential knowledge of Board staff. No organisation had conducted research on whether overseas-qualified nurses were competent to practice following a paper-based assessment or an examination. This study demonstrated that policies used to assess OQNs were not developed from an evidence-based perspective. This highlights the need to undertake internationally collaborative research on the evaluation of current policies, in order to develop future policies that determine the competence of a nurse to practice in another country.

STATEMENT OF ORIGINALITY

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference has been made in the text.

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GLOSSARY OF TERMS

Competence

The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.

Competent

The person has competence across all domains of competencies applicable to the nurse, at a standard judged to be appropriate for the level of nurse being assessed.

Enrolled Nurse

A person licensed to practice nursing under an Australian State or Territory Nurses Act under the supervision of a registered nurse.

Migrant Bridging Program

A program, which consists of theory and clinical components and provides an avenue for migrant nurses to demonstrate the Australian Nursing and Midwifery Council competency standards for registered or enrolled nurses in Australia.

Overseas-Qualified Nurse

A nurse and/or midwife who holds registration in a country, which is different to the country in which they are applying to register in order to practice.

Registered Midwife

A person licensed to practice midwifery under an Australian State/Territory or overseas country's Nurses Act.

Registered Nurse

A person licensed to practice nursing under an Australian State/Territory or overseas country's Nurses Act.

(Australian Nursing Council Inc 2002).

ABBREVIATIONS

ANC	Australian Nursing Council
ANCI	Australian Nursing Council Inc
ANMC	Australian Nursing and Midwifery Council
ASLPR	Australian Second Language Proficiency Rating
BRNC	Board of Registered Nursing California
CAP	Collaborative Advisory Panel
CNO	College of Nurses Ontario
DEST	Department of Education Science and Training
DIMIA	Department of Immigration, Multicultural and Indigenous Affairs
EN	Enrolled Nurse
EU	European Union
IELTS	International English Language Testing System
ICN	International Council of Nurses
ISLPR	International Second Language Proficiency Rating
NBACT	Nurses Board of the Australian Capital Territory
NBNT	Nurses Board of the Northern Territory
NBSA	Nurses Board of South Australia
NBT	Nurses Board of Tasmania
NBV	Nurses Board of Victoria
NBWA	Nurses Board of Western Australia
NCNZ	Nursing Council of New Zealand
NESB	Non English Speaking Background
NLFR	Nursing Labour Force Report

NMBNSW	Nurses and Midwives Board of New South Wales
NMC	National Midwifery Council
NMRA	Nurse and Midwife Regulatory Authority
NOOSR	National Office Overseas Skills Recognition
NRBNSW	Nurses Registration Board of New South Wales
OET	Occupational English Test
PBN	Philippine Board of Nursing
QNC	Queensland Nursing Council
RM	Registered Midwife
RN	Registered Nurse
SATAC	South Australian Tertiary Admissions Centre
TER	Tertiary Entrance Rating
UK	United Kingdom
USA	United States of America

PUBLICATIONS

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CHAPTER 1:   INTRODUCTION

Introduction

Nurses have historically been a highly mobile group. Some nurses migrate to start a new life in another country, while others travel to undertake postgraduate study or to gain experience working in a different healthcare system. Having an accurate account of the numbers who migrate, whether permanent or temporary, has been problematic as there is limited accurate data collected by countries to monitor the international movements of nurses (Buchan, Kingma & Lorenzo 2005). Although it is acknowledged that other factors such as poor conditions of practice and personal safety push nurses to move to another country, the pull factors such as increased pay and better practice conditions also contribute to this movement (Kline 2003). Migration of nurses has been the centre of much debate internationally over the past five years, specifically in relation to the ethical recruitment of nurses from developing to developed countries (Hawthorne 2001b; Buchan, Parkin & Sochalski 2003; Kingma 2004). The International Council of Nurses (ICN) released a position statement in 2001 on Ethical Nurse Recruitment, which outlined the right to freedom of movement, freedom from discrimination, good faith contracting and several other conditions believed to protect nurses considering practicing in a different county (ICN 2001a). This statement was produced, because there was evidence to support the view that nurses from developing countries were being discriminated against when applying and practicing in countries such as the United States of America, Canada and the United Kingdom (Iredale 1997; Godfrey 1999; Hagey, Choundry, Guruge, Turrittin, Collins & Lee 2001).

The right to practice in another country often requires the nurse to undergo an assessment of qualifications, language and experience (in some countries) which may be difficult, costly and time consuming. Nurse and Midwife Regulatory Authorities (NMRA) are the most common bodies authorised by statute to assess a nurse's eligibility to practice in the designated country. Other organisations responsible for assessing nurses' qualifications are professional nursing bodies, Ministries for Health or Hospital Administrators.

There are several models of assessment used by NMRAs in various countries around the world, which range from paper based examinations for all applicants to assessment by comparing qualifications. The impact of these models of assessment is particularly relevant given that the profession has been experiencing a global shortage, which is unlikely to improve in the short to medium term (Buchan 2002; Kingma 2004). However there is some anecdotal evidence just recently that the shortage is disappearing.

The processes used to assess a nurse's suitability to practice in a country are in place primarily to ensure the public is protected, by requiring that nurses register before being legally competent to practice. The policies underpinning these processes for assessment of overseas-qualified nurses require some scrutiny to determine whether their development has been systematic and evidence based, as well as fair, equitable, consistent and transparent for all nurses who apply for registration in another county. Anecdotal evidence suggests that perhaps these policies are none of the above (ICN Iredale 1997; Hagey et al. 2001; ICN 2001a).

The study described in this thesis is a critical analysis of the policies used by NMRAs in a number of countries that underpin the assessment process for overseas-qualified nurses. When referring to nurse/s in this study, the use of this term infers registered nurses, enrolled nurses, practical nurses and midwives. There is no intention to offend or minimise the importance of any of this group of nurses and midwives, the decision is based purely on the practicality of using one consistent term.

This chapter provides a brief overview as to why the study was undertaken, an overview of the research aims and an outline of the research design. The final part of the chapter is a synopsis of each chapter in the thesis.

Impetus for the Research

In 1994, I was appointed Manager of the Education and Registration Service at an NMRA in Australia. One of my responsibilities was to manage the development and implementation of policies and procedures for the assessment of both local and overseas-qualified nurses applying for registration. While there was excitement in starting a new position there was also a shock when it was discovered that six boxes sitting on the floor of my office were applications from overseas-qualified nurses awaiting assessment. Some of these applications had been there for over twelve months pending an outcome. I considered this unacceptable, as during this wait the nurse's life and that of their family was in some cases on hold until a decision was made. To migrate to another country is not a decision most people would take lightly.

My employing organisation's service standard for assessment of overseas-qualified nurse applications for registration was one to three months and therefore we were working outside the organisational service standard. Given my relative inexperience in the assessment process and the volume of work in commencing a new position, it was decided in consultation with the Chief Executive Officer to send all applications to the Australian Nursing and Midwifery Council (ANMC) for assessment.

The ANMC is authorised in Australia by the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) to assess overseas-qualified nurse registration applications under the 'General Skilled Migration category'. The ANMC's assessment determines whether nurses are eligible for migration based on whether the nurse would meet the requirements for registration with a nurse regulatory authority in Australia. If deemed ineligible, it may be recommended for the nurse to undertake further education and/or assessment in order to be eligible for registration hence meeting the requirements for migration (ANMC 2005). The reason for a recommendation only, is that the ANMC does not have the legislative authority to register nurses in Australia. The ANMC is an advisory body not empowered by legislation, therefore is only empowered to make recommendations. NMRAs in Australia are the only bodies with the authority to register a nurse in Australia. This causes confusion for nurses if they are deemed eligible for registration by the ANMC for migration and are then assessed as not eligible by the NMRA in the state or territory they wish to practice.

Nurses applying for a working holiday visa to practice in Australia as opposed to migrating to Australia are not required to have their qualifications assessed by the ANMC. These nurses may apply for registration directly to the NMRA in the state or territory in which they wish to practice.

As the ANMC assesses nurses for migration purposes, it was believed that by sending all outstanding applications to the ANMC, these assessments would be performed in a timely manner by experienced assessors. While this was believed to be the most expedient action, the outcomes of the assessments led to even greater concerns.

There were inconsistencies in recommendations of assessments, especially for those nurses who had undertaken their initial nurse education in non-English speaking countries. Recommendations for registration regarding nurses who were educated in English speaking countries appeared to be made with greater consistency than those for nurses from non-English speaking countries. This was despite the fact that the curriculum outline submitted by each group of nurses appeared to be similar. Whilst it was understood that in order to practice in Australia, a command of the English language was pivotal, it was difficult to understand why only nurses from a non English speaking background (NESB) were also required to undertake further nursing education. It was as though the nurse's knowledge must be deficient if they did not speak English suggesting that language proficiency appeared to underpin some assumptions made during the assessment process.

Discussion was pursued with ANMC staff as to the rationale for this and they indicated that they had visited other countries to evaluate the systems in place to determine whether nurses from these countries would be competent to practice in Australia. Their process of evaluation was unclear and it appeared somewhat adhoc. It was difficult to understand how visiting a country, observing it's healthcare system and assessing various curricula would be enough to determine whether a nurse was competent to practice in Australia.

Countries such as India and the Philippines have hundreds of nursing schools, which would mean that in order to undertake an assessment of curricula, all nursing schools would need to be visited, which is impractical. Making an assessment on how a nurse will adapt and practice in Australia based on healthcare and nurse education systems in another country could and should be viewed as very subjective.

This led me to question how one could assess a nurse's competence to practice from afar. What were the indicators of competence? Was it the content of a nurse's undergraduate curriculum? Was it the number of hours spent on theory and clinical practice in the curriculum? Was it the healthcare system in which they had completed their initial nursing education? Was it the experience and or postgraduate education they had gained after they were initially registered? Was it influenced by the economy of the country in which they undertook their nurse education? Many questions but there appeared to be little documented information available to provide adequate answers.

There was a general view that nurses from developing countries were not considered as competent to practise in a country like Australia, although how one came to this conclusion did not appear to be based on a fair and equitable assessment. There were so many questions that needed answers, however, the most burning question was, how were the decisions made either to recommend or not a nurse's eligibility for registration?

In order to understand what was required to determine an overseas-qualified nurse's competence to practice in Australia, a meeting was convened of local stakeholders to discuss what they believed were important considerations. These stakeholders included employers, tertiary institutions responsible for migrant bridging programs, overseas-qualified nurses (who had undergone an assessment), providers of English language courses, DIMIA and nurse regulatory authority staff. This group met twice and subsequently developed a discussion paper on the issues they believed were important to consider when assessing overseas-qualified nurses.

The main issues identified were, the ability to determine whether a nurse had the necessary skills and language to practise in Australia, the length of time it took to assess applications and the costs involved in the process. Other issues were, the importance of an overseas-qualified nurse's understanding of the Australian culture, healthcare system, medication management, scope of nursing practice and patients' expectations. The issues identified were placed on my employing Board's agenda for discussion and direction. The Board determined that discussion needed to occur on a national basis and referred the issues to the ANMC with a request that they place the assessment of overseas-qualified nurses on the national agenda.

Subsequently the ANMC initiated a working party called the 'Collaborative Advisory Panel' (the Panel) to review the policies for assessment of overseas-qualified nurses. The Panel consisted of members from each nurse regulatory authority in Australia. I was a member of this panel representing the jurisdiction in which I worked. The ANMC's brief to the Panel was to work towards the development of nationally consistent policies regarding the assessment and recognition of overseas-qualified nurses.

It soon became apparent at these meetings, that most nurse regulatory authority policies were based on staff's historical and anecdotal experience. Therefore national consistency was difficult as the experience of individual NMRA varied, as did the number of overseas-qualified nurses assessed per year in the different jurisdictions. It looked as though decisions made by the Panel were greatly influenced by the jurisdictions that assessed the largest number of overseas-qualified nurses per year, as they were considered to have the most experience and knowledge. While this may have been viewed as appropriate, there could have been any number of factors that may have led the particular NMRA to assess nurses the way they did. These factors may have included the individual staff member's knowledge of the countries from which the nurses came, mental models regarding persons with a non English speaking background and previous experiences with nurses from particular countries when practicing in the clinical environment. The power and control in determining assessment policy was held by the NMRA with the largest number of nurses on their registers or roles.

The greatest concern in using this approach to develop national polices was that decisions were based on historical experience and tacit knowledge. While this may seem appropriate, there was inconsistency between states and territories regarding which overseas-qualified nurses met the requirements for registration. It was difficult to ascertain the basis for the differences in assessment outcomes other than the variation in experience of the assessors. This appeared to be a very subjective decision making process. It was this experience and my concerns about assessment practices that led to the decision to undertake this research to determine how assessment policies and procedures were developed and implemented by each nurse regulatory authority in Australia. I also decided to collect data from selected overseas countries regarding their assessment policies and procedures to obtain a wider perspective on the issue.

It was expected that this study would make an original contribution to knowledge in relation to the assessment of overseas-qualified nurses, as there was limited literature on this subject. It was anticipated that by critically analysing the development of assessment policies and procedures both in Australia and overseas that recommendations could be made to encourage a review of the current model for the assessing of overseas-qualified nurses.

Another driver for the research was my appointment as Deputy Chair of the Overseas Qualifications Board (OQB), which was an advisory Board to the government on matters concerning the overseas-qualified professionals and trades persons. Involvement with the OQB enabled me to consider the similarity and differences in issues affecting other overseas-qualified professionals and tradespersons applying to work/practice in Australia.

These issues were predominately qualification/skill assessment, language assessment and the time taken to assess applications, not unlike those experienced by nurses.

The final driver was the perceived lack of fairness and equity for nurses from countries where the healthcare system was different and English was their second language. Having practiced overseas in countries such as Malaysia, the UK and Papua New Guinea, I had a strong belief that there were more similarities in the way nurses practised from a variety of countries than differences. Australia is a culturally diverse nation and the benefit of a workforce consisting of nurses from different cultural and linguistic backgrounds ought to contribute to better health outcomes for the public (Omeri & Atkins 2002). These nurses should not be treated as though their qualifications and skills are inferior to that of an Australian educated nurse.

An example of this attitude is highlighted in the following statements from a study by Omeri and Atkins on the lived experiences of immigrant nurses.

> Most people I came in contact with did not have any knowledge of different people from different backgrounds. They were treating me like I was stupid, that I was from a third world country. It was not nice (Omeri & Atkins 2002) p 502).

> Talent and experiences of overseas nurses are over-looked and they should be taken seriously. Refugees don't have the necessary documents, therefore their skills are overlooked (Omeri & Atkins 2002) p 501).

> Immigrant nurses are frontline practitioners in their own countries, take leadership and overcome obstacles with minimal equipment and educational materials. Their experiences are not recognised there they just look for a piece of paper (Omeri & Atkins 2002) p 500).

These statements suggest a silent voice in the assessment process, namely that of the nurse who appears to be disempowered in this process, due to a lack of knowledge of the NMRA in regard to practice in the nurse's country of origin. My concern was for these nurses and for the decision-making processes used by the NMRAs.

Terminology

Before pursuing further discussion relating to the assessment policy, explanation is needed to clarify the term overseas-qualified nurse. Australia is an island and therefore, anyone who comes from another country is from overseas. This is why nurses from countries other than Australia have been referred to as overseas-qualified nurses by the ANMC. However, in the past two years the ANMC has changed their terminology in relation to these nurses to overseas-educated nurses. Other countries refer to these nurses as Internationally Educated Nurses, which I believe, could give the perception that these nurses are educated in a number of different countries, or are internationally recognised like the international baccalaureate, which may not be the case.

For the purposes of this study I have identified these nurses, as overseas-qualified nurses as a recognised qualification leads to registration, education on its own may not. In most countries it is the qualification such as Bachelor or Certificate in nursing that meets the requirements for registration therefore, education is what leads to the attainment of a qualification.

Aim of the Research

The aim of this research was to critically analyse policy development and policies, relating to the assessment of competence to practice and language proficiency of nurses who had not received their nursing qualification in the country in which they were applying to practice.

Thesis Overview

To achieve the research aim, it was necessary to obtain current policies and procedures used to assess overseas-qualified nurses from NMRAs in Australia and overseas. It was also necessary to interview selected NMRA staff face-to-face, to determine their understanding and underlying assumptions of the policy development, policies and procedures in relation to the assessment of overseas-qualified nurses. It was believed that by critically analysing policy development and policies employed by selected NMRAs a greater understanding of how and why decisions were made in relation to assessing overseas-qualified nurses would be achieved.

Presented in chapter two is an overview of the literature, which identifies and explains the current knowledge in relation to policy development and policies used by Regulatory Authorities responsible for the assessment of overseas-qualified nurses and other health professionals. Also discussed are the issues relating to barriers experienced by overseas-qualified nurses in the assessment process. Dialogue focuses on the global shortage and movement of nurses, followed by the issues affecting the Australian nurse shortage and mobility taking into account the influence of trade agreements on the global movement of nurses.

Further discourse pertains to the concept of regulation in the public interest and how this affects the assessment process for overseas-qualified nurses. The final section of the chapter reviews assessment of language and competence to practice, and how this is determined by NMRAs.

Chapter three provides a discussion of the rationale for the use of Critical Social Theory as the philosophical underpinning of the study. A brief history and critique of the development of Critical Social Theory is provided.

Chapter four outlines the research methodology, which was critical to the policy analysis. The use of Bridgman and Davis' (2000) policy cycle is discussed in depth, as this cycle was pivotal to the analysis of each policy and process involved in the research. The methods used are also discussed which include: determining the research setting, the selection and recruitment of participants, data collection techniques and stages followed by the data analysis framework. Discussion on establishing and ensuring rigour in the research and the ethical considerations are presented in the final parts of this chapter.

Chapter five presents findings of the data collected from the NMRAs in Australia. Initially demographic data are provided to contextualise the number of overseas-qualified nurses applying for registration.

The composition and decision making of each NMRA Board and Board committees is discussed in relation to determining who had the decision-making powers in the policy development process. Each NMRA's policy development process is then compared to Bridgman and Davis' (2000) policy cycle.

Chapter six is presented in the same format as chapter five, however the information pertains to the overseas NMRAs. Chapter seven is a discussion of the findings of the study in relation to Bridgman and Davis' policy cycle and Prunty's signposts for critical policy analysis.

The final chapter provides the conclusions and recommendations for future action in relation to policy for the assessment of overseas-qualified nurses in the Australian and global context. This discourse relates to policy development and the use of a policy cycle as a framework for policy development in the future. This chapter also acknowledges the limitations of the research and the how these limitations could be addressed in the future.

CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter presents an overview of the current literature relating to and influencing policy development and policies used to assess overseas-qualified nurses by nurse regulatory authorities in Australia and overseas. The primary search revealed a dearth of literature on policy development and policies relating to both nurses and other professional groups who qualified in another country. However, there was literature on the factors that may affect policy development and the ensuing policies. These factors were the global shortage and movement of nurses and its affect on Australia's nurse shortage. There was also literature on trade agreements affecting both Australia and other countries and the influence these agreements have on mutual recognition of qualifications and the skills of persons from countries between which, agreements exist.

The concept of regulation and its history in Australia, which has lead to the requirement of overseas-qualified nurses to register in the jurisdiction in Australia in which they wish to practice, is discussed. Language requirements and qualification screening for the assessment of overseas-qualified nurses and other professionals is also discussed.

The literature supported the view that there was a global movement of nurses, which has placed increased pressure on nurse regulatory authorities to assess nurses from other countries favourably and in a timely manner. However, not all nurses are assessed favourably, which has led some overseas-qualified nurses to believe that they are discriminated against in the assessment process (Hawthorne & Toth 1995; Hawthorne 2001b; Omeri & Atkins 2002).

An exhaustive search of the literature demonstrated that there was an absence of information relating to the policy development and policies used to assess overseas-qualified nurses both in Australia and overseas, supporting the researchers position that there is a gap in current knowledge.

Parameters of the Literature Search

An extensive and comprehensive search of the literature was undertaken, using the search terms assessment, qualifications, credentials, educated, professional, nurse, medical practitioner, overseas, shortage, mobility, regulation, international, policy and policy development. Electronic databases searched were CINAHL, MEDLINE, ERIC and AUSTROM as these databases capture literature relating to health, nursing and multicultural issues. Reference lists and bibliographies of all retrieved articles were also searched to identify any further relevant literature. The search engine Google was used to identify any papers presented at conferences, which may not have been published.

The initial literature search related to overseas-qualified professionals and the policy development and policies used in the assessment process. This search revealed literature that mainly focussed on the policies that affect the assessment process, such as immigration policy, settlement policies, labour market regulation and in Australia state and federal jurisdictions. Whilst reviewing the literature it became apparent overseas-qualified nurses were seen as migrants first and professionals second, therefore the words foreign, migrant and immigrant were added to the search terms.

This changed the focus of the literature search and yielded literature relating to the global migration of nurses. Information was also sought from individuals within Australia and overseas who had conducted research or had influenced the area of overseas qualification assessment to determine where any unpublished literature could be located. However, most of the literature retrieved related to the shortage and movement of nurses globally.

Global Shortage and Movement of Nurses

There is a significant shortage of nurses in most countries of the world (Kline 2003). Factors that have led to this situation are an ageing nursing workforce, more career choices for woman and healthcare systems where nursing care and nursing work are more demanding due to the higher acuity of patients (Kingma 2001; Buchan 2002; Clark 2002). These factors have in some cases led nurses to seek alternative careers that have meant a move away from nursing. Other factors influencing nurses to move are, to improve their learning and practice opportunities, higher wages, better working conditions and personal safety (Kingma 2001). In developing countries, factors such as low pay, poor career structure, inadequate educational opportunities and a devaluation of women and women's work are catalysts for nurses pursuing employment in developed countries (Buchan 2001).

In the United States of America (USA), Canada and the United Kingdom (UK) the nursing shortage is a recurring theme in the literature (Buchan, Seccombe & Thomas 1997; Buerhaus, Staiger & Auerbach 2000; Sibbald 2000).

It has been reported that in Ontario, Canada there is a shortfall of 12,000 nurses, with the shortage expected to become worse as older nurses reach retirement age (Sibbald 2000). The main reasons for the shortage appears to be similar in all three countries namely, fewer young people are choosing nursing as a career as there has been many more career choices open to women since the women's movement in the 1970s and the generation of baby-boomers increased the population but growth in subsequent generations has not been as large (Buerhaus, Staiger & Auerbach 2000). Quite simply, there are not as many young people available to enter the workforce as during the baby-boomer generation. Another trend is the number of mature people entering nursing in their 30s and 40s, reducing their potential years of work, compared to those of a person entering nursing in their early twenties (Buerhaus, Staiger & Auerbach 2000). This trend is leading to a rapidly aging nursing workforce. Another issue of importance is that nurses aged in their 40s and 50s tend to reduce the number of hours they work or retire altogether leading to a gap in the nursing workforce, in other words more nurses are needed to fill twenty four hour rosters (Kline 2003).

The shortage of nurses in developed countries has led to the global movement of nurses from other countries to fill the gaps in the nursing workforce (Hawthorne & Toth 1995; Buchan, Seccombe & Thomas 1997; Godfrey 1999; Payne 2000; Hawthorne 2001b; Kingma 2001; Buchan 2002). However, the current global movement of nurses could be viewed as a 'global treasure hunt or disaster-in-the-making' (Kingma 2001, p. 250). The concern is that nurses from developing countries are encouraged to fill nursing shortages in developed countries to the detriment of their country of origin (Kingma 2001).

This issue has fostered debate about the ethical issues associated with the recruitment of nurses from one country to the detriment of another (Buchan 2001; Kingma 2001). For example Nelson Mandela spoke out against countries such as the United Kingdom poaching South African nurses, as his country was experiencing an AIDS epidemic and required all the skilled nurses available (Payne 2000). However, it could be said that any nurse has the right to travel and gain experience in another country for both personal and professional reasons.

This is true of Chinese nurses wishing to practice in the USA. There is currently an oversupply of secondary nursing school graduates in China, as urban hospitals are favouring hiring nurses who hold associate or baccalaureate qualifications (Xu 2004). This has meant that graduates of secondary nursing schools are looking to work in countries such as the USA. In order for this to happen all overseas-qualified nurses are required to obtain a certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS). The CGFNS is the primary agent responsible for screening foreign nurses for the United States government by certifying their education, qualifications and English language proficiency (Commission on Graduates of Foreign Nursing Schools 2005). The CGFNS in July 2003 set-up a testing centre in Beijing to enable Chinese nurses to undertake the necessary testing in order to meet the requirements to practice in the USA. It is anticipated that Chinese nurses will ease the USA nurse shortage in the short to medium term. Although, the import of Chinese nurses may alleviate this shortage, issues relating to how these nurses transition into the American workplace requires careful consideration (Xu 2004).

The global mobility of nurses relates proportionally to the global movement of women as a whole (Hawthorne 2001b). Women, prior to the 1980s were considered, from a migration perspective, as dependants of male migrants or as passive participants in migration. This has changed in the 1990s with professional women increasing their mobility in the global market, especially in response to civil unrest in their homelands (Hawthorne 2001b).

The global shortage has forced countries such as the USA, UK and Australia to reconsider nurses' applications from countries where they have previously been judged as not holding qualifications suitable for registration such as the Philippines, India and China. The affect of this global shortage is now discussed in the context of the Australian nurse workforce.

The Australian Nurse Shortage

The Australian Institute of Health and Welfare (AIHW) Nursing Labour Force Reports (NLFR), provide statistics on the supply and distribution of the nursing labour force in Australia. The statistical data are collected annually by all NMRAs in Australia, however this is a voluntary process in most states/territories. Nurses are sent a survey form, which has been developed by the AIHW in consultation with the NMRA as part of nurses' annual registration renewal process. In some states/territories it is mandatory to return the survey, however in other states/territories this is not the case. Hence the return rate varies from each state/territory and provides data that could be flawed. Nonetheless this is the only data available that relates to the working trends of nurses in Australia.

The total number of nurse registration and enrolments between 1993 and 1999 dropped from 270,720 to 257,662 (Australian Institute of Health and Welfare 1999; 2001). Given that the Commonwealth Government has decreased the number of full-time student positions allocated to nursing over the past 10 years (as different disciplines vie for student positions within the universities) this has had a profound effect on the number of students completing nursing degrees. This situation is further exacerbated by young people's perceptions of nursing as cleaning up after people, having to work on weekends and receiving poor pay, resulting in nursing not having a high preference as a career choice for the youth of today. However, anecdotal information suggests that this is slowly changing with places in undergraduate degrees in nursing in 2004 being filled by all first preference applicants.

The shift from full time to part time employment has also contributed to the nursing workforce shortage. The 2001 Nursing Labour Force Report (Australian Institute of Health and Welfare 2003) indicates an increase from 46.8% in 1993 to 53.8% in 1999 of nurses working part-time (less than 35 hours per week). The national supply of nurses decreased from 1,074 Full-Time Equivalent (FTE) nurses per 100,000 population in 1993 to 1,018 FTE in 1999 (Australian Institute of Health and Welfare 2003). However, the number of patients admitted and discharged from healthcare settings increased from 5.3 million 1995-96 to 6.0 million in 1999-2000 (Australian Institute of Health and Welfare 2003). Whilst it could be perceived that nurses do not wish to seek full-time employment, employers in an effort to decrease wage costs appear anecdotally to encourage part-time employment for nurses and are not backfilling these positions. However, there is no literature or evidence to support this view.

The age structure of the nursing workforce has undergone a considerable change from the 1986 Australian census where 23.3% of nurses were aged less than 25 years and 17.5% were aged 45 years or more(Australian Institute of Health and Welfare 1999). By 1996 nurses less than 25 years old had fallen to 7.7% while nurses aged 45 years or more had increased to 30.3% (Australian Institute of Health and Welfare 1999).

The number of Australian students commencing basic nursing courses decreased from 8,010 in 1993 to 7,195 in 2000 while the number completing basic nursing courses decreased from 6,397 in 1993 to 4,465 in 2000(Australian Institute of Health and Welfare 1999). These figures indicate an attrition rate of 38% in 2000 compared to the national crude attrition rate for all undergraduate students of 22.1% in 2000 (DEST 2004). It would appear that the attrition rate for nurses was higher than the national attrition rate for undergraduate students. There could be a number of factors influencing the attrition rate for nurses. One factor could be that enrolled nurses undertaking a Bachelor of Nursing enrolled in their degree as mature age students, hence factors such as having to manage a family as well as work and study may influence their attrition rate. Another factor could be students' perceptions of what constitutes nursing practice and the reality when exposed to clinical practice.

In 2004, the Australian Government announced an increase in university places for nursing undergraduate degrees in an attempt to decrease the nursing shortage, however this increase will not be realised for another four years (DEST 2004). In order to maximize completion rates in nursing degrees, it may be prudent for the government to determine why the attrition rate in nursing degrees has been higher than the national rate for all undergraduate students.

There is a higher rate of the student cohort being female in undergraduate nursing programs in comparison to other disciplines such as teaching. If nursing students are mature age and have children, the level of support they receive could be a factor that influences whether they complete their nursing degree or not. The entrance scores required by universities for students entering nursing degrees is lower than most other health professional programs such as physiotherapy and pharmacy (SATAC 2005). This could be the situation due to the limited available places in programs such as physiotherapy and pharmacy, which has led to a higher Tertiary Entrance Ranking (TER).

In February 2001 a national shortage in specialist nurses was apparent, in particular critical/intensive care, operating theatre, accident and emergency, cardio thoracic, neonatal intensive care, neurological, paediatric, aged care, renal, oncology, palliative care indigenous health, mental health and midwives (Australian Institute of Health and Welfare 2001). At the same time there was a decrease in the number of nurses commencing post-basic courses from 2,075 in 1997 to 1,757 in 1999 (Australian Institute of Health and Welfare 2001). The reasons indicated for this decline in the 1999 NLFR were that postgraduate training involved significant costs for nurses in course fees and a loss of income during time out of the workforce while studying (Australian Institute of Health and Welfare 2001). Given the experience shortage there has been a push to import nurses from other countries to fill the current skills gap particularly in relation to specialist nurses.

Mobility of Nurses To and From Australia

In the past few years marketing campaigns for nurses to work in the UK and USA have been evident in the Australian press. Incentives include higher wages and free flights to and from each country. On the other hand the NFLR 1999 indicate that, Australia has a relatively low level of recruitment of overseas-trained nurses (Australian Institute of Health and Welfare 2001). However, in 1999-00, 854 nurses migrated to Australia temporarily for employment, in the main 489 were from the UK and Ireland while 251 were from New Zealand, the remaining 120 were from a variety of other countries(Australian Institute of Health and Welfare 2001). In addition 1,866 Australian nurses returned to Australia from long-term stays overseas. Offsetting these numbers, 834 Australian nurses with temporary visas left for countries such as the UK/Ireland, the Middle East, USA and Canada. In the period 1999-2000 there were 1,158 nurses from other countries who permanently migrated to Australia, while 752 Australian nurses permanently migrated to another country, leading to a net gain of 406 nurses for Australia (Australian Institute of Health and Welfare 2003).

Buchan et al (1997) examined the overseas mobility of UK based nurses to determine the effect of their mobility on national resources. They found that there was a reduction in the numbers of nurses both leaving and entering the UK. Australian nurses accounted for most applications for registration in the UK followed by Nigeria. Buchan et al (1997) suggest that Europe may be a significant source and destination for UK based nurses. This could be occurring due to the trade agreements between the UK and European countries as part of the European Union. The same could be said of Australia with the 1998 Trans Tasman Mutual Recognition Agreement between Australian and New Zealand.

Mutual recognition of qualifications for nurses between Australia and New Zealand has meant that of the nurses entering Australia in 1999-00, 29.4% were from New Zealand (Australian Institute of Health and Welfare 2003). However there are many trade agreements that currently and in the future will affect the movement of nurses.

World Trade Agreements and the Movement of Nurses

Current world trade agreements have had a profound affect on the ability of nurses to move in the global market. So much so that the International Council of Nurses (ICN) commissioned a monograph to fill an information gap relating to trade agreements affecting nurses and to assist nurses to consider issues of practice, education, administration and policy positions in relation to cross border regulation (ICN 2000). The following is a brief overview of the current trade agreements that could and do affect nurses and their ability to practice in another country.

The General Agreement on Tariffs and Trade (GATT) was created in 1947 to regulate international trade in materials and products (ICN 2000). This agreement was responsible for consolidating trade between countries and negotiating lower trade tariffs on goods. However, in 1986-1993 GATT focused on areas such as, production standards, investment, intellectual property rights and importantly the trade in services (ICN 2000). The World Trade Organization (WTO) created by the Uruguay Round Multilateral Trade Negotiations in 1986-94 effectively replaced the GATT secretariat. The WTO represents 144 countries and is responsible for administering WTO trade agreements, handling trade disputes, monitoring national trade policies and is a forum for trade negotiations (WTO 2002).

In 1994 the General Agreement on Trade Services (GATS) was formed and administered by the WTO and is a very broad and enforceable agreement affecting trade in services. One of the considerations for GATS is the movement of natural persons (natural person being a person rather than a corporation) specifically ensuring that qualification requirements and licensing do not cause unwarranted obstacles to trade in services. While it would appear that the WTO and the GATS foster the movement of natural persons, the extent to which the GATS support qualifications obtained in one country and automatically recognised in another it would appear, is limited. An example is that of the 144 WTO members, Australian NMRAs recognises nurse's qualifications in only nine countries.

Regional Trade Agreements

European Union (EU)

In 1957, the Treaty of Rome established the European Economic Community (EEC), which became the European Union (EU) in 1993. This was a significant development as the EU now consists of most countries in Western Europe. The EU acts as a framework for united positions on security, foreign policy, police and issues of justice (ICN 2000). The framework consists of a Council of Ministers, a Commission, a Court of Justice, a Parliament, a Committee of Permanent Representatives and an Economic and Social Committee. The most relevant group for professionals is the Council of Ministers who develops regulations and directives, which are binding on all member states. The Council of Ministers initially worked towards unity of standards, however its focus has now moved to mutual recognition, which entails recognition of each state's professional regulation.

Therefore, a person recognised as a nurse in one EU member state must be recognised in all EU member states. This was further enhanced in the 1993 Maastricht Treaty, which included members of the European Free Trade Association as part of the mutual recognition across member states (ICN 2000). Consequently most countries in Europe are subject to trade agreements, which mean nurses' qualifications are recognised across these countries.

North American Free Trade Agreement (NAFTA)

The Trilateral Initiative for North American Nursing was established to address common professional standards in Canada, Mexico and the United States of America. The push for its development was the North American Free Trade Agreement (NAFTA) initiated to promote freer, fairer trade in goods and services such as nursing (Maroun 1997). Trade agreements in the Americas prior to the late 1980s related to goods only, however services were added to the agreements which meant professional groups were required to negotiate standards of practice (Maroun 1997). NAFTA encouraged the three countries to develop mutually recognised standards and to work towards mutual recognition for nurses (ICN 2000). However, it would appear that mutual recognition of qualifications for nurses between Canada, Mexico and the USA has not yet occurred, as nurses from Canada and Mexico are required to undertake a national Examination enforced by American state NMRAs (Wisconsin Department of Regulation & Licensing 2002).

The Asia-Pacific Economic Cooperation (APEC)

The Asia-Pacific Economic Cooperation (APEC) was launched in 1989 and has become the conduit for promoting trade liberalisation and economic cooperation in the Asia Pacific region (Iredale 1997). In 1994 APEC declared a common resolve to free and open trade by the year 2020 (Maroun 1997). Twenty-one countries are involved in APEC with representatives from a range of countries such as Australia, Vietnam, Korea, Philippines and China.

Another group of countries named the Association of Southeast Asian Nations (ASEAN) consists of all Southeast Asian countries. ASEAN has committed to a Framework Agreement on Services, however, currently it is not mandatory to recognise education or experience, licensing or certification of other members (International Council of Nurses 2000). The ICN in it's Regulation Bulletin in 1999 published a study conducted on 'Nursing in APEC-Member Countries' (Barcelo 1999). The results of the study were that most of the seventeen countries offered degree programs as educational preparation for nurses, six did not require nurses to pass a national examination and majority had government agencies as regulatory bodies (Barcelo 1999). Recommendations from this report were that the region moves toward immediate discussions on reciprocity or mutual recognition of qualifications among APEC countries. The Trans Tasman Mutual Recognition Agreement between Australia and New Zealand was cited as an exemplar of how this may be achieved.

Trans Tasman Mutual Recognition Act (TTMRA)

The *Trans Tasman Mutual Recognition Act 1997* (TTMRA) is a Commonwealth of Australia Act to facilitate the recognition within Australia of regulatory standards adopted by New Zealand regarding goods and occupations. Each state/territory of Australia was encouraged to adopt the TTMRA, which was the case in all states/territories except Western Australia. However, it is understood that the legislation to bring the TTMRA into effect has sat in the legislative Council of the Western Australian Government since August 2002 (McGinty 2004). The TTMRA has meant that nurses registered with the Nursing Council of New Zealand are eligible to register in all states/territories of Australia except Western Australia. The eligibility to register in Australia is based on the mutual recognition of qualifications between Australia and New Zealand. The TTMRA also means that Australian nurses are eligible to register in New Zealand without assessment of their qualifications.

To date the TTMRA is the only mutual or reciprocal agreement in relation to occupations that Australia has with another country. There is mutual recognition between the states and territories in Australia as a consequence of the *Mutual Recognition Act 1992* where persons with a registered occupation in one jurisdiction can freely enter an equivalent occupation in other jurisdictions. This means that nurses who apply under the TTMRA from New Zealand to Victoria and meet the requirements for registration are then able to apply to Western Australia under the *Mutual Recognition Act 1992,* which effectively creates a backdoor process.

Singapore-Australia Free Trade Agreement (SAFTA)

The Singapore-Australia Free Trade Agreement (SAFTA) signed by both countries in February 2003 is an agreement developed to guarantee increased market access for Australian exporters of services, particularly education, environmental, telecommunications, and professional services. However, there is no agreement in relation to occupations.

Thailand-Australia Free Trade Agreement (TAFTA)

The Thailand-Australia Free Trade Agreement (TAFTA) was signed in 2004 and came into force on 1st January 2005. The main objectives of the Agreement are: 'to liberalise trade in goods and services and to create favourable conditions for trade and investment; to build upon the countries' WTO commitments and to support trade liberalisation and facilitation in APEC; and to establish a program of cooperative activities' (Department of Foreign Affairs and Trade 2004c).

The liberalisation of trade in services between Australia and Thailand is to enhance the cooperation between parties and to improve the efficiency, competitiveness and diversity of services. The agreement provides the following information in relation to recognition of qualifications.

> For the purposes of the fulfilment of its standards or criteria for the authorisation, licensing or certification of services suppliers, each party may recognise the education or experience obtained, requirements met, or licences or certifications granted in the other party. Such recognition may be based upon an agreement or arrangement between the parties. The parties acknowledge that, wherever appropriate, recognition should be based on multilaterally agreed criteria. The parties shall encourage their relevant competent bodies to enter into negotiations on recognition of qualification requirements, qualification procedures, licensing or registration procedures with a view to the achievement of early outcomes (Department of Foreign Affairs and Trade 2004b).

Clearly from this agreement there appears to be a strong push by both governments for mutual recognition of qualifications, however this has not occurred to date in relation to nursing.

Australia-United States Free Trade Agreement (AUSFTA)

Negotiations on the AUSFTA were finalised in February 2004 after 11 months of negotiations. The AUSFTA was signed on the 18 May 2004 with both Australia and the United States passing enabling legislation giving effect to their respective commitments under the agreement, which came into force on 1st January 2005 (http://www.dfat.gov.au/trade/negotiations/us.html). This agreement is more prescriptive than the TAFTA and clearly sets out the definition of professional services and recognition as follows:

Professional services are defined in this agreement means:

> The supply of which requires specialised post-secondary education, or equivalent training or experience, and for which the right to practice is granted or restricted by a Party, but does not include services supplied by trades persons or vessel and aircraft crew members (Department of Foreign Affairs and Trade 2004a).

Recognition is defined as:

1. For the purposes of fulfilment, in whole or in part, of its standards or criteria for the authorisation, licensing, or certification of services suppliers, and subject to the requirements of paragraph 4, a party *may* recognise the education or experience obtained, requirements met, or licences or certifications granted in a particular country. Such recognition, which may be achieved through harmonisation or otherwise, may be based on an agreement or arrangement with the country concerned or may be accorded autonomously.
2. Where a party recognises, autonomously or by agreement or arrangement, the education or experience obtained, requirements met, or licenses or certifications granted in the territory of a non-party, nothing in Article 10.3 shall be construed to require the party to accord such recognition to the education or experience obtained, requirements met, or licenses or certifications granted in the territory of the other party.

3. A party that is a party to an agreement or arrangement of the type referred to in paragraph 1, whether existing or future, shall afford adequate opportunity for the other party, if the other party is interested, to negotiate accession to such an agreement or arrangement or to negotiate a comparable one with it. Where a party accords recognition autonomously, it shall afford adequate opportunity for the other party to demonstrate that education, experience, licenses, or certifications obtained or requirements met in that other party's territory should be recognised.

4. A party shall not accord recognition in a manner which would constitute a means of discrimination between countries in the application of its standards or criteria for the authorisation, licensing, or certification of services suppliers, or a disguised restriction on trade in services. Annex 10-A (Professional Services) applies to measures adopted or maintained by a Party relating to the licensing or certification of professional service suppliers as set out in that Annex (Department of Foreign Affairs and Trade 2004a).

The AUSFTA uses wording such as may, in relation to recognition of education or experience obtained, requirements met, or licences or certifications. However, it would appear that there are avenues for both countries to discuss mutual recognition of qualifications. It will be interesting to monitor whether there is any mutual recognition of qualifications between Australia and the USA in the future, as it would appear that the process determined by the CGFNS is entrenched.

Future Trade Agreements with Australia

Australia is currently undertaking scoping and feasibility studies with Malaysia and China in relation to Free Trade Agreements and it is anticipated that these agreements will be similar in relation to occupations. While the current trade agreements Australia has with countries do not consider mutual recognition of professional services (other than New Zealand) this may not be the case in the future. Therefore nurse regulators should be cognisant of the impact these agreements may have on policies relating to the assessment of overseas-qualified nurses in the future.

The mobility of nurses may change in time as policy makers develop long term strategies to address the current shortage of nurses, such as increasing the number of positions available in undergraduate nursing programs, increasing nurses' salaries and improving conditions in which nurses work rather than relying on nurses from other countries (Hawthorne 2001b; Kline 2003; Xu 2004). It is likely that there will always be mobility of nurses perhaps not to the extent there currently is, as countries attempt to address the nursing shortage by creating more places in nursing programs. Nonetheless it is believed that nurses will continue to be a mobile profession, which means there will be a need to consider mutual recognition to foster the sharing of knowledge and skills in this multicultural world.

In summary, trade agreements appear to have varying ability to affect nurses' movements from country to country but must be considered when discussing the global shortage of nurses. If some or any of the trade agreements discussed were pursued with greater vigour there could be an increased movement of nurses, perhaps influencing the regulatory process. For instance if the Thailand-Australia Free-Trade Agreement included the word *will* instead of *may* there could be an influx of Thai nurses seeking registration as a nurse in Australia. Therefore the systems would need to be in place to ensure timely assessment of qualifications by NMRAs in Australia and visa versa, in order to ensure nurses are able to practice at the determined standard.

Regulation in Order to Protect the Public

Regulation and deregulation have shared much public debate as a socio-political issue in the past 20 years (Affara & Styles 1990). Where previously, the government controlled or regulated services in the public interest such as water, electricity and airlines, deregulation has moved that control to different groups. Tesh (1990) suggests that economic individualism and political individualism make government regulations perverse, as government regulation allows no ability for individuals to self regulate. An opinion not shared by Edwards who states that social control is, 'the utilization of various mechanisms and techniques to discourage, restrict, prevent, divert or otherwise alter the behaviour of those who constitute an actual or potential problem to the majority' (1988 p. 4). In other words there is a need to have social control or regulation in order to protect the majority.

Social control does not necessarily mean punitive or repressive control. Institutions such as government departments, police or the courts system are often seen as the only form of control (Edwards 1988). Other forms of socialisation agencies are groups such as the family, schools and religion, which use education and persuasion as their techniques for control (Edwards 1988).

There are two forms of regulation or control for nurses, statutory and self-regulation. Statutory regulation for nurses is administered by a regulatory authority to protect the public from nurses practicing either incompetently or unprofessionally (Robinson 1995; Caulfield, Gough & Osbourne 1998; Pickersgill 1998). Statutory regulation is derived from an Act of Parliament and is enacted by an independent body, where as self-regulation is overseen by the professional nursing organisation.

Ironically, in many places to ensure standards of nursing practice are met, nurses are often required to financially support both the statutory regulation and self or professional regulation. Statutory regulation is viewed as mandatory, as the title 'nurse' is protected and may only be used by persons who hold registration with the particular nurse regulatory authority. Statutory regulation determines the educational standards and the standards for continuing registration. If a nurse breaches the determined standards, disciplinary action may be taken.

Professional regulation or self-regulation is 'the means by which order, consistency and control are brought to the profession and its practice' (Ralph 1993 p. 60). The ICN notes that 'the goals of regulation relate to defining the profession and its members, determining the scope of practice, setting standards of education, ethical and competent practice plus establishing systems of accountability and credentialing processes' (ICN 1997, p. 3). The ICN acknowledges that the context for regulation is influenced by technological advances, consumer participation and expectations of healthcare, plus the formulation and application of various laws affecting nursing practice (ICN 1997).

Technological advances have been enormous in the past twenty years and with the advent of the Internet there is a greater focus on telecommunication and developments in biomedical research (Gaffney 1999). These developments have had a major influence on nursing practice and the regulation of that practice. An example of this is that rural nurses have the ability to link via telemedicine with a medical officer to assist with diagnoses and treatment of a patient (Bryant 2001).

This poses an interesting scenario about who is legally responsible for the patient's care, the nurse or the doctor and so, the debate continues amongst the profession as to what regulation is required to ensure public safety is maintained.

Recognition of a nurse's qualifications is part of the regulatory process which presumes holding a qualificaiton in nursing from an accredited institution ensures competency and therefore protects the public. However, regulation in relation to overseas-qualified nurses seeking registration appears to be based on the process used by either statutory bodies or professional bodies to determine whether a nurse has the qualifications and skills to practice. In other words, holding a qualification does not necessarily mean a nurse will be assessed as competent to practice, especially if the nurse is from another country. The global nursing movement is dependent on this assessment process as part of regulation of the profession.

Iredale cautions regulators on the assessment of a person's qualifications gained in another country.

> Governments are trying to promote labour mobility and break down the practices that have prevented or inhibited the free flow of labour across internal and external borders. Their success in doing this will depend on a number of factors, the most important of which are a willingness to adopt a broad view of skills, a reduction in the chauvinism that exists towards other countries' training standards and the abolition of closed shops and the practices associated with them (Iredale 1997, p. 138).

Professionals concur with Iredale's comment in relation to chauvinism as a barrier to gaining entry or utilising the knowledge and skills gained in their native country when applying for registration in Australia (Hawthorne 2001b; Omeri & Atkins 2002).

This approach appears to be exclusivist-protectionist where regulatory bodies accredit individuals who they believe have the ability to immediately integrate into the workplace (Iredale 2003). An approach such as this fosters the notion that professional groups have the ability to protect their patch, by keeping individuals from certain countries out of Australia. The medical profession for example does have a finite market in relation to Medicare provider numbers in Australia and therefore would have a vested interest in limiting the number of practitioners with area specific skills such as plastic surgery or orthopaedics to protect their income.

The main objective of statutory regulation for nurses is to protect the public by exercising a protective jurisdiction. This protective jurisdiction is part of administrative law, which is the branch of law that deals with the administrative processes of governments and quasi-judicial decision-making bodies such as nurse's boards (Staunton & Chiarella 2003). Each nurse regulatory authority in Australia, as part of administering the Nurses Act in their jurisdiction has the delegated authority to establish and administer systems for accrediting various categories of nurses (Chiarella 2001).

The ICN has indicated that there are three tiers to a system of governmental regulation. The first level is the statues or Acts, the second, regulations and the third, are the interpretations of those Acts and regulations that are put into guidelines or policies by the delegated authorities such as nurses boards (International Council of Nurses 2001b). It is the third tier in this system, interpretation of the Acts and regulations that are the main focus of this discussion. Particular attention is given to the interpretation of policies relating to the registration requirements for overseas-qualified nurses in the Australian context.

The Beginning of Nurse Regulation in Australia

The first nurses in Australia were reformed convicts who were described as dirty, frowsy old women (Russell & Schofield 1986; Smith S 1999). Henry Parkes a colonial secretary resolved that there was a need to improve the standard of nursing in Australia (Smith S 1999). He sent to England for Nightingale-trained nurses who were to establish training programs for Australian nurses based on the British model of nursing which was initiated by Florence Nightingale and was highly respected (Minchin 1973; Smith S 1999). The Australasian Trained Nurses Association (ATNA) was established in NSW to coordinate the standard of nurse training. Branches were subsequently launched in other states with a break away branch established in Victoria called the Royal Victorian Trained Nurses Association (RVTNA) (Minchin 1973; Smith S 1999). The ATNA developed curricula for hospital training courses, facilitated examinations and approved training institutions. In an effort to improve the status of nurses both ATNA and the RVTNA sought registration for nurses.

It was not until 1920 that the first Nurses Act was proclaimed in South Australia. Subsequently other states followed, and by 1928 all states of Australia had a Nurses Act and so statutory regulation had begun for nurses in Australia. This regulation was influenced by the British model of nursing practice, medical practitioners who were predominate members of nurses boards and in the case of overseas-qualified nurses the White Australia Policy. Given that this study concentrates on assessment of overseas-qualified nurses there is a need to discuss the influences that stem from beginning regulation for nurses, which may still influence nurse regulation today and in turn the policies for assessing overseas-qualified nurses.

The White Australia Policy

The White Australia Policy was instigated by Australian Labour Party via the *Immigration Restriction Act 1901*, which was established 'to place certain restrictions on immigration and to provide for the removal from the Commonwealth of prohibited immigrants' (Department of Immigration and Multicultural and Indigenous Affairs 2003) p1). The Act was used to discriminate against Asiatics and Coloureds as they were referred to by politicians (Department of Immigration and Multicultural and Indigenous Affairs 2003). Migrants were required to undertake a 50-word dictation test in either English or a European language selected by immigration officials. In 1972 the White Australia policy was abolished which saw an increase in non-European migrants. Nonetheless, there has continued to be English language testing as a form of screening migrants (Iredale 1987). Nurses applying to work in Australia from NESB have been required to provide evidence of English language skills since the late 1980s as a pre-requisite of registration (Hawthorne 1997). Therefore, one could reasonably question whether the White Australia Policy is covertly continuing to influence policy relating to language requirements for NESB nurses.

The nursing profession in Australia is controlled and regulated by each state or territory's Nurses Act. The reason for this is that each Australian colony was set up under its own constitution therefore is governed by both its constitution and the Commonwealth of Australia's constitution (Forrester & Griffiths 2001). According to Staunton and Chiarella, 'all statutes are enacted for the purpose of establishing and administering a regulatory framework for accrediting various categories of nurses' (Staunton & Chiarella 2003 p. 187). The governing bodies responsible for the registration of nurses in Australia are the state or territory Boards.

Part of the registration process is to ensure there are processes in place to assess the competence of a nurse to practice.

Assessment of Competence to Practice

Several Australian authors have examined the issue of competence assessment for overseas-qualified nurses in an attempt to clarify the processes used by regulatory bodies (Jackson 1995; Iredale 1997; Hawthorne 2000; Bryant 2001). Australia has a qualification framework based on competence, therefore it would seem reasonable that any assessment of overseas-qualified nurses should be similarly based (National Office of Overseas Skills Recognition 1995). Traditionally in Australia and overseas, assessment of qualifications is paper based or an evaluation of formal qualifications. A paper-based assessment is fraught with difficulties as an understanding of qualifications in one country may be very different to another country's understanding (Iredale 1997).

The different terminology used when discussing qualification assessment is another factor to consider when discussing the assessment process (Iredale 1997). Terms such as registration, credentialing, accreditation, certification, licensing and regulation are used in relation to the qualification assessment process in various countries and sometimes interchangeably as though they mean the same thing. However, terms are not necessarily interpreted in the same context. This is problematic when attempting to understand processes used in other counties. The inconsistencies of using the word 'registration' in various countries, for example, in Canada, the USA and New Zealand the term is used for occupations not necessarily legislated by statute, whereas in Australia only groups legislated by statute use this term.

The terms licensing and certification are used for professions or trades, again depending on the country of origin. The terminology is confusing when attempting to determine whether qualifications are considered equivalent from one country to the next. Consideration as to whether qualifications are equivalent or comparable in the assessment process is an important concept.

> An 'equivalent' qualification means 'equal in value and content'. This requires compilation of a register of qualifications, which is accurate, comprehensive and up-to-date. 'Comparable' allows for more flexibility and a 'comparable' qualification is judged to be of equivalent value but not necessarily the same content (Iredale 1997 p. 11).

The interchange of these two concepts used in the assessment process are what cause barriers to overseas applicants (Hawthorne 2001b). The Australian Government established the National Office of Overseas Skills Recognition (NOOSR) in 1989 to take responsibility for encouraging the professions and para-professions to develop national competency standards. NOOSR stated that 'The Government had concluded that a greater reliance on demonstrated competence, rather than paper qualifications alone, would improve overseas skills recognition arrangements by establishing more open and equitable procedures' (1995 p. 2). It appears that, although competencies were developed they were not used in the assessment of overseas-qualified professionals (Iredale 1997).

Nursing was considered the only profession, using competence assessment for assessing overseas-qualified nurses who were predominately from a non-English speaking background (Hawthorne 2001b). This competence assessment is in the form of bridging programs, which includes theory and clinical assessment over a period of time.

Nurses from countries where the nurse regulatory authority has information regarding the education and healthcare system are less likely to be required to undertake a competence based assessment program (Hawthorne 2001b).

In 1993-94 a study was conducted involving nurses from NESB, who had participated in the New South Wales College of Nursing, Overseas-qualified Nurses Assessment Program (Jackson 1995). All nurses in the study were assessed against the ANMC competencies for registered or enrolled nurses. The study consisted of nine female nurses from Scandinavia, Europe, Asia-pacific, Eastern Europe and South America, each was interviewed and asked to describe their experiences in the hospital environment as qualified nurses. The findings of the study indicated that nurses believed that their technical proficiency was judged as a determinate of their competence to practice.

Equally if they were not technically adept they were deemed as incompetent despite their background, knowledge and understanding of primary nursing. One of the key findings was that the nurses believed that due to their own communication difficulties they were able to relate to clients who were of NESB. The conclusion of the study was that the ANMC competencies were being used to reinforce the dominant monocultural ethic that exists in nursing in Australia (Jackson 1995). Jackson does not consider that the AMNC competencies are able to embrace the different cultures that exist in Australia (1995).

However, if a nurse came from a country where the native language was English and the healthcare system was similar to Australia, there was a belief that this nurse would provide a standard of nursing commensurate with an Australian nurse and meet the ANMC competencies.

The notion of Australia being a multicultural society with residents from a variety of countries appears to be ignored when considering what skills and attributes nurses from NESB and countries with different healthcare systems could bring. It appears that the ANMC competencies do consider cultural sensitivities, however these seem not to be applied when assessing NESB nurses using a paper-based assessment. Jackson's findings do not support Hawthorne's suggestion that NMRAs are using competencies to determine a nurse's ability to practice in Australia. Jackson asserts that she believed that the ANMC competencies may not 'represent the values and beliefs of all sections of the community' therefore are not a true indicator of competence to practice as a nurse (1995 p. 36).

The other issue is that Australian Nurse Regulatory Authorities assess an overseas-qualified nurse's competence by ensuring that there is equivalence in qualifications. This is questionable in that competence is difficult to determine using a paper-based assessment. This discrepancy is highlighted by the fact that nurses from ESB are eligible for registration without having to undertake a bridging program (Hawthorne 2001a). In 1982/3, 48% of NESB nurses were recognised as eligible to register in Australia however by 1994/5 this percentage had decreased to 29% (Hawthorne 2001a).

The grounds for this decline may have been due to the ANMC's review of the standards and criteria for assessing overseas-qualified nurses that were embraced by most NMRAs in Australia.

Another issue discussed in the literature was the discrimination that NESB nurses believed they were exposed to from Australian nurses. It would appear that Australian nurses have had difficulty adjusting to nurses who have a different native language, skin colour, culture and educational preparation (Hawthorne 2001a). The reason may be that Australian nurses simply do not understand how nurses from some countries practice therefore cannot relate to how and why they practice the way they do. While this may not appear to be relevant to the assessment process, if all overseas-qualified nurses were given immediate recognition of qualifications due to trade agreements, the increased volume of nurses from NESB and developing countries would challenge Australian nurses need to change their perceptions of how these nurses practice.

The literature search also involved determining whether there was any information regarding the development of policies used to assess overseas-qualified nurses. In other words was there any literature or evidence to support the practice that currently existed for assessing overseas-qualified nurses. There was limited literature that related to policy development, as indicated earlier the literature predominately focussed on the shortage, mobility and barriers for nurses to achieve reciprocal qualifications in another country. Policies were discussed in relation to barriers for nurses to integrate into another country. The literature in relation to policy development was minimal hence the reasons why paper-based assessments, paper-based examinations and bridging programs were used remain a mystery.

Assessment of Other Overseas-Qualified Professionals

The literature search in relation to assessment policies for other overseas-qualified professionals revealed similar information to that of nurses. There was limited literature found in relation to policy development for the assessment of any group of overseas-qualified professionals. Literature related to issues of mobility and competence assessment and the discrimination of overseas-qualified professionals experience if they were from NESB countries (Hawthorne & Toth 1995; Iredale 1997; Basran & Zong 1998; Hawthorne 2000; Luo 2001; Groutsis 2003; Whelan, Arkles, Dewdney & Zwi 2004).

Policy in relation to assessment of overseas-qualified doctors has come under much scrutiny in Australia over the past ten years as the medical profession has strictly controlled the assessment process. Overseas-qualified doctors have been subjected to quota systems for eligibility to sit entrance examinations for registration, given 'conditional registration' to work in rural areas of need, for periods of five years and restriction in obtaining a Medicare provider number (billing number) until after a minimum of five years practicing in a rural area (Iredale 1997; Groutsis 2003). The medical profession has driven policy by restricting services despite demand and controlling the labour market supply using the assessment process (Groutsis 2003). This monopoly by the medical profession has occurred despite the Australian Commonwealth and state/territory initiatives to set simpler, more flexible, transparent, non-discriminatory accreditation processes (National Office of Overseas Skills Recognition 1995).

Other groups such as information technology (IT) professionals appear to have achieved global recognition of qualifications due to the fact that there is a universal language of computer terminology. However, there is no regulatory authority for IT professionals to place standards or barriers on their ability to practice in another country. It has emerged that demand for service is the closest form of regulation that IT professionals are experiencing. Although it appears that IT professionals have been subjected to possible regulation by governments in that temporary visas are offered for temporary skill shortages rather than permanent residency (Iredale 2003).

Self-regulated professions are occupations where the professional body regulates the practitioner, such as Accountants and Engineers. Accountants for example are required to meet the educational requirements of the Institute of Chartered Accountants (ICAA) or Certified Practicing Accountants (CPA) or National Institute of Accountants (NIA) for eligibility to hold membership of one or more of these institutions in Australia. If a Chartered Accountant from an overseas country wished to practice as a Chartered Accountant in Australia they may be required to undertake subjects in Australian tax and company law. Similar requirements exist for CPAs and NIAs. The three institutions advocate that membership of anyone of these institutions enhances the overseas-qualified applicants ability to find employment in Australia. However membership is not mandatory to practice as an accountant in Australia.

Overseas-qualified engineers on the other hand, are assessed by Engineers Australia (professional body), for equivalence of qualifications with an Australian engineering degree, plus evidence of an English language level of band 6, for all categories in either general or academic modules of IELTS.

However, if the overseas-qualified engineer's qualifications are not deemed equivalent they do have the ability to undertake a Competency Demonstration Report (CDR), where the applicant demonstrates their engineering knowledge and competence, to determine whether they are equivalent to an Australian qualification.

Mutual recognition of equivalent undergraduate qualifications does exist for signatories of the Washington Accord, which is an agreement between engineering accreditation bodies in eight different countries (The Engineering Centre 2005). These countries are Canada, Hong Kong SAR, Ireland, New Zealand, South Africa, United Kingdom, the United States of America and Australia. The Washington Accord participants agree that the criteria, policies and procedures used to accredit engineering academic programs are comparable and acceptable by all signatories. They also agree to regular communication and sharing of information with signatories of, accreditation criteria, procedures, manuals and to provide lists of accredited programs (The Engineering Centre 2005).

It would appear that Australian engineers are one of the only professional occupations that have mutual recognition of qualifications with countries other than New Zealand.

Summary

In this chapter an outline of how the literature search was conducted is described. The issues that effect the assessment of overseas-qualified nurses were examined, which included the mobility and shortage of nurses, trade agreements, regulation, assessment of competence to practice and policy development. It became apparent that the global shortage and hence movement of nurses has and is creating different expectations in relation to nurse regulatory authorities and overseas-qualified nurses.

Nurses with an ESB from a developed country have a less rigorous journey through the assessment process than nurses with NESB from a developing country. Competence appears to be linked to an ability to speak English and the healthcare system being similar from where a nurse has come to where they are applying for registration.

The literature review also focussed on policy development policy and for the assessment of overseas-qualified nurses and other professionals. However, it became apparent that there was a dearth of information in relation to policy development and policies in the assessment process. Therefore the chapter identified the need to explore how the policies were developed and the evidence that was used to inform the policies currently being used to assess overseas-qualified nurses. The following chapter provides and discusses the theoretical underpinnings of the study.

CHAPTER 3:   THEORETICAL PERSPECTIVE

Introduction

This chapter provides a synopsis of the development, goals and critique of Critical Social Theory as the theoretical perspective underpinning this study. The theoretical stance informing the methodology and methods used in this research was pivotal to the critical analysis of the assessment process of overseas-qualified nurses.

This chapter is presented in five sections. The first provides an overview of the factors considered in determining the appropriate theoretical perspective to underpin the study. The second discusses the history and development of Critical Social Theory and the third section discusses the guiding principles of this theoretical perspective. The fourth section critiques Critical Social Theory in order to provide a balanced argument as to why this perspective was chosen for this study. The final section provides discussion on the methodology used in the study.

Determining the Appropriate Theoretical Perspective

A theoretical perspective exemplifies how one views the world and reflects one's beliefs in relation to the human world and the social life within that world (Crotty 1998; Ranjha 1998). My basic beliefs are that all human beings should be treated as equals regardless of their race, religion or culture. In particular, nurses who have been educated in another country and who have English as a second language have the right to a fair, equitable and transparent assessment of their qualifications and language abilities.

However, it is known that there is inequality in the world and that some nurses are discriminated against in the assessment process on the basis of their race, religion and culture (Iredale 1987; Omeri & Atkins 2002; Wickett & McCutcheon 2002). Nurses who are educated in a country where English is a second language or where their elementary nursing education is perceived as not equivalent to nurses educated in Australia, appear to be disadvantaged when their qualifications are assessed. Anecdotal evidence from the literature suggests that the policies used in the assessment of overseas nurse's qualifications are inconsistent, inequitable and covert (Omeri & Atkins 2002). Therefore it was imperative that the reasons why this is the case were explored in a structured manner.

Undertaking research in this area necessitated determining what policies existed, how they were developed and whether they were overt in relation to the assessment of overseas-qualified nurses. It was anticipated that the study would also provide information in order to make recommendations for change if required, to ensure a consistent and equitable assessment process. It was considered for such research to be successful, that Critical Social Theory provided the theoretical underpinning best suited to the subject area.

The major theoretical perspectives underpinning research are positivism, post positivism, postmodernism, interpretivism (symbolic, phenomenology and hermeneutics) and critical (Denzin & Lincoln 1998). Each perspective has been developed from the philosophical beliefs of theorists about how their worlds were shaped. The positivism and post positivism perspectives are based on deduction.

The ontology of the positivist is based on realism rather than the relativity of the nature of reality. In other words, reality exists independent of our knowledge of that reality (Connole, Smith & Wiseman 1995). The epistemology of positivism is that knowledge is impersonal and objective with information gained independent of the researcher. Therefore, the methodology is experimental where a hypothesis may be tested using controlled conditions. Knowledge gained is considered to be objective, general and not affected by the context in which information has been gathered. This approach is predominately used in scientific inquiry where evidence is collected in a structured manner and measured against a predetermined control group. The results are usually presented statistically with information on whether or not they are statistically significant. There is usually little discussion as to the context in which the data collection occurred, other than in relation to sampling technique and issues of reliability and validity. The scientific approach has never professed to unravel the moral and ethical issues of society however, has an important place in providing technically analysed information.

Post positivism is a modified version of positivism. Its ontology is based on a concept of realism, however it is acknowledged that humans do not have the capacity, due to imperfect sensory and intellective mechanisms, to truly determine the ultimate truth (Guba 1990). Post positivists recognise that epistemologically it is impossible to truly divorce the inquirer from the inquiry situation. Therefore, they accept that the researcher attempts to remain neutral and acknowledges any personal predispositions.

Methodologically, post positivists advocate conducting inquiry in more natural settings rather than the laboratory setting, indicating a move toward collection of qualitative and quantitative data. However, it needs to be noted that the basic belief system of post positivism varies little from positivism.

Interpretivism is based on relativism, which is based on local and specifically constructed realities existing in people's minds (Guba 1990; Guba & Lincoln 1994). The epistemology is therefore constructionism as opposed to the objectivity of the positivist paradigm. Subjectivity allows the inquirer to explore what exists in the participant's mind in order to determine their reality. The researcher plays an integral role in understanding the meanings and beliefs of the information provided by participants. The methodology is hermeneutic and dialectical, meaning that individual constructions are interpreted as accurately as possible and then compared and contrasted with others to develop one or more constructions based on consensus.

Interpretivism emerged in contrast to positivism by attempting to understand and explain human and social reality (Crotty 1998). The researcher attempts to find meaning in an action by interpretive understanding or *Verstehen*. The reliability of the findings depends on the social, linguistic and cognitive skills of the researcher in analysing the data (Connole, Smith & Wiseman 1995).

Feminists challenge the notion of value-free objective, technical knowledge (Cheek, Shoebridge, Willis & Zadorozny 1998). Specifically in medicine, which is determined by men as an illness model as, opposed to the feminist's wellness model.

Some researchers consider that positivism, post positivism, constructivist and interpretivism perspectives lack the ability to address power inequities, structural constraints, and oppression within society (Fay 1987; Guba 1990; Agger 1991; Calhoun 1995; Browne 2000; Patton 2002). The critical approach is broader than both the positivist and constructivist, in the sense that not only is information sought and interpreted, but also this interpretation is undertaken in the context of the social, economic and power influences of one's world. The critical paradigm has an ontology, which is based on critical realism. Critical theorists (ideologists) believe in an objective reality by raising oppressed people to a level of true consciousness (Guba 1990). They also believe that once the oppressed recognise their oppression they are able to transform their world. This ontology coupled with an epistemology which is subjectivist, where the inquiry relates strongly to the values of the inquirer, is considered a forward step in lifting the oppressed (Guba 1990). In relation to method, critical theorists take an approach which requires dialogue between the researcher and the subjects of inquiry (Denzin & Lincoln 1998). The dialogue must be dialectical in nature, transforming ignorance and misapprehensions into an informed awareness and becoming a foundation for change.

The use of the word social with critical theory emphasises that this philosophical belief is about a theory of society, which goes beyond the concept of social structure as determined by Marx (Morrow 1994). The constructs and history of the critical approach as the guiding theoretical perspective for this research are now discussed further.

Development of Critical Social Theory

Karl Marx, Max Weber and Emile Durkeim are the three theorists most closely associated with the formation of contemporary sociology hence, indirectly influenced the development of Critical Social Theory (Morrow 1994). Marx and Weber recognised the historical nature of sociology, which put them outside the positivist interpretation of society. Both Marx and Weber were concerned with the contradictory notions of a capitalist society, the long-term effects of economic rationalisation and the effects of science and technology on society (Morrow 1994). Durkeim in contrast, was concerned with the breakdown of cultural organisation and the impact this would have on society long term (Giddens 1987; Guba 1990). All three questioned the nature of society.

The critical theory of society development is however, most closely linked to a group of German scholars known as the Frankfurt School. The school was comprised of members of the Institute for Social Research, formed in Frankfurt, Germany in 1923. Founding members were the theorists Horkheimer, Adorno and Marcuse, who were influenced by the devastation of Germany after World War I to reinterpret the world (Kincheloe & McLaren 2000; Kellner 2002). These scholars were concerned with the limitations of orthodox Marxist philosophy. They argued that the Marxist notion of the economic base determining the cultural backbone of society was a limited analysis of society. Those in the Frankfurt School believed there were other factors such as oppression, injustice and distorted communications, which affected and influenced the culture of society.

The significant features of this group were, that they were the first independent research group able to work initially within a Marxist framework, they were open to theories and methods from the social sciences and humanities and were the first group to use empirical research techniques to test Marxist theory (Morrow 1994).

Ten years after the school's beginning, Nazis controlled Germany. This situation created an unsafe environment for the members of the school who were predominately Jewish. Horkheimer, Adorno and Marcuse moved to the USA where they continued developing their work on what would become Critical Social Theory (Agger 1991; Kincheloe & McLaren 2000). However, shocked by the American culture of egalitarianism and the apparent racial and class discrimination present in this society, Horkheimer and Adorno subsequently returned to Germany in 1953 and re-established the Frankfurt School, while Marcuse remained in the USA and continued his work on social theory. Much of their work concentrated on critiquing and exposing scientism as reducing moral and ethical issues to that of technical issues. Some may view this as harsh, given that scientism has had a profound effect on society in relation to medical research involving treatment of various diseases.

Another critical theorist involved in the Frankfurt School was a second-generation member, Jurgen Habermas. Much of Habermas' work concentrated on the social construction of an individual's identity, which negated the basic differences amongst groups and how groups affect their members differently (Calhoun 1995; Crotty 1998). Habermas centred his critical theory on the potential for unimpeded communication suggested by the wisdom implied in speech itself.

He believed communicative actions grounded in presumptions of language were foundational to the social construction of an individual's identity (Habermas 1984; Calhoun 1995; Browne 2000).

Habermas developed an alternative theory of knowledge, which was based on technical, practical and emancipatory interests (Habermas 1970; Fulton 1997; Patton 2002). According to Habermas, technical interest generates knowledge, which attempts to provide causal explanations, it is the 'how to knowledge' (Habermas 1970; Smith B & Speedy 1995). Knowledge based on practical interest informs communicative understanding and is situational, however does not take into account social constraints. Knowledge based on emancipatory interest allows people freedom from the social constraints of their actions and understandings (Cheek et al. 1998). Habermas' theory fosters emancipation of the people to determine their own destiny, free from coercion or domination, which ultimately assists in a reflective awareness of their world (Habermas 1987).

Members of the Frankfurt School played a significant role in the development of Critical Social Theory, however their work remains in a highly abstract form, which has isolated them from the majority of theorists in the area of empirical social science (Giddens 1987; Calhoun 1995; Cheek et al. 1998). It appears that none of the Frankfurt school theorists claimed to develop a unified approach to cultural criticism (Kincheloe & McLaren 2000). Instead they all developed variations of a critical theory. This has become more apparent since the 1980s when a separation between Habermas and the two theorists Adorno and Benjamin emerged (Morrow 1994).

Habermas' work has become more popular with philosophers and social scientists as it addresses more familiar problems and rejects the work of Adorno and Benjamin, which is centred on Marxian theory of history and aesthetic theory (Crotty 1998).

While it is acknowledged that there are variations of Critical Social Theory initiated by the Frankfurt School, the theoretical and political positions held by this school have been used by contemporary Critical Social Theorists in the creation of theories to enhance social transformation in contemporary society (Kellner 2002).

This emergence of contemporary sociologists, social, political and cultural theorists worldwide includes Giddens, Held, Fay and Thompson (UK), Agger, Bernstein, Kellner and Piccone (North America), Neilsen, Rioux and Taylor (Canada), Beilharz, Connell, Pussey and Smart (New Zealand and Australia), who are closely associated with further development of Critical Social Theory (Morrow 1994).

However, Fay a critical social scientist, challenges the underlying principles of Critical Social Theory as being too narrow and not operating from a scientific base. Hence, Fay describes Critical Social Science as:

> An attempt to understand in a rationally responsible manner the oppressive features of a society such that this understanding stimulates its audience to transform their society and therefore liberate themselves (1987 p. 4).

Fay suggests that Critical Social Science attempts to generate an understanding of society in order to change it and does so in a scientifically respectable manner.

He also believes that Critical Social Science seeks to reclaim the *critical* function of theory, to reassert the scientist's role as an observer who is a critical voice of social consciousness, to assert a practical political voice and to change the world, not just describe it (Fay 1987). However, I do not support the notion that Critical Social Theory simply interprets the world and does not take the vital steps to in fact change it. Critical Social Theory identifies and challenges the underlying sources of domination and is no less ideological than mainstream research (Lather 1985).

Critical Social Theory is about changing the status quo through emancipation. Therefore one has to question why Fay believes the only way to initiate change is to use a scientific model. The four traits of Critical Social Science outlined by Fay could be considered fundamental to Critical Social Theory and are often used to describe critical theory (Agger 1991; Morrow 1994; Cheek et al. 1998).

Therefore I believe Critical Social Theory and Critical Social Science are from the same philosophical base, although Fay considers them to be dissimilar. Bearing this debate in mind the next section examines the foundational processes of Critical Social Theory.

The Foundational Processes of Critical Social Theory

There are a number of critical theorists who have a variety of positions and thoughts on what guides Critical Social Theory. However, while their positions and thoughts are different, their basic goals are similar. These are to construct knowledge, which leads to emancipation and empowerment and through this ultimately leads to change.

Critical Social Theorists believe that in the circumstance of oppressed individuals, knowledge exposes and determines where hidden power is situated. Once this hidden power is exposed, individuals are empowered to take action.

Freire, a Brasilian philosopher, believed that in order to overcome false consciousness caused by oppression, people had to emancipate themselves, which stemmed from the Marxist tradition (Fontana 2004). His theory of emancipatory education and liberalisation was foundational in the literacy programs he launched amongst the peasant people of northeast Brasil in the early 1960s (Crotty 1998).

Freire's literacy programs were not just about learning the alphabet, they were about teaching the words that were most meaningful to people. Hence, Freire spent time in the communities learning what words evoked responses from people and evolved their teaching from these words. He called these words 'generative words' which he displayed visually then discussed their meaning in groups (Crotty 1998). This meant that the people had power by using words that which lead to conscientisation or awakening of consciousness (Crotty 1998; Fontana 2004).

This consciousness led to people questioning then transforming their world. In the case of overseas-qualified nurses, the language used in the assessment process is unique to each NMRA. Understanding this language is important for these nurses in the assessment process in order for them to be empowered to challenge assessment policies when and if necessary.

To empower overseas-qualified nurses there is a need to understand where the underlying power lies, in other words who has a vested interest in keeping the status quo and who is affected by not having the power to question or change that status quo. More often than not, this questioning relates to race, gender and sexuality in minority groups (Fay 1987; Guba 1990; Fleming & Moloney 1996; Browne 2000). This appears to be the case in relation to overseas-qualified nurses who are a minority in Australia and even more so for nurses with English as a second language. Before discussing where the power lays in this situation the types of power noted by critical researchers requires more detailed discussion.

Types of Power

Power is three-dimensional, with the types of power being hegemonic, ideological and linguistic. Gramsci's notion of hegemony recognised that physical force was not the only form of power (Ransome 1992). Another form was by using mediums such as the media, school, family and the church to influence peoples' thinking (Ransome 1992). People are led to believe that if an idea or notion is projected to society by the media, school, and church or family, it must be reasonable to consent to or accept.

The critical researcher is aware that power achieved through hegemony should be questioned. Hegemonic ideology is the bigger picture in which power may be exerted which distorts people's reality. An example was Hitler's vision that blonde haired, blue eyed, Aryan people were a smarter race and should rule the world. Hitler had an idealistic hegemonic assumption that people would passively accept his vision.

Many did just that, however some began to question his ideological power, such as the critical theorists of the Frankfurt school.

Critical Social Theorists have also questioned the use of language as a source of power. Linguistic descriptions are an interpretation of an author's perception of a situation and may not necessarily reflect what really occurred. This is depicted in relation to the way the media presents an account of a situation. The same story may be presented differently depending on the interpretation of the presenting journalist. Therefore a Critical Social Theorist is aware of the way language in the form of discourse is able to regulate and dominate an individual or group (Kincheloe & McLaren 2000). Another example is the reference texts used in undergraduate nursing programs overtly or covertly influencing the thinking of students (Huntington & Gilmour 2001). The choice of texts are predetermined and influenced by lecturers who themselves have been influenced by their lecturers.

The use of terminology exerts a form of power in western countries especially for people who have English as a second language. Not knowing how to interpret the terminology leads to powerlessness when attempting to understand terminology and the culture of a new country (Iredale 1997). In particular this occurs when completing application forms for registration/enrolment as a nurse in another country. Words such as Christian or given name to a person who is of an Islamic background could lead to confusion.

Critical Social Theorists are conscious of the power of a few elite on the systems within society and are intent on exposing the facts to others. However, there is another side to power and that is empowerment as discussed by Fay:

> …power exists not only when a group is controlled but also when a group comes together, becomes energised, and organises itself, thereby becoming able to achieve something for itself. Here the paradigm case of power is not one of command but one of enablement in which a disorganised and unfocused group acquires an identity and a resolve to act in light of its newfound sense of purpose. I call this sort of situation one of empowerment (1987 p. 130).

It is empowerment that will enable the oppressed to challenge the system that suppresses them and therefore achieve emancipation. The Critical Social Theorist strives to achieve emancipation for those researched. Achieving emancipation by providing information hence increasing knowledge for overseas-qualified nurses is fundamental to this research. However, caution is required of the Critical Social Theorist, as emancipation may not be achieved due to the influence of an individual's socio-political upbringing.

An example would be Islamic women who are brought up to believe that the role of woman is to be subservient to men. An increase in knowledge may not influence Islamic women to question the assessment process if a male provides the reasons for not meeting the requirements for registration/enrolment. However, by researching and questioning how policies and procedures are developed for the assessment of overseas-qualified nurses, it is envisaged that this information will empower nurses from all cultures to question the assessment process. In other words even the oppressed may be represented by others who have achieved emancipation.

It may be considered arrogant to expect emancipation of the disempowered to be the by-product of a researcher's findings, however one would hope that some change would occur, if not emancipation for overseas-qualified nurses.

Kincheloe and McLaren believe that Critical Social Theorists accept the following basic assumptions, which I too support:

- That all thought is fundamentally mediated by power relations that are social in nature and historically constituted;

- That facts can never be isolated from the domain of values or removed from ideological inscription;

- That the relationship between concept and object, and between signifier and signified, is never stable and is often mediated by the social relations of capitalist production and consumption;

- That language is central to the formation of subjectivity, that is both conscious and unconscious awareness;

- That certain groups in any society are privileged over others, constituting an oppression that is most forceful when subordinates accept their social status as natural, necessary or inevitable;

- That oppression has many faces, and concern for only one form of oppression at the expense of others can be counterproductive because of the connections between them;

- That mainstream research practices are generally implicated, albeit often unwittingly, in the reproduction of systems of class, race and gender oppression (2000 pp. 139-140).

The theoretical framework of Critical Social Theory allows the researcher to undertake an investigation with overt assumptions, hence their political or epistemological perspectives are explicit. The researcher does not try to hide the assumptions they hold, therefore I support the notion that all thought is influenced by power, which has been embedded in societal and historical values. In relation to this research, power is held by nurse and midwifery regulatory authorities to register nurses based on the assessment process.

Overseas-qualified nurses are disempowered as they are not always aware of the exact requirements for comparing or equating their qualifications with a nurse educated in Australia. An implicit notion held by nurse regulatory authorities is that a nurse/midwife's understanding of English is pivotal to their ability to practice in Australia. However, the current English level requirements of NMRAs, necessitates questioning as to how the required level of English was determined and whether the designated levels are in fact required for a nurse to practise safely in Australia. It appears that there is only anecdotal evidence to support the required English levels for some overseas-qualified nurses. The same issues apply to the determination of an overseas-qualified nurse's competence to practice. Therefore Critical Social Theory appears to be an entirely appropriate theoretical perspective to underpin this research.

Critical Social Theory's contribution to nursing inquiry began in the early 1980s as nurses began to question the lack of appreciation for the social, political and economic factors that influence clients, nurses and the healthcare system (Browne 2000). Nurses have slowly embraced this philosophical orientation as they question the very essence of their practice.

Medical practitioners have always dominated the decision making in the healthcare system. However politicians, nurses and midwives are now questioning the power base on which this decision making has occurred. An example is the nurse practitioner movement in Australia. Nurses have presented models of client care where nurse practitioners are pivotal to that care. However, some medical practitioners and pharmacists are attempting to block the ability of these nurses to prescribe medication (Bryant 2005).

This is despite government backing in most states of Australia for nurse practitioners to prescribe medication to clients. Power in relation to prescribing medication has always sat with medical practitioners by virtue of the state Controlled Substances Acts. These Acts clearly indicate that medical practitioners, veterinary surgeons and dentists are the only professionals endorsed to prescribe medications. Nurses and governments are now questioning the purpose and interpretation of these Acts. However, I would question the motive for each. Nurses believe that endorsed nurse practitioners have the knowledge, skills and attitude to prescribe medication appropriately and safely. Governments on the other hand see nurse practitioners as a cheaper alternative in the medical practitioner shortage in the rural and remote areas of Australia. The power in this scenario lies with the government as they have the power to change the legislation around prescribing.

Critical Social Theory has enabled nurses to challenge the status quo by examining the dominant ideologies that influence existing nursing praxis (Browne 2000). However, one cannot assume that this theoretical perspective does not have limitations or as discussed previously criticism, which are now discussed.

Critique of Critical Social Theory

The strongest criticism of Critical Social Theory is that it is antiscientific, as it rejects empirical research's attempt to measure social facts and develop general laws of social life (Morrow 1994). Critical social research does not use a specific method that would assist in developing an empirical research program, which is repeatable and measurable against a control group. In fact it is the questioning of what constitutes an individual's reality that interests Critical Social Theorists.

Given that all individuals are different it would be difficult if not impossible to repeat the investigation and reach the same conclusions. However, Fay is sceptical of Critical Social Theory, as he believes that:

> Critical Social Theory starts with the a priori assumption that it has the answer to which it necessarily holds no matter what occurs; that it is inherently subjectivistic because it irreducibly contains a moral element; and that the goal of transforming society is incompatible with the objectivity required to study with scientific rigour (1987 p. 5).

I disagree with Fay's assumption that Critical Social Theorists are unable to be objective in their studies. Despite the fact that Critical Social Theorists do not use scientific methods there is still a need to demonstrate rigour albeit differently to what is used in empirical studies. Rigour is established by demonstrating auditability, credibility, fittingness, and confirmability in the research study, which is discussed later in this chapter.

Critical Social Theorists' concepts are also criticised by empirialists as being too ideologic to be proper science (Morrow 1994). However, it is the ideological assumptions that are made overt which allow debate and questioning of the status quo. An interesting criticism is that Critical Social Theory is elitist, which may have been the case in its founding years with the Frankfurt School's use of pretentious theoretical language (Morrow 1994; Cheek et al. 1998).

However, contemporary Critical Social Theorists attempt to present a picture using common sense and language reconstructed through philosophical thought, hence less elitist than in previous times.

The criticism of greatest concern is that Critical Social Theorists do not have the ability to lead change (Held 1980; Fay 1987; Cheek et al. 1998; Crotty 1998). However, it is believed that Critical Social Theory searches for emancipatory knowledge, which will ultimately lead to action and/or change. There are no guarantees in any research that change will occur. There is only the researcher's personal drive to ensure that with emancipatory knowledge they are in a position to enlighten people in power to make those changes. The literature suggests that many PhD, Masters and Honours theses from a range of theoretical perspectives are written and never published or recommendations acted upon (Wilkes, Borbassi, Hawes, Stewart & May 2002). This creates an environment where valuable information is collected, analysed and discussed but never made overt. So one could question whether Critical Social Theorists do not have the ability to lead change or is it the researcher who undertakes such research who does not make overt the emancipatory knowledge gained which could lead to change.

An extension of the philosophical unpinning of the study is the methodology used. The terms method and methodology are often used interchangeably, however are markedly different (Fontana 2004). The methodology is the strategy or design behind the choice of the methods chosen and reflects the overall conceptual approach of the study (Crotty 1998; Fontana 2004).

Research Methodology

The following is an overview of Critical Policy Analysis which was the methodology selected for the study.

Determining the research methodology is a crucial step in the research process, as the methodology is the blue print that guides the researcher in choosing the appropriate data collection and analysis methods to undertake the research. The preferred methodology for this study was critical policy analysis, as this methodology allowed examination of assessment policy beyond simply analysing the content and implementation to determining the power, control, legitimacy, privilege, equity, justice and values implicitly embedded in policy and policy development (Prunty 1985). This methodology also fitted most appropriately given the theoretical underpinning of the research.

Before discussing critical policy analysis the terms, critical, policy and policy analysis are discussed in order to clarify the use of these terms in this study. The term critical was derived from the Greek word *krinein, which* means to judge or discern (Reese 1999). In critical research the term means to judge by standing apart from current thinking and questioning why a situation has come about (Fontana 2004).

Policy on the other hand, is not as easy to define, as there are many definitions of the word policy (Miliken cited by Hogwood & Gunn 1990; Miliken cited by Ball 1993; Cheek & Gibson 1997; Haynes 1997; Taylor 1997; Hancock 1999; Bridgman & Davis 2000; Colebatch 2000). According to Colebatch, a policy is best defined 'as a concept which dominates our understanding of the ways we are governed' (2000 p. 1). However, Prunty suggests that policy is the 'authoritative allocation and legitimation of values… and is fundamentally ameliorative' (1985 p. 137).

Considine's concept of policy is what policy developers or actors drive through public institutions as the things they value (1994). This in itself could be detrimental if these values are not inline with either the organization or the persons affected by the policy. Anderson (2003) considers the term policy can be used in two different ways. The first is policy that designates what government agencies will or will not do, such as provide public transport. The second is policy that is developed to guide the general direction of the decision making process such as how and when public transport will be provided (Anderson 2003).

For the purposes of this study, Bridgman and Davis' definition of public policy has been adopted. This definition is that a policy is a "description of principles governing the way decisions are made" (Bridgman & Davis 2000 p. 175). In relation to overseas-qualified nurses it is the principles or policies governing the decisions made on how to assess the qualifications of overseas nurses, which are analysed and compared.

It is important to have an understanding of the different types of policy in order to steer through the complexities of policy development and the factors that influence its development. There are different types of policy, substantive, procedural, distributive, redistributive, regulatory, self-regulatory, material and symbolic (Colebatch 2000; Anderson 2003).

Substantive policies involve what the decision maker or government will do, such as building highways or paying welfare payments. Procedural policies are about how something will be done, such as how overseas-qualified nurses will be assessed.

Distributive policies entail the allocation of services for groups or individuals, for example providing free English language classes for all migrants who have English as a second language. Redistributive policies relate to redistribution of money, rights or power, such as taxes, where high-income earners pay a higher percentage of their income in tax to support the health of low-income earners. Regulatory policy is usually developed from legislation to regulate the activity and behaviour of groups, for instance nurses are obligated to have practiced within a five year time frame in all but one state in Australia.

Self regulatory polices are developed usually by groups who are wanting to protect the interests of their members, such as auctioneers who allow only members who have completed a specified course to register as an auctioneer. Material policies provide physical resources or power to recipients, for example the government enforcing a minimum wage for workers. Finally, symbolic policies appeal to people's values such as peace and social justice and they do not impose any material impact (Anderson 2003).

However, symbolic policies may result in the introduction of material or regulatory policy in the long term. Examples of this are the symbolic policies produced by the International Council of Nurses on Nurse Retention, Transfer and Migration (1999) and Ethical Nurse Recruitment (2001a). These policies urge employers to discourage poaching nurses from countries already acknowledged as experiencing a shortage of nurses and to employ nurses from developing countries under the same conditions as nurses from developed countries are employed.

Both policies are symbolic but may in the future be the foundation for legislation or policies developed in relation to employment of overseas-qualified nurses from developing countries.

Policy as a component of regulation is of particular interest in this research in terms of the processes used to assess overseas-qualified nurses. The analysis and comparison of procedural and regulatory policy are foundational to this study.

Policy has three fundamental features in the way the term is used, these are authority, expertise and order (Colebatch 2000). Policy usually asserts authority, meaning an authorised person or group such as a board of directors would endorse policy. The development of policy is reliant on expertise based on the knowledge of an issue and the ways of achieving the best outcome. Policy provides consistency and order, so people working with policy have a common framework to guide them. To apply this term to the assessment of overseas-qualified nurses, policy would be legitimised by an authoritative group, developed and researched by experts who have sound knowledge in this area, in order to provide a consistent framework for decision making. The concept of policy analysis could simply mean analysing a policy, however this is not the case.

There are many definitions developed by a range of authors, for example Majchrzak, considers that:

> Policy analysis is the study of the policymaking process and is typically performed by political scientists interested in the process by which policies are adopted as well as the efforts of those polices once adopted (1984 p. 13).

Majchrzak (1984) suggests that policy analysis is only one part of the policy research process, which is about researching social problems then providing policy makers with recommendations for alleviating the problems.

Another interpretation of policy analysis is one that suggests, policy analysis is client-orientated advice which is relevant to public decisions (Weimer & Vining 1989). These authors contend that the major objective of policy analysis is to analyse a problem then provide an authoritative decision maker (usually a political representative), with an alternative for solving a public problem (Weimer & Vining 1989). The process used to achieve this, is to incorporate existing research and theory in an attempt to predict the consequences of alternative policy decisions.

Bridgman and Davis' position (2000) is that policy analysis is two-fold, initially it is the analysis of a problem, then development of a policy, which addresses the problem. Secondly, it is the 'analysis of government's action, designed to discern the underlying policy choices of government' (Bridgman & Davis 2000, p. 174). In other words it may be the questioning of the outcomes of government policy, such as in the areas of health and education.

Policy analysis as discussed by Weimer and Vining (1989) and Bridgman and Davis (2000) is predominately the domain of public policy analysts, professionals whose role it is to advise government on all aspects of policy, be it identifying a problem, developing a policy for endorsement or determining the impact of that policy. The number of policy analysts drawing predominately on economic theory, statistical and mathematical techniques has grown in recent decades (Anderson 2003).

This is of concern when analysing whether policy achieves the goals set and the effects policy may have on society. It could be questioned as to whether determining the effect of policy on society is measurable using economic, statistical and mathematical techniques.

However, before one attempts to analyse policy it is important to discuss how policy should or could be developed as:

> Policymaking is political and hence unpredictable. Few decisions are afforded sufficient time or resources for every step in the policy cycle; most are rushed, and the pressure for ad hoc work remains great. Reality tempers the ideal of systematic policy development (Bridgman & Davis 2000, p. 149).

Several authors have described what they consider the policy cycle or process to be, namely a range of steps such as problem identification and agenda setting, formulation, adoption, implementation and evaluation (Hancock 1999; Colebatch 2000; Anderson 2003). Bridgman and Davis (2000) developed a policy cycle with more detail, which included identifying issues, policy analysis, policy instruments, consultation, coordination, decision, implementation and evaluation. This policy cycle was designed to inject rigour into the policy process without necessarily limiting the potential or creativity of this process.

For the purposes of this study, Bridgman and Davis' (2000) policy cycle is used as a framework for policy development as the inclusion of policy instruments, consultation and coordination were seen as important components of the policy cycle. An overview is now presented on what constitutes the policy cycle.
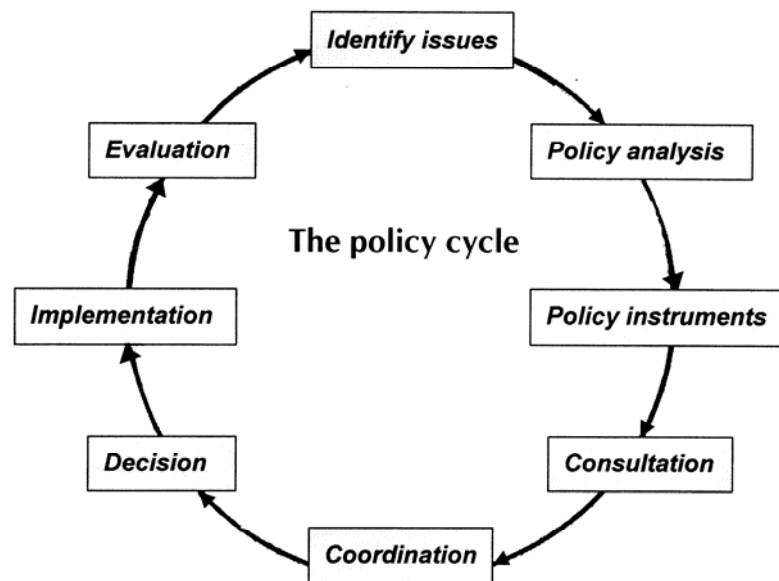
Figure 1:   The policy cycle: (Bridgman & Davis 2000)

The initial part of the cycle is identifying the issues, which may emerge from a range of groups including lobby groups, the media demanding government action, or a policy identified as being out of date or needing review. An example of one such policy is the age of school leavers currently in South Australia, which is sixteen years, however the government is now questioning whether it should be seventeen years and therefore the review of the policy is on the government agenda.

Once the issue has been identified a policy analysis is initiated. This involves researching the issue and providing enough information for decision makers to make an informed judgment on the best approach to address the issue.

The analysis consists of formulating the problem, setting objectives and goals, identifying decision parameters, searching for alternatives and proposing a solution (Bridgman & Davis 2000). Consideration is given to the economic factors involved, such as cost-benefit, cost effectiveness and opportunity costs.

In other words what is the financial impact on all parties of the effect of either the creation or review of policy? Other factors for consideration are the social, environmental, legal and political impacts of the policy. Creating policy without deliberation of these factors could result in inaccurate or superficial information being provided to decision makers. The next part of the cycle is determining the instruments to be used to achieve policy objectives.

The policy instruments are the methods used to achieve the policy objectives. These may be:

- Policy through advocacy - educating or persuading, using information available to government, such as providing funding for anti-smoking campaigns.

- Policy through money - using spending and taxing powers to shape activity beyond government such as taxing tobacco.

- Policy through direct government action - delivering services through public agencies such as banning smoking in government buildings.

- Policy through law - legislation, regulation and official authority such as laws banning the sale of cigarettes to persons under the age of 18 years (Bridgman & Davis 2000).

The right choice of a policy instrument is vital as it could mean the difference between successful and unsuccessful outcomes of policy. Once the determined policy instrument has been established, consultation on its use occurs.

Consultation is pursued throughout the policy process with all stakeholders who are believed to be or will be affected by the policy. However, this is not an easy process given the amount and diversity of stakeholders involved in policy development. Consultation may involve public forums, surveys, advisory committees and circulation of policy drafts for comment. Most importantly it is essential that consultation has taken place to ensure adequate input and testing of the policy has occurred across the perceived stakeholder group. This action effectively lessens the likelihood of policy failure. The consultation and policy development process require coordination by a delegated person or group.

Coordination cannot be underestimated in the policy process given the amount of people or departments involved in the policy cycle. This is particularly relevant with government policy, which may involve a number of departments researching or providing information for a briefing paper to go to government ministers. There must be a central coordinator who ultimately is responsible for the final product whether it is a draft policy or policy analysis.

The next part of the policy cycle is, the final policy decision, which should be informed. Whoever the decision maker is, they should be assured that the information provided has been comprehensively researched, involving all stakeholders and been analysed from a financial or cost implication perspective. Once the decision regarding what constitutes the policy has been made, implementation of the policy takes place.

The implementation plan should be an integral part of the policy development process.

This plan needs to be systematic and simple with a person accountable for the outcome of implementation. Integral to the implementation plan is an evaluation strategy. According to Bridgman and Davis 'the policy cycle begins and starts with evaluation' (Bridgman & Davis 2000, p. 126). This is why policy is seen as a continuous cycle. Evaluation determines whether the policy objectives have been met and whether the policy is appropriate, effective and efficient.

While it is acknowledged that the policy cycle as applied by Bridgman and Davis (2000) appears to be a systematic and evidence based approach to policy development, this cycle does not appear to determine the power, control, legitimacy, privilege, equity, justice and values implicitly embedded in policy (Prunty 1985). These factors ultimately affect the development, effectiveness and outcome of policy on all players' expectations involved in or effected by the policy.

In fact, Bosetti, Laudry and Miklos assert that:

> Policy-makers, through policy decisions, are instrumental in determining who gets what, when and how. The questions critical theorists raise are whose needs, values and preferences are represented by the policy decisions', and 'on what basis are the goals and objectives which the policy aims to achieve validated as being appropriate and good (Bosetti, Landry & Miklos 1989, p. 4).

In the case of assessing overseas-qualified nurses one questions whose needs, values and preferences are represented and whether policies reflect a fair and equitable process for nurses qualified in a different country. Prunty (1985) suggests that in order to understand the needs and values represented in policy, a critical policy analysis needs to be undertaken.

Critical Policy Analysis

Critical policy analysis endeavours to overcome the criticisms raised against traditional approaches to policy analysis as it is overtly political, emancipatory in intent and attempts to expose favoured values, social arrangements, sources of power and the control underpinning this power (Starr 1992). The researchers determine what the policy really says and what the perceived and actual outcomes are. Policy may be developed without consideration for social, health or educationally related problems and is driven by the values of people involved in the development of policy. Therefore, it is important that the ethical and moral values inherent in policy formation are questioned (Prunty 1985). This study will assist in determining whether NMRAs have questioned or considered the values, ethical and political implications in policy development. In order to undertake this, critical policy analysis needs to occur otherwise the research would simply be describing the policies rather than what has driven their development and outcomes.

Prunty developed six signposts when undertaking critical policy analysis. These signposts are further discussed as they underpinned the framework developed to analyse policies used in the assessment process of overseas-qualified nurses in this study.

Sign Posts for the Critical Policy Analyst

Prunty (1985) developed the signposts as a guide to educational policy analysis as he believed traditional policy analysis did not address values or ethical issues and was dominated by functionalist, systems theory perspectives, which failed to improve socio-educational problems.

Prunty's signposts for critical policy analysis were based on Critical Social Theory, particularly the work of the Frankfurt School and Habermas (Prunty 1985). He believed an ethical and political framework of social justice underpinned the signposts. The following is a précis of Prunty's signposts of critical policy analysis.

1. The policy analyst is overtly political, where personal values and political commitment are secured in the vision that justice, equality and individual freedom are not compromised. The analyst endorses political, social and economic arrangements that ensure the person has the best possible outcome as a result of the policy objectives.

2. The policy analyst assumes an advocacy role for oppressed groups such as the poor, ethnic and racial minorities. In order to achieve this, policy is analysed to expose domination, repression and exploitation entrenched and legitimated by policy.

3. The policy analyst determines how policy is validated, in particular the principles of inclusion and exclusion in deciding what really matters.

4. The policy analyst strives to disclose the false consciousness of the oppressed. In other words why overseas-qualified nurses determined as not meeting the requirements of a particular regulatory authority's assessment of their qualification, accept the decisions made without challenge. Do they believe they have no power to question the system?

5. The policy analyst is committed to changing practice not just exposing the issues but also turning rhetoric into reality.

6.   The policy analyst must be knowledgeable in the policy arena and have a sound knowledge of policy development and the policy cycle (Prunty 1985).

Guided by Prunty's (Prunty 1985) signposts and Bridgman and Davis' (2000) policy cycle, the design of this study seeks to determine where the power lies in the policy cycle, what the underlying assumptions are and the outcomes of policies that guide assessment of overseas-qualified nurses. These are factors that have guided the research design of this study in order to achieve a greater understanding of policies that underpin the assessment of overseas-qualified nurses

Summary

In this chapter an overview was provided of the theoretical paradigms of positivism, post positivism, interpretivism, constructivism and critical to contextualise why the study was situated within the critical paradigm. The theoretical underpinning of the study was Critical Social Theory hence discussion was provided on the development, goals and critique of Critical Social Theory. In addition, discussion occurred on critical policy analysis as the chosen methodology for the study.

The next chapter presents a discussion of the research methods, data collection, establishing rigour in the study and the ethical considerations.

CHAPTER 4:   RESEARCH METHODS

Introduction

Research methods are techniques used to collect data for analysis and are informed by the research methodology. The methods include the selection of data sources such as, people, documents or laboratory material, recruitment or selection criteria and the data collection instruments, for example questionnaires, interviews, participant observation, policies, record analysis and experiments. Each data source and collection instrument provides the researcher with a different perspective of the research with the aims of the research methods to provide rich, interpretable, unbiased data, which is credible (Silverman 2001; Thurmond 2001).

It is essential to consider a number of factors before determining the appropriate methods for collecting data for a study. Patton (2002, p. 13) suggests that the following six questions are important considerations in determining method decisions.

- What are the purposes of the inquiry?

- Who are the primary audiences for the findings?

- What questions will guide the inquiry?

- What data will answer or illuminate the inquiry questions?

- What resources are available to support the inquiry?

- What criteria will be used to judge the quality of the findings?

This chapter provides an overview of how these questions have guided the determination of the research setting, recruitment of participants, tools and techniques for data collection and the framework for data analysis. Also provided is discussion on how rigour was established and maintained in the study and the ethical considerations when undertaking a study of this nature.

What is the Purpose of the Inquiry?

The purpose of this study was to contribute to elementary knowledge and elucidate a concern in relation to how policy was developed and implemented in the assessment of overseas-qualified nurses.

Who are the Primary Audiences for the Findings?

It was envisaged that the primary audience for the findings of this study would be nurse regulatory authorities (both nationally and internationally), overseas-qualified nurses, the International Council of Nurses, other professional regulatory authorities such as medical, teaching and pharmacy Boards, government departments such as the DIMIA and providers of English language testing. Most of these groups are involved in the assessment of overseas-qualified nurses and/or professionals for migration or registration purposes. The International Council of Nurses has involvement with a number of different countries and the ability to influence discussion on the assessment process. The Australian Government may be interested, due to the current and perceived continued shortage of nurses and the present and pending trade agreements with other countries.

Informal discussions with other professional regulatory bodies has lead to an interest in this study as issues of competence and language assessment are common, hence it will be important to share the findings of this study.

Determining the Research Setting

The selection of the research setting impacts greatly on the definitive quality of the research, which means it is imperative that careful thought and consideration are given to selecting the appropriate research setting and participants. In this study a global setting was chosen as the policies and processes for assessing overseas-qualified nurses varied from country to country. The advantage of using a global setting was that the research provided data from a range of countries with different healthcare systems, different education programs for nurses, different languages and different regulatory frameworks.

The disadvantages of using the global setting were the cost and time involved for the researcher to travel from Australia to overseas countries to conduct face-to-face interviews.

Selection and Recruitment of Participants

The process for selection of participants involved searching the Internet to find contact details for nurse regulatory authorities in a variety of countries globally. This process identified a number of nurse regulatory authorities and consideration was then given to the range of countries that would provide diversity in the policy, and procedures for assessing overseas-qualified nurses.

The following were applied as selection criteria:

- What policy instruments were used to assess overseas-qualified nurses such as written examination, paper-based assessment of qualifications or no assessment at all was considered.

- What was the native language of each country? Countries with English as the first language were selected, countries with English as a second language and countries where English was not the native language or taught as a second language were excluded.

- The economic environment was considered as most nurse regulatory authorities identified on the Internet were high income or developed countries. It was believed to be important to compare the policies and procedures for assessing overseas-qualified nurses from countries of different economic backgrounds, especially as the movement of nurses globally was from countries in a variety of economic states.

- The distance and accessibility the country was from Australia in order to conduct the face-to-face interviews was also a consideration.

- Nurse Regulatory Authorities in Australia, which included the ANMC, as they are involved in the assessment of overseas-qualified nurses.

Therefore, using the stated criteria the following participants were invited to participate.

Board of Nursing Professional Regulation Commission, Philippines

Nursing and Midwifery Council, United Kingdom

National Board of Health and Welfare, Sweden

College of Nurses, Ontario, Canada

Board of Registered Nursing, California, United States of America

King Fahad Hospital, Saudi Arabia

Nursing Council of Hong Kong, China

Nurses Board of the Australian Capital Territory

Nurses Board of the Northern Territory

Nurses Registration Board of New South Wales

Nurses Board of South Australia

Nurses Board of Tasmania

Nurses Board of Victoria

Nurses Board of Western Australia

Queensland Nursing Council

Australian Nursing and Midwifery Council

Rationale for Selection of Participants

The Board of Nursing Professional Regulation Commission, Philippines was selected as this country was the largest exporter of nurses globally and was classified as a lower middle income economy according to the World Bank Group based on the gross national income per capita (World Bank Group 2003). Hence, for the purposes of this study the Philippines represented a lower to middle income economy as all other participants were from high-income countries (World Bank Group 2003).

The Nursing and Midwifery Council of the United Kingdom was selected, as it is a destination of choice for many overseas-qualified nurses to seek registration and is the body responsible for assessing all nurses with overseas qualifications in the UK (N&MC 2004).

The special significance with the UK was that it was also a member state of the European Union therefore has mutual recognition of qualifications with other member states which includes countries with different language, education and healthcare systems. The NMC was also known to conduct a paper-based assessment of nurses' qualifications from overseas.

The National Board of Health and Welfare, Sweden is the body responsible for assessing overseas-qualified nurses in Sweden and is a member state of the European Union. Swedish is the first language in Sweden, therefore how language requirements were determined in the assessment process was of interest.

The College of Nurses of Ontario, is the body responsible for assessing overseas-qualified nurses for the province of Ontario, and was selected as the largest employer of nurses in Canada (Canadian Institute for Heath Information 2002). Another reason for selection as a participant was that it was a country that was officially bilingual (French and English). This was considered important in determining the assessment policies and processes for nurses from other countries and the requirements for language skills. Canada also requires all nurses from overseas to sit a written examination in order to assess the nurse's knowledge and skills.

The Board of Registered Nursing California, United States of America (USA) was selected, as a national written examination is a mandatory part of the assessment process for overseas-qualified nurses. There was also a requirement for nurses from overseas to sit a state of California written examination.

The population of California is the largest in the USA therefore appears to be the most likely state, nurses will apply to for registration in the USA (Pearson Education 2003) .

The Nursing Council of Hong Kong was selected as in 1999 it had decided to implement a written examination for all nurses not qualified in Hong Kong, when previously a paper based assessment had been used.

Therefore it was of interest in determining the rationale for policy change from paper-based assessment to written examination.

The King Fahad Hospital in Saudi Arabia was selected, as there is no registering authority for nurses in Saudi Arabia. Instead employers require nurses wanting to practice in Saudi Arabia to be registered in their country of origin; further registration was not required in Saudi Arabia. It was of interest to me as to why registration in Saudi Arabia was not required and what policies and procedures were in place to accept a nurse's registration from another country.

Nurse regulatory authorities in each state of Australia were selected as participants, as each state has their own Nurses Act and are responsible for assessing and registering overseas-qualified nurses. The autonomy of each state means there were variations in the policies and processes for assessment of overseas-qualified nurses, which were pivotal in deciding to undertake this study initially. Therefore it was deemed important to determine and discuss the variations in each state of Australia given that this was predominately an Australian study.

Finally the ANMC was selected as a participant as it has the authority from the Department of Immigration in Australia to assess nurses with qualifications from overseas for the purposes of determining eligibly for immigration purposes. Therefore it was considered appropriate to include the ANMC as a participant. However, it had no legislative authority to register nurses therefore nurses were still required to be assessed by a regulatory authority.

Before commencing a research study an essential component is to bear in mind the ethical considerations of the study.

Ethical Considerations

Approval was obtained from the Royal Adelaide Hospital, Research and Ethics Committee (Appendix 1) to conduct the research. Consent to take part in the study was implied as each organisation had the ability withhold their policies and procedures on assessing overseas-qualified nurses and/or not to take part in a face-to-face interview. Participants identified by the organisations were contacted by telephone to ask if they would be willing to take part in a face-to-face interview. The interview guide questions were sent to each participant prior to conducting the interview.

Organisations involved in the research are identified; however participants involved in each interview are not. Verbal consent was gained from each participant to audiotape the interview prior to commencement, with an understanding that the tape could be stopped at any point in the interview.

The typist who transcribed the audio taped interviews was advised of the confidential nature of the transcripts and signed a confidentiality agreement. The raw data collected throughout the study is stored in a locked cupboard and will continue to be for a period of seven years ensuring confidentiality of the information.

Data Collection Techniques

A variety of techniques may be used to collect data. The techniques commonly used to collect qualitative data are case documents, interview using open-ended or closed questions, focus groups and observation.

The data collection in this study included obtaining policies and procedures on the assessment of overseas-qualified nurses from NMRAs in each country and in the case of Australia, NMRAs of each state/territory and face-to-face interviews with persons responsible for the assessment of overseas-qualified nurses.

The data collection used different techniques and data was collected in two stages. The use of different techniques of data collection with similar foci was used to enhance confidence in the findings and may be referred to as triangulation (Kimchi, Polivka & Stevenson 1991; Morse 1991).

Triangulation

The concept of triangulation was originally used in land surveying to determine an intersection point using bearings from two landmarks (Fielding & Fielding 1986).

However, over time the notion of a triangle or three points, has been challenged as inappropriate, with the metaphor triangulation considered, as the use of two or more data sources, investigators, methods, theoretical or analytic methods in the same study (Thurmond 2001).

The debate for triangulation of methods is that it assists in determining whether there is consistency in the findings of data collected from different sources of one phenomenon (Denzin 1989; Patton 2002). Using triangulation, I hoped to minimise bias that may occur using a single method such as policy content analysis. Information gained from policy documents was further explored during interview to clarify and understand the underlying assumptions, implementation and actual affects of policy. It was believed that this information would not be gained by exploring only the content of the policy. It was considered that this combination of methods facilitated the capture of different information and the potential to demonstrate both consistencies in patterns of data and explainable differences that gave credibility to the findings (Patton 2002). Hence, what was considered a potential flaw in one method could prove to be strength in another, so by combining methods it was anticipated that adequate data would be obtained (Denzin 1989).

Combining methods is referred to as between-methods triangulation and was used, as this method combines different methods to clarify or illuminate the same phenomenon. These in turn assisted in achieving completeness of the data, which may not exist if individual methods were used in isolation (Redfern 1994).

This was particularly important in relation to the participants' understanding of policy and my interpretation of each policy in determining the power, control, legitimacy, privilege, equity, justice and values implicitly embedded in policy. Face-to-face interviews were used to clarify both the participants and my potential bias in the understanding of the context and content of policy. Also the use of field notes assisted in taking focused and strategic notes which allowed new questions to be asked, plus the ability to go back to a point which may have been made earlier during the interview (Patton 2002).

It was considered that by using between-method triangulation such as policy content analysis, then face-to-face interviews, the participants would augment the researcher's analysis and interpretation of policy, which in turn increased confirmability of the data. Redfern (1994, p. 44) indicates that:

> The important point about between-methods triangulation is that it constitutes more than merely using several methods in the same research design. The methods are selected as a combined strategy so that the strengths of each are maximised and their limitations minimised. Moreover, linking the data in a coherent and systematic way is essential.

Triangulation was considered an important strategy to enhance the completeness of this research, however, there were limitations in its use. Utilising different methods to increase the likelihood of completeness, was the desired outcome when using triangulation, nonetheless, there are no guarantees (Redfern 1994). Other limitations of triangulation were that it is considered more time consuming than a single method and results in large amounts of data that is expensive to collect and analyse (Denzin 1989; Redfern 1994; Thurmond 2001).

This certainly was the case, however despite the described limitations it was believed that the advantages of using triangulation out weighed the limitations in enhancing completeness of the research. The two stages of data collection are now discussed in detail.

The Stages of Data Collection

Stage One

A letter (Appendix 2) was sent to the participants inviting them to participate, and requested copies of their policies and procedures used for the assessment of overseas-qualified nurses. In the same letter I also requested the opportunity to conduct a face-to-face interview with persons responsible for policy development and the assessment of overseas-qualified nurses. By requesting the policies and procedures prior to the face-to-face interview, I could analysis the policies and procedures before undertaking the interviews. This would be an advantage, as the face-to-face interview would allow clarification of the organizations policies and procedures.

During the process of seeking eligible participants for the study, the International Council of Nurses (ICN) website was viewed and a members list of the ICN noted. Letters were sent to all nursing bodies that were members of the ICN inviting them to participate and requested copies of any policies and procedures they had pertaining to the assessment of overseas-qualified nurses. This was considered another means of obtaining information on policy development and policies involved in the assessment process, beyond the selected countries.

However, of the total number of ICN members only three responded and indicated that they did not have policies for the assessment of overseas-qualified nurses. Therefore, face-to-face interviews were not requested of the authorities initially in these countries as, it would have been difficult to conduct interviews in these countries due to resource and time constraints, therefore only the selected countries were pursued for interview.

Stage Two

In each of the participating countries, face-to-face in-depth interviews took place with persons responsible for development of policy and assessment of overseas-qualified nurses. The interviews were conducted to clarify the policies and processes each country undertook for assessment of qualifications for overseas-qualified nurses.

Criteria used in determining the appropriate person to interview was informed by the work of Weimer and Vining (1989, p. 235) who considered there were four questions that were the major issues relating to interviewing:

- What kind of information does interviewing elicit most effectively?
- How can you judge the efficacy of the information you get?
- How do you get interviewees to talk?
- Whom should you interview and when?

These questions are considered individually in relation to their use in this study.

What information will interviewing elicit most effectively?

It was possible that information about the historical and contextual background of the policy development, implementation, and political attitudes of the assessing bodies not on paper may be revealed during face-to face interview.

It was also believed that projections about the future of policy direction, other potential contacts and references to written material would be elicited.

How can you judge the efficacy of the information you get?

The consistency and familiarity of answers in relation to the policies received and examined by the researcher would be elucidated. Also the participant's motivation, values and position in relation to the effectiveness of the policies and procedures could be explored or clarified during interview.

How do you get interviewees to talk?

The energy in an interview at least to begin with, needed to come from the interviewer, so it was important to provide my understanding of the organisation's current policies and procedures initially. This also meant indicating that I was a previous manager at a nurse regulatory authority, therefore had an understanding of some policies and procedures in relation to assessing overseas-qualified nurses. It was important to allow the participant to give their interpretation of the assessment polices and processes and to share any other thoughts they may have on this issue in an attempt to understand their underlying assumptions regarding the assessment process.

Whom should you interview and when?

There were many considerations in determining the appropriate person to interview. In fact once the letters were sent to the organisations and they had agreed to participate in the study, I then contacted each organisation to determine who would be the most appropriate person to interview. Consideration was given as to the person most likely to have the greatest knowledge of the policy cycle.

Given that the travel involved considerable distances, it was intended to visit all overseas countries in one trip in an attempt to keep the costs of the study to a minimum, therefore the availability of the person to be interviewed was an important consideration.

Interviewing

Interviewing is rather like a marriage: everybody knows what it is, an awful lot of people do it, and yet behind each closed door there is a world of secrets (Oakley 1981). The purpose of interviewing is to determine another person's perspective by exploring their story or secrets. The quality of the information obtained in this exploration is dependant on the disciplined skill and technique of the interviewer (Patton 2002). There are three basic interview approaches in gathering qualitative data, the informal conversational interview, the interview using a guide list and an open-ended interview. Each approach has its own merit and is used for different purposes. The informal conversational interview relies on spontaneous questions and may be part of observational fieldwork, where the interviewer may ask the participant why or how they have undertaken a task. Data analysis could be difficult using this approach as different questions elicit different responses, hence the researcher may spend significant periods of time determining themes in responses received (Patton 2002). This approach does allow spontaneous responses, which may not be achieved using other methods.

The interview guide approach entails the interviewer providing the issues and/or questions to be explored to participants prior to the interview, then using the these issues or questions to ensure all topics are covered. This approach is more systematic and focused which does assist when interviewing in a tight timeframe.

There is also the ability to explore topics in greater depth' although new topics are not usually pursued using this approach.

The final approach is using opened-ended questions, which is series of questions asked of all participants with little flexibility to pursue topics of further interest. This approach is very structured in that the responses should be consistent as each participant is asked exactly then same question. Data collection may be carried out by a number of people, as the questions are specific with little or no room to explore any topics not provided in the preset questions.

A general interview guide approach was used to gather data for the study. This involved outlining issues to be explored with each participant before the interview (Patton 2002). The issues to be explored were communicated in a letter via email as this could be received immediately by participants, as opposed to sending via post, which would have taken longer.

The general interview guide (Appendix 3) involved a basic checklist to ensure all relevant topics were covered with an ability to vary how questions were asked of each participant. The guide allowed a systematic, consistent and focused framework for the interview process (Patton 2002). There was an ability to vary what questions were asked depending on the information obtained previously and analysed from the individual country's policies and procedures. The interview style was conversational with a focus on the predetermined topic of the assessment policies and processes, which was anticipated to contribute to the richness of the data.

Weaknesses of this approach were that important topics may be inadvertently omitted and the interviewer's flexibility in questioning may incur different responses from participants (Patton 2002). It was therefore important to refer to the interview guide regularly during the interview. The questions needed to be asked in a manner that obtained opinions, values and knowledge. I was cognisant of allowing the participants to express themselves using their own terminology and judgments.

Each interview was recorded on audiotape to allow unencumbered attention to the interviewee (Patton 2002). Field notes were taken to assist in formulating further questions during the interview and to use, as a backup should the audiotape malfunction.

Data Analysis

The data to be analysed were the policies and procedures, organisational annual reports, information for applicants when applying to register (including application forms), Nurses Acts and transcripts from each face-to-face interview with the participants.

The Data Analysis Framework

Bridgman and Davis' policy cycle had been determined as the benchmark to compare each organisation's policy development for assessing overseas-qualified nurses. Prunty's critical policy analysis was also considered an important method of determining the underlying assumptions in the policy development process and the policies. Consequently, Bridgman and Davis' policy cycle and Prunty's critical policy analysis underpin the a priori questions used in the analysis of the data.

There are few documented methods to undertake a critical policy analysis of this nature (Taylor 1997). Much of the literature related to analysing the effects of government or public policy as discussed previously. A number of authors have given broad considerations on how policy could and should be analysed (Majchrzak 1984; Weimer & Vining 1989; Hogwood & Gunn 1990; Hancock 1999; Bridgman & Davis 2000; Colebatch 2000).

Given that most of the literature relating to policy analysis focuses on analysis in order to develop or review policy it was difficult to find a process that could be used in the context of analysing policy as determined in this research. Therefore it was decided to adapt Framework Analysis as described by Ritchie and Spencer (1999), as this was developed for applied policy research. Framework Analysis was originally developed by an independent social research institute called the Social and Community Planning Research (SCPR) in the UK to assist in the conduct of applied qualitative research (Ritchie & Spencer 1999). A large portion of the work of the SCPR related to applied policy research, as there was a 'persistent requirement in social policy fields to understand complex behaviours, needs, systems and cultures' (Ritchie & Spencer 1999, p. 173). The SCPR had used a significant amount of qualitative data to provide insights, explanations and theories of social behaviour in relation to policy research (Ritchie & Spencer 1999).

The key features central to the development of Framework Analysis are that it is grounded or generative, dynamic, systematic, comprehensive, enables easy retrieval of data collected, allows between and with-in case analysis and was accessible to others (Ritchie & Spencer 1999).

Framework Analysis was a systematic and analytical process relying on the creative and conceptual skills of the analyst to determine meaning, importance and links between data collected. Framework Analysis was essential to the documentation of a systematic process for charting and sorting data into key issues and themes in a structured way that contributed to the auditability of the research.

'Framework' analysis consists of five key stages:

- Familiarization

- Identifying a thematic framework

- Indexing

- Charting

- Mapping and interpretation.

(Ritchie & Spencer 1999; Lacey & Luff 2001)

Familiarization relates to the researcher's immersion in the data, by reading policy documents, listening to audiotapes, reading transcripts, annual reports, Nurses Acts and field notes. Identifying a thematic framework was the initial process that identified themes based on an a priori series of questions as discussed later in this chapter. The responses to each question were then indexed according to the identified themes. The data was charted in relation to each theme and participating organization. Subsequently mapping and interpretation occurred which involved identifying common and different themes across all participants' policy cycles.

The a priori questions used were developed using the same elements of the policy cycle as determined by Bridgman and Davis (2000) and incorporated Prunty's (Prunty 1985) signposts for a critical policy analysis and my knowledge and experience of the assessment process. These questions should not be confused with the guided interview questions asked of participants during the face-to-face interviews. The a priori questions were developed in order to analyse the data and were questions that I used to determine how each organisation's policy development compared to Bridgman and Davis's policy cycle. At the same time I was analysing the actual policies themselves, to determine what they were and to discover the underlying assumptions used in their development. A diagrammatic account of the model of analysis is as follows:
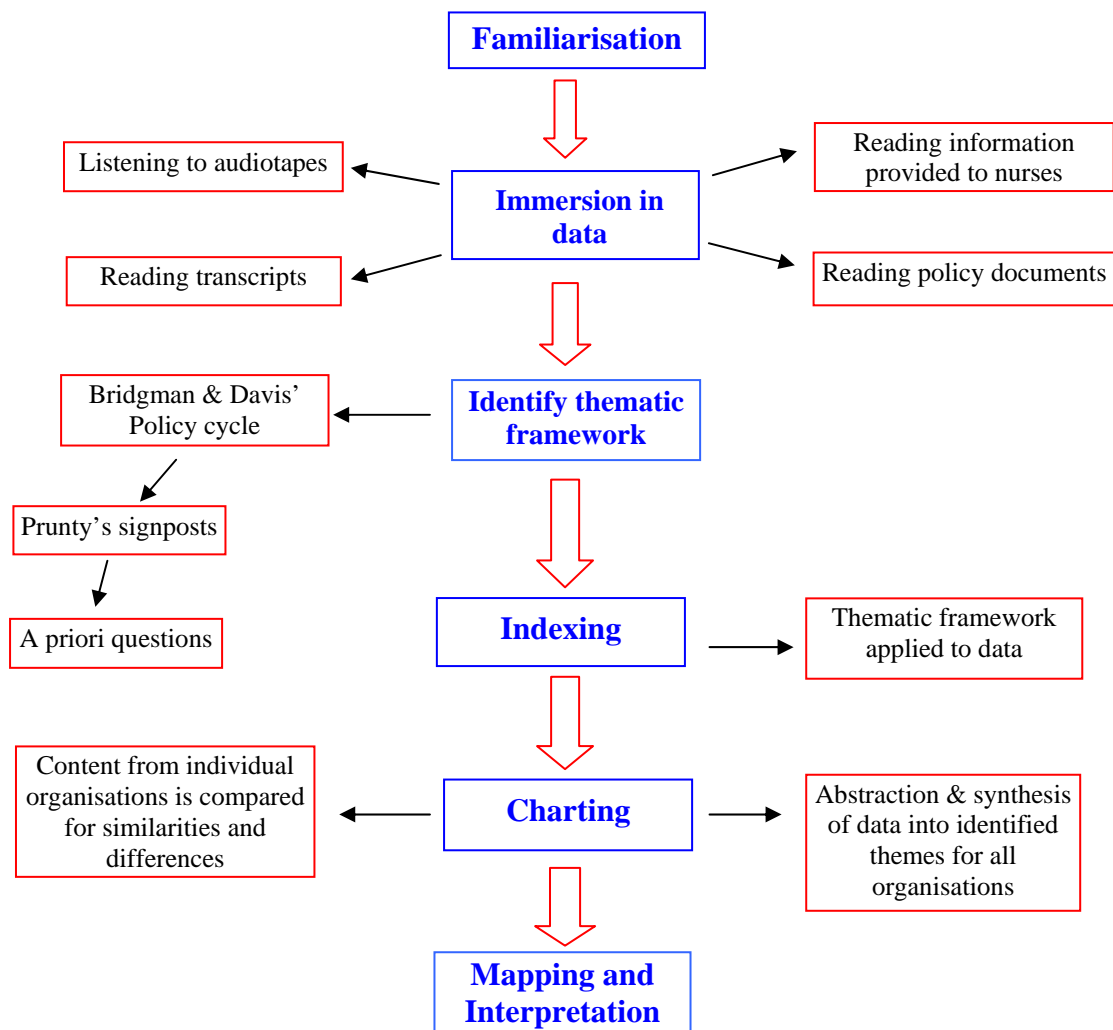
Figure 2:   Framework Analysis

The a priori questions applied to the data were as follows:

Identify Issues

How was the issue of qualification assessment for overseas-qualified nurses identified and by whom? Who was responsible for identifying the need for a policy to be developed? How was the need for a policy on qualification assessment bought to the attention of the regulatory authority?

Policy Analysis

What research was conducted to identify the appropriate policy instrument for qualification assessment? Was research conducted to determine whether nurses who had previously been assessed as competent to practice, were in fact competent to practice? Were industry asked to give feedback on the assessment process and the outcomes of assessment? How were the current policies developed and by whom and when were they last reviewed? What were the costs of the assessment process to both regulatory authorities and overseas-qualified nurses?

Policy Instrument

What were the policy instruments? Were they a paper-based assessment or a written exam both for determining competence in English language and skills? Who determined which policy instrument was to be used and how often was this instrument reviewed? How were the policy instruments developed? Did the policy instruments acknowledge a nurse's experience and continuing education?

What were the underlying assumptions in the policy process? Were there memorandums of understanding with any other countries in relation to mutual recognition of qualifications?

Consultation

Who had been consulted in the policy development process? Had all stakeholders been identified and included in the policy cycle? Were industry and overseas-qualified nurses considered as stakeholders? Has feedback from consultation been incorporated into policy advice?

Coordination

Who was responsible for coordinating the policy cycle? Who was accountable for the policy outcomes? Who was responsible for the administrative and financial outcomes of the policy? Was the policy applied consistently and equitably?

Decision

Who authorised the policy for assessment of overseas qualification nurses? Who was involved in the decision process? How did the policy relate to the regulatory authorities legislation?

Implementation

Who was responsible for implementation of the policy? Was the assigned agency the most appropriate to implement the policy? What resources were identified as necessary for implementation of the policy? How was the policy implemented? Was the policy enforceable? Has an evaluation strategy been included in the implementation plan?

Evaluation

How was the policy evaluated? Were all stakeholders involved in the evaluation process? How often was policy evaluated? Was the performance of the policy monitored?

The Framework Analysis entailed examining each policy, Nurses Act, annual report, information given to nurses and interview transcript using the above series of questions based on the elements of the policy cycle and at the same time using Prunty's signposts to determine the reality in policy. In other words was the policy being used as it was described by the individual organisations. It was anticipated that the answers to each question would be located in the policy document, Nurses Act, annual report, or the interview transcripts.

Once the individual organisations' policy documents, Nurses Act, annual report, information given to nurses and the participant's interview transcripts were examined in relation to the framework, the data was analysed and then compared. Framework Analysis is discussed as it was applied to the data in Chapter 5.

Part of the research design is to consider how rigour is established and maintained in the study.

Establishing Rigour in the Study

The main focus of research is to contribute knowledge gained, by using a scholarly and rigorous approach. A considerable amount of the literature regarding establishing rigour in research relates to the reliability and validity of research data (Hinds, Scandrett-Hibden & McAulay 1990; Mays & Pope 1995; Emden & Sandelowski 1999; Lacey & Luff 2001). However, the concepts of reliability and validity have been considered benchmarks in determining rigour in research, specifically in relation to scientific research using quantitative data.

Reliability of the research is achieved when methods used are reproducible and consistent (Lacey & Luff 2001). Whereas validity is achieved when findings reflect reality (Hinds, Scandrett-Hibden & McAulay 1990). In other words the description fairly and accurately represents the data collected. On the surface these two concepts are quite feasible in determining rigour, however it is believed that qualitative data are unable to be reproduced exactly, therefore there is no guarantee that two researchers perceptions of the data are the same (Koch & Harrington 1998).

Sandelowski advocates that: 'Qualitative research emphasises the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses' (1986, p. 33).

The challenge for researchers using qualitative data are to identify strategies establishing rigour that are compatible with the theoretical and philosophical tenets of the research (Schneider 2003). The four criteria used to demonstrate rigour in this study were credibility, auditability, fittingness and confirmability (Sandelowski 1986; Schneider 2003). In order to achieve credibility or truth relating to the findings, the data from participants such as policies, transcripts of interviews and field notes were an accurate account of information provided by participants.

This accuracy was achieved by ensuring with each participant that the policies obtained from their organisation were in fact the policy and procedures used for the assessment of overseas-qualified nurses. Each interview was audio taped and transcribed verbatim then checked word for word for accuracy of content. Then the field notes taken were cross-referenced with the transcripts. These processes were used to ensure the credibility of the data collected.

Auditability is the criterion of rigour where consistency is measured, however not in the sense of consistent findings. Consistency refers to the researcher's decision trail, where another researcher could arrive at the same or similar conclusions walking through the steps of data collection, analysis and findings (Koch 1994). However, the theoretical underpinning of this study was Critical Social Theory, which means the researcher was subjective rather than objective. This meant that I was overt about my beliefs in relation to the assessment process in an attempt to gain more insight into the assessment policies. Therefore prior to each interview I outlined my background and beliefs to each participant regarding the assessment process for overseas-qualified nurses.

However it was imperative that I used my knowledge and experience to gain information regarding the power and underlying assumptions in assessment policies rather than drive the participant's responses. I was also cognisant of using the guided interview questions to ensure that consistent questions were sought from each participant. However when appropriate, more in-depth questions were asked in order to obtain further understanding or clarity of the assessment policies being described. The model of analysis used, describes the decision trail, which could be used by other regulatory authority to replicate the study.

Auditability was achieved by clearly articulating the drivers for the research, my basic beliefs and inherent values and by describing the methods used to collect then analyse the data, using the framework discussed.

The criterion of fittingness is met when the findings are meaningful and applicable to others (Sandelowski 1986). Throughout the study the findings were compared to the current literature, however there was an absence of literature in relation to policy development and policies for assessing overseas-qualified professionals, which meant it was difficult to determine fittingness during the study. I did however present preliminary findings at professional conferences and academic seminars where there was great interest in the outcome of the research and questioning about how a policy cycle could be used in policy development.

The final criterion of rigour is confirmability, which is the agreement between two or more independent people as to the relevance or meaning of the data (Polit & Hungler 1999).

In the case of this study, confirmability was achieved though discussion with my two PhD supervisors to ensure the data analysis was true to the model of analysis. I met with my supervisors on a fortnightly basis or more frequently when required to ensure the data analysis followed the determined decision trail. Confirmability may be also achieved by the findings reflecting credibility, auditability and fittingness in the eyes of the reader, which may be achieved once this research is published.

Summary

In this chapter the research design, data collection and ethical considerations have been described. The data was collected in two stages from selected participants in Australia and overseas. Stage one was the collection and analysis of policies and procedures for assessing overseas-qualified nurses while stage two consisted of the face-to-face interviews with participants from each organisation using guided interview questions.

The method of data analysis was described, which for this study, was Framework Analysis. The policies and transcripts from the interviews were analysed using Framework Analysis based on a priori questions adapted from the policy cycle and the signposts for critical policy analysis.

Establishing rigour in the research was discussed in relation to credibility, auditability, fittingness and confirmability with discussion as to why these were used as opposed to reliability and validity commonly used when addressing the use of quantitative data. The next chapter provides the data collected from the Australian NRA and analysis of that data.

CHAPTER 5:   DATA ANALYSIS - AUSTRALIA

Introduction

The challenge for any researcher is to present the data in a cohesive and organised manner. Data from this study included interview transcripts, organisational policies and procedures, Nurses Acts, information provided on organisational websites and annual reports. The data collected from each organisation is presented and analysed using Framework Analysis which is a process of familiarisation, immersion in the data, identifying a thematic framework, charting, then mapping and interpretation of the data (Ritchie & Spencer 1999).

Of the sixteen organisations invited to participate, thirteen consented to take part in the study. The National Board of Health and Welfare, Sweden, King Fahad Hospital, Saudi Arabia and the Nursing Council of Hong Kong all declined to participate in a face-to-face interview, therefore, were excluded from the study. The National Board of Health and Welfare, Sweden indicated that the Board was only interested in applicants with Swedish language skills, therefore they did not see the relevance in participating in the research.

The King Fahad Hospital declined as they had many new projects in progress therefore was unable to participate in an interview. The Nursing Council of Hong Kong simply indicated that an interview was not possible, I confirmed this during a telephone discussion with the Secretary of the Council.

Consequently the participants of the study were: all Australian nurse regulatory authorities, the Australian Nursing and Midwifery Council, the College of Nurses Ontario, the Nursing and Midwifery Council United Kingdom, the Philippine Board of Nursing and the Board of Registered Nursing, California.

Four of the thirteen organisations (the College of Nurses Ontario, the Nurses Board of Tasmania, the Australian Nursing Council and the Queensland Nursing Council) provided their policies for assessing overseas-qualified nurses prior to the visit to their organisation. The following ten organisations did not provide their policies prior to interview:

- Nursing and Midwifery Council

- Philippine Board of Nursing

- Nurses Board of the Northern Territory

- Nurses Board of South Australia

- Nurses Board of Western Australia

- Nurses Registration Board of New South Wales

- Nurses Board of Victoria

- Nurses Board of the Australian Capital Territory

- Board of Registered Nursing California.

The reasons why the above did not provide their policies is discussed in the analysis of the data for each organisation. The available policies were analysed using Framework Analysis prior to undertaking the face-to-face interviews.

There were some initial problems with overseas participants in the coordination of the face-to-face interviews due to difficulty in establishing the appropriate person to interview therefore organisations were telephoned to establish who this person might be. This involved several telephone calls, to ensure an interview was secured prior to arrival in the country. When I arrived in the UK, the person who was to participate in the interview at the Nursing and Midwifery Council was unavailable to conduct the interview, and this was also the case with the person at the Board of Registered Nursing, California. However, other staff from these two organisations participated in a face-to-face interview. In the case of the Nursing and Midwifery Council the person interviewed was unable to answer some questions, consequently these were followed up with the appropriate person via email.

A general interview guide (Appendix 3) was used when interviewing the participants and field notes were taken in order to prompt further questions or clarify answers given at a later stage should this prove necessary.

This chapter focuses on the analysis of data collected in Australia and Chapter Six provides analysis of the data collected from overseas organisations. The reason for dividing the analysis chapters into Australian NMRAs and overseas NMRAs was to present Australia as individual States/Territories then as a whole before analysing other countries. The rationale for presenting Australia as a whole was to highlight the commonalities and differences between each state and territory.

Demographic data are presented which includes information about the number of overseas-qualified nurses assessed per year and their place of origin.

This data are presented as background information to assist in situating the participating organisations in relation to how many assessments were undertaken per year, and the implications this may have on policy development. Also presented is the composition of Board/Councils and the committees identified as relevant to the assessment of overseas-qualified nurse's policy. This information was obtained to determine whom were the ultimate decision-makers involved in policy development and policy decisions regarding overseas-qualified nurses.

It is acknowledged that the Australian Nursing and Midwifery Council has no legislative authority to register a nurse, however the ANMC is considered pivotal to the assessment process for nurses migrating to Australia, as the ANMC has initiated the development of standards and criteria for assessment of overseas-qualified nurses used by most states/territories in Australia. Therefore could be seen as an influential contributor in the development and implementation of assessment policy in Australia. Also when referring to nurse/s, the use of this term infers registered, registered practical and enrolled nurses and midwives unless otherwise stated.

For the purposes of this study the term 'Board' is used when referring to Boards/Councils of NMRAs to ensure consistency in terminology. To maintain uniformity and ease of comparison, the costs of the policy instruments, such as assessment and language tests, have been converted from the local currency to Australian dollars, at the current rate on the day of writing this part of the chapter.

The steps involved in the Framework Analysis are shown in figure 2 p 100.

The first step was to become familiar with the data through, reading the transcripts, listening to the audiotapes, reading the policy and procedures and any other information obtained such as annual reports and Nurses Acts. The thematic framework informing the analysis consisted of the determined a priori questions used for analysing the assessment policy and policy development processes used by participating organisations. The information organisations provided was then indexed using the stages of the policy cycle, these were, identify issues, policy analysis, policy instruments, consultation, coordination, decisions, implementation and evaluation. Individual tables were constructed to collate the information provided by each organisation in response to the a priori questions, an example is provided in Appendix 4. Once this was completed the data was mapped and interpreted and a comparison was made between the Australian Nursing Council, Australian and overseas nurse regulatory authorities (Appendix 5).

Demographic Data

Data collected from annual reports and interviews, indicated variation between states in the number of nurses on the registers and the number of overseas-qualified nurses applying and assessed per year. The number of nurses on the registers in 2001/2002 ranged from 93,770 nurses in New South Wales to 3,378 in the Northern Territory. The number of nurses on the registers related directly to the size of each state's general population. Five states were unable to supply accurate information on the number of overseas-qualified nurses applying for assessment and the actual number of nurses assessed as eligible for registration.

Table 1 provides a summary of the number of nurses on the register, the number of overseas-qualified nurses who applied for registration and the number of overseas-qualified nurses who were assessed as eligible for immediate registration in the year 2001/2002. Information on the countries from where the nurses had applied and the number of nurses applying from each country was only obtained from the ANMC, Nurses Registration Board of New South Wales and the Nurses Board South Australia all other organisations were unable to provide this data.

Organisation	Nurses on register/roll in year 2001/2002	Overseas-qualified nurses applying to register/enrol in year 2001/2002	Overseas-qualified nurses assessed as eligible to register/enrol in 2001/2002
NBACT	4,691	Approx 12	N/A
NBV	75,879	N/A	1,550
NBNT	3,378	Approx 10-20	N/A
NBWA	26,678	Approx 995	N/A
NRBNSW	93,770	2,202	1,851
NBT	6,645	Approx 1-2	N/A
NBSA	23,638	170	135
QNC	44,791	Approx 650	N/A
ANMC	N/A	1204	877

N/A indicates the information was not available.

Table 1:   Nurse registration and OQN applications per organisation

As indicated in table 1 only three organisations provided accurate information on the number of nurses applying for registration from overseas, the remainder gave approximate figures. Four organisations provided data on the number of nurses assessed as eligible for immediate registration, without having to undertake further requirements. Given the lack of data available from most Boards it was difficult to determine how many overseas-qualified nurses actually applied to Australia for registration and from which countries they applied.

Board Composition

The composition of Boards varied, as did the way in which the Board members were elected or appointed. All Boards had both registered and enrolled nurses in their membership, and in the case of the Nurses Board of the Australian Capital Territory, all Board members were nurses. Other Boards were comprised of nurses, lawyers, doctors, ethicists and consumers. The method of appointment of Board members varied, in that five Boards were nominated by the Minister (the Minister's portfolio varied, however was predominately the Minister for Health) and appointed by the Governor. In the case of three Boards, all members were appointed by the Minister, whereas four Boards had a combination of members appointed/nominated by the Minister and elected by nurses and/or professional nursing/midwifery bodies and unions representing nurses. Five of the nine Boards had a lawyer as a member and one Board had an ethicist. Consumer representation varied from one to three members while the NBNT was the only Board to specify three indigenous persons as members (one to be a nurse). The ANMC was different in that the Council's membership had a representative from each nurse regulatory authority in Australia, plus two members from the general public.

All Boards with the exception of the Nurses Board of Western Australia had a nurse as the presiding member. Only one Board stipulated that the presiding member was required to be a registered nurse, all others indicated simply, a nurse (enrolled/registered). The following table provides an overview of each individual Board's composition in relation to number of Board members, composition, whether they are appointed or elected and how the chairperson is determined. This information was important when determining who empowered the Board, was it the profession, consumers or the government?

Organisation	No. of Board members	Composition	Elected/Appointed	Chairperson
NBACT	9	7 registered nurses 2 enrolled nurses	5 nurses appointed by Minister 4 nurses elected by profession	Nurse appointed by Minister
NBV	12	6 registered nurses division 1 2 registered nurses division 2 1 registered nurse division 3 1 lawyer 2 consumers	All nominated by the Minister	Nurse Appointed by Governor
NBNT	10	4 nurses (1 indigenous) 1 lawyer 1 ethicist 1 consumer 1 consumer (representing indigenous persons) 1 registered nurse 1 enrolled nurse	Appointed by minister 2 nurses elected or appointed (not indicated by whom)	Nurse appointed by the Board members
NBWA	12	6 registered nurses 1midwife 1psychiatric nurse 2 enrolled nurses 1 consumer 1 other person	All appointed by Minister	Appointed by Minister from Board membership
NRBNSW	13	3 registered nurses 1 midwife 1enrolled nurse 1 registered nurse 1 registered nurse 1 mental health nurse 2 registered nurses 1 lawyer 2 consumers	Elected by RN's Elected by RM's Elected by EN's Nominated by NSW nurses Assoc Nominated by NSW College of Nursing Nominated by Minister	Registered nurse appointed by the governor
NBT	7	5 nurses 2 consumers	All nominated by the Minister	Nurse Nominated by the Minister
NBSA	11	5 nurses 1 nurse (presiding member) 1 medical practitioner 1 lawyer 3 consumers	Elected by nurses Nominated by Minister of Human Services	Nursing qualifications nominated by Minister of Human Services
QNC	13	9 registered nurses 1 enrolled nurse 1 consumer 1 lawyer Executive Officer of Council	All nominated by the Minister	Nurse appointed by Governor
ANMC	10	8 representatives nurse regulatory authorities 2 consumers	Nominated by individual regulatory authorities	Nurse elected by Council members

Table 2:   Board Membership Composition

All Boards have the capacity to convene standing committees to assist in the work of the Board. The committees involved in the policy development for assessing overseas-qualified nurses were commonly referred to as the Registration Committee (and are referred to as such for the purposes of this study). Table 3 represents the organisations that had Registration committees and provides information on the composition of these committees. This information is important in determining who provides information, influences and is involved in decision making in the policy development process.

Organisation	No. of members	Composition	Elected / Appointed	Chairperson
NBACT	4	4 Board members	All appointed by the Board	Board member
NBV	No committee	-	-	-
NBNT	No committee	-	-	-
NBWA	4	Registrar 1 Board member 2 nurses (not Board members)	All appointed by the Board	Board member
NRBNSW	9	7 members nominated by various nursing professional bodies 1 member from NSW migrant employment qualifications board Board staff	Appointed by Board	Board staff member
NBT	5	1 Board member 1 registered nurse in clinical practice 1 consumer 1 nurse employer 1 nurse educator	Appointed by Board	Board member
NBSA	11	4 Board members 4 members of profession 3 Board staff	All appointed by Board Professional members by expression of interest	Board member
QNC	9	2 Council members 2 registered nurses 1 enrolled nurse 4 staff members	Appointed by Council	Council member
ANMC	11	2 ANC staff members 8 regulatory authority members (1 representing each state of Australia 1 representing Nursing Council of New Zealand	ANMC staff appointed by ANMC Nominated by individual regulatory authorities	Appointed by membership of committee

Table 3:   Registration Committee composition

Two Boards did not have an advisory committee on registration policy. The Nurses Board of Victoria indicated that this was the responsibility of the Board itself and should not be delegated. The Nurses Board of the Northern Territory has the power to convene standing committees, however it was indicated by the participant, that the Board has chosen not to convene committees at this present time. The size of each committee varied from four members to eleven members. Some were made up of all Board members while others had representation from Board, consumers and members of the profession. All committees were appointed by the Board and had a Board member as the chair, except the ANMC, which had a Collaborative Advisory Panel (CAP), which had representatives nominated by each Australian nurse regulatory authority and the panel members elect the chair. The Collaborative Advisory Panel was established by the ANMC as a way of consulting with the Australian nurse regulatory authorities about issues relating to the assessment of overseas-qualified nurses.

The Nurses Board of Western Australia also has a Network Advisory Panel, which was comprised of forty-eight expert nurses and relevant persons committed to progressing the strategic directions of the Board. The Queensland Nursing Council had a Consumer Advisory Panel consisting of forty-nine members of whom fifteen were consumers and thirty-four were nurses from all levels of nursing practice. However, while these panels are the conduits to consult with a broad range of stakeholders, neither had been involved in policy development for assessing overseas-qualified nurses. Both panels demonstrate broad stakeholder consultation was considered appropriate for informing policy development however has not been used in relation to policy involving the assessment of overseas-qualified nurses.

The demographic data in relation to the number of overseas-qualified nurses applying to register in Australia and the composition of the Boards and the associated committees has been provided. It was envisaged that this data would be used to determine whether the number of nurses assessed per year influenced policies relating to the assessment of overseas-qualified nurses. In other words if there were large numbers of nurses to assess did the policy reflect a one size fits all ethos, rather than individual assessments purely for ease and speed in processing. The composition of the Boards and advisory committees were of interest in determining which stakeholders were involved in influencing decision-making and how powerful they were in that process.

The analysis of the data collected is presented using the Bridgman and Davis steps of the policy cycle with the first step, determining how the issue of assessing overseas-qualified nurses is identified.

Identifying Issues

Issue identification is frequently the indicator or alarm that signifies that a policy requires development (Bridgman & Davis 2000). Although, how an issue is identified may be serendipitous, by the legislation or by systematically monitoring the environment in which the organisation practices. Issue identification should not be left to chance and should involve systematic monitoring of the regulatory environment (Bridgman & Davis 2000).

In the Australian context, all participants indicated that the Nurses Act was the primary source of issue identification in relation to assessing overseas-qualified nurses for nurse

regulatory authorities. Secondary sources were indicated as Board members, Board advisory committees, Board staff and the ANMC Collaborative Advisory Panel. The Department of Immigration Multicultural and Indigenous Affairs (DIMIA) identified the issue of qualification assessment for immigrating nurses and delegated its authority to the ANMC. The Collaborative Advisory Panel was the primarily source for identifying issues in the assessment process for the ANMC.

The data revealed that issues surrounding the assessment of overseas-qualified nurses were identified by internal sources, such as Nurses Acts, Board members and internal committees (Appendix 5). When comparing the sources used to identify issues for the Australian nurse regulatory authorities, to Bridgman and Davis' (2000) best practice model, the current practice proved to be limited and should have included all stakeholders involved and affected by policy relating to assessing overseas-qualified nurses.

Policy Analysis

Policy analysis is a rigorous process that requires a significant investment of time and money, in order to provide decision makers with sufficient, objective information in order to make an informed decision. Policy analysis entails an analysis of the economic, social, legal and political frameworks in which the policy sits. This involves determining whether the current policy meets the requirements of the jurisdiction's Nurses Act and/or any other legislation affecting nurses. However, while this addresses the legal framework, consideration also needs to be given to the social, economic and political frameworks influencing policy.

Policy analysis should involve representatives of key stakeholders such as overseas-qualified nurses themselves and the groups who employ these nurses. Other sources of information should include factors that may influence nurse's practice.

The term policy analysis is used here even though participants had not specifically identified this part of the policy cycle as policy analysis *per se*. The data collected indicated that policy analysis occurred in different ways in each organisation. An overview of the different ways and sources of information relating to policy analysis are indicated by each organisation in table 4.

There were five different sources identified as involved in the policy analysis phase for organisations. These sources were: formal research either undertaken by the organisation or by external consultants, monitoring of complaints received regarding overseas-qualified nurses, the CAP, policy review and others sources such as visiting other countries.

Organisation	Formal research	Monitor reports of incompetence to practice	Collaborative Advisory panel	Policy review	Other
NBACT	no	no	yes	2 yearly	
NBV	no	no	yes	2 yearly	Previous decisions
NBNT	no	no	yes	annually	
NBWA	no	no	yes	annually	
NRBNSW	no	no	yes	continual	Previous decisions Feedback from provider of bridging programs
NBT	no	yes	yes	3 yearly	
NBSA	no	yes	yes	ongoing	
QNC	no	no	yes	annually	Visit other countries
ANC	no	no	yes	annually	Requests from DIMIA Visit other countries Gather data from other countries

Table 4:   Sources of information used in policy analysis

No organisation had undertaken formal research to determine whether the outcomes of the current policy/s for assessing overseas-qualified nurses met the requirements of the legislation or whether nurses were competent to practice.

Two organisations (NBSA and NBT) indicated that data regarding the number of overseas-qualified nurses reported for incompetence would be used to inform policy development.

The Nurses Registration Board of New South Wales indicated that they requested information from the provider of bridging programs regarding the number of nurses who pass the competence assessment and the country in which the nurses undertook their initial education. The NBNSW also requested the program provider indicate how many nurses were recommended to undertake further education in order to satisfactorily meet competence requirements.

The Queensland Nursing Council indicated that in the past their policy was informed by actually visiting a country to determine 'what was happening there' as they had received applications from that country (Queensland Nursing Council 2001). The QNC did not provide information or criteria used to determine 'what was happening' in each country.

All NMRAs indicated that the ANMC Collaborative Advisory Panel, provided information used to inform policy development. However, the ANMC indicated that it was difficult to obtain accurate information in relation to overseas-qualified nurses from the Boards to inform policy development. This appeared to be a circular process as information gathered was adhoc and believed to be inaccurate.

Previous decisions in relation to the assessment of overseas-qualified nurses made by the Board also informed policy development according to the NBNSW and the NBV. The ANMC indicated that part of their policy analysis was considering requests from organisations such as the Department of Multicultural and Indigenous Affairs such as consideration be given to the English language proficiency of nurses from a certain country in relation to the current ANMC policy.

The data collected from each organisation has shown that their policy was not based on research and policy analysis appears to be based on historical knowledge, is somewhat adhoc and is based on information gained in an informal manner due to the lack of reliable data. The following examples of comments by participants support this view:

> We haven't conducted any research in the area simply because it is difficult to get information from the Boards (participant 9 p19: 7-8).
>
> These policies have been based on historical data based on experiential knowledge formed by regulatory authorities (participant 11 p6: 3-5).
>
> The only thing that we have done is sent some people to Papua New Guinea to see what was happening there because we have a few nurses here. As far as I can think we have not really done any research (participant 10 p13: 14-17).

From the data collected it appears that policy analysis addresses the legal framework however is silent on the social, economic and political frameworks that are so important in determining factors affecting the outcome of policy relating to the assessment of overseas-qualified nurses. No organisation indicated that they conducted environmental scans as part of policy analysis which is vital in determining the social, economic and political factors that influence both policy development and outcomes.

Policy Instruments

The policy instruments are the tools used to achieve the policy objectives. In this instance the tools are the processes used to ensure overseas-qualified nurses meet the requirements for registration as determined by the individual Nurses Act.

All but one nurse regulatory authority indicated that they use the standards and criteria policy instruments developed by the ANMC as a guide for assessing overseas-qualified nurses. The Queensland Nursing Council has developed their own standards and criteria (policy instruments) adapted from the ANMC policy instruments for assessing overseas-qualified nurses.

The ANMC policy instruments relate to language, competence to practice and identity requirements. The ANC has produced 'Standards and criteria for the assessment of qualifications of overseas-educated nurse' (2002) (see Appendix 6) as their policy instruments. The five standards are:

- Applicants have undergone educational preparation for nursing leading to eligibility to practice in the country where the education program was undertaken;

- Applicants are eligible for registration if the educational program they have undertaken enables them to demonstrate the national competency standards;

- Applicants provide evidence of competence to practice;

- Applicant's true identity is established; and

- Applicants meet English language proficiency requirements.

Most Boards have adopted the standards and criteria in their entirety. The Nursing Board of the Northern Territory, the Nursing Boards of Tasmania and the Australian Capital Territory, (due to the small number of overseas-qualified nurses requiring assessment per year) request the ANMC undertake the assessment of all overseas-qualified nurses and provide a recommendation to the Board. It was indicated by staff from all three Boards that they considered the ANMC had expertise in this area due to the volume of nurses assessed by this organisation, compared to the limited number between 1–20 overseas-qualified nurses applying for assessment per year in their jurisdiction.

The standards and criteria are now discussed individually to determine similarities and differences in their application between Boards and the ANMC.

Standard 1: Applicants have undergone educational preparation for nursing leading to eligibility to practice in the country where the education program was undertaken.

The data from this study indicates that all Boards require a nurse to provide a certified copy, in English, of their certificate, degree or diploma in nursing issued by the educational institution in which their course was undertaken. All Boards also require verification of registration by the regulatory authority that endorsed the nurse's initial education course as meeting requirements for registration. Boards request that this verification be sent directly from the regulatory authority to the Board where the nurse is applying for registration. It was indicated by all Boards that the requirement to send verification directly to the Board was to minimise the incidence of fraudulent documents and to verify registration and educational status.

Standard 2:   Applicants are eligible for registration in Australia if they have undergone educational preparation for nursing which enables them to demonstrate the ANMC national competency standards.

Eight of the nine Boards have identified those countries where nurses meet requirements for registration in Australia as determined by the ANMC criteria for standard two (see Appendix 6). The NRBNSW and the QNC have indicated that nurses from some additional countries also meet their competence requirements for registration. The following table shows the variation in the Boards of the countries of origin for nurses who are determined as meeting requirements for registration and the countries where nurses are required to prove English fluency:

It appears that most Boards follow the ANMC criteria for determining whether nurses from specific countries meet competence requirements. However, the Nurses Board of Victoria indicated that they did not consider automatically, nurses from any country as meeting competence requirements, but prefers to assess nurses on an individual basis and include post registration experience as part of this assessment. Given that the NBV is a member of the ANMC Collaborative Advisory Panel it is curious that this practice deviates from the ANMC standards and their criteria for assessing overseas-qualified nurses.

The NRBNSW also indicated that a nurse's post registration experience was considered when assessing whether a nurse meets the requirements for registration as all nurses are assessed on an individual basis. This is contrary to the QNC who indicated that they had received a legal opinion, which advised the QNC that post registration education and experience couldn't be considered when determining eligibility for registration.

The legal opinion in interpreting the Queensland Nursing Act 1992 indicated that pre-registration education was all that could be considered in a nurse's application for registration. There was no specific reason as to why this was the case only that this is the current interpretation of section 54, Nursing Act 1992 (*Nursing Act - Qld* 1992).

Organisation	Country determined as meeting competence requirements		Countries where proof of English fluency is required	
NBACT	United Kingdom Republic of Ireland United States of America Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands	Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands
NBV	Based on individual assessment which includes post registration experience		Any country where English is not the first language	
NBNT	United Kingdom Republic of Ireland United States of America Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands	Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands
NBWA	United Kingdom Republic of Ireland United States of America Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands	Republic of South Africa Zimbabwe	Canada (Quebec) Singapore Hong Kong Netherlands
NRBNSW	United Kingdom Republic of Ireland United States of America Republic of South Africa Zimbabwe Canada	Singapore Hong Kong Netherlands Countries of the European Union if directive 77/453 applies	Austria Belgium Denmark Denmark Finland France Germany Greece Italy Luxembourg Portugal Spain Sweden	Cyprus Czech Republic Estonia Hungary Latvia Lithuania Malta Poland Slovakia Slovenia
NBT	United Kingdom Republic of Ireland United States of America Zimbabwe	Canada (Quebec) Singapore Hong Kong Netherlands	Canada (Quebec) Singapore	Hong Kong Netherlands
NBSA	United Kingdom Republic of Ireland United States of America Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands	Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands
QNC	United Kingdom Republic of Ireland United States of America Canada Czech republic Egypt Fiji	Ghana Hong Kong Netherlands Singapore South Africa Sri Lanka	Czech Republic Egypt Fiji Ghana	Hong Kong Netherlands Singapore South Africa Sri Lanka
ANC	United Kingdom Republic of Ireland United States of America Republic of South Africa Zimbabwe	Canada Singapore Hong Kong Netherlands	Republic of South Africa Zimbabwe Canada	Singapore Hong Kong Netherlands

Table 5:   Countries determined as meeting competence requirements and the countries identified where nurses are required to prove English fluency.

Overseas-qualified nurses from the European Union see (Appendix 6) whose education program complies with the European Union Directive 77/453 meet the educational requirements for registration with the NRBNSW. The NRBNSW indicated that nurses from countries previously determined as meeting educational requirements, were not obliged to provide an educational transcript, therefore recognising the qualification gained by the nurse without further assessment. The NRBNSW were clearly working outside the ANMC standards and criteria for assessing overseas-qualified nurses in relation to accepting the European Directive 77/453.

For all the Australian Boards, overseas-qualified nurses were required to provide a certified copy, in English on organisational letterhead, of their academic transcript of initial nurse education (except as indicated above by the NRBNSW). This academic transcript must include hours of theoretical and clinical experience. The academic transcript is then used to make a comparison between a curriculum endorsed by the individual nurses Board and that which the nurse has undertaken.

All Boards (except the Nurses Board of Victoria) indicated that overseas-qualified nurses who were not from the countries specified as meeting requirements by each Board are required to undertake a competency based assessment/migrant bridging program. Each organisation indicated that competency based assessment/migrant bridging programs were required to be endorsed by the individual Board as meeting the requirements for registration. These programs vary in content and length, from days to eighteen months duration. A description of competency-based assessment/migrant bridging programs offered in each state of Australia is provided in (Appendix 7).

What is significant about these programs is that they all lead to registration, however, some also lead to a Bachelor of Nursing degree while others achieve a certificate of completion, this has no apparent relationship with the length of the course. Participants in each program receive no remuneration during the program.

Three Boards did not charge an assessment fee, as the ANMC undertook the assessment of overseas-qualified nurses on behalf of the Board. Therefore these Boards indicated that the nurse was already paying the ANMC for assessment of their qualifications. All other Boards charged a fee on a cost recovery basis, which varied between Boards, however the fee charged by the ANMC was significantly greater than all other Boards. The costs involved for applicants in the assessment process and to undertake competency-based assessment/migrant bridging program are presented in table 6.

As demonstrated in table 6 the costs of competency assessment/migrant bridging programs vary considerably from no charge to $10,500. The high cost of some programs would appear to be a disincentive for any nurse considering applying for registration from overseas. There is obviously a belief held by some Boards that they should absorb the cost of determining competence of the overseas-qualified nurse while others believe the user should pay.

Organisation	Assessment Fee	Bridging Program Fee
NBACT	Full - $530 Modified- $150 (As ANC do assessments) no charge by Board	No cost
NBV	$ 80 (if unsuccessful 1/3 retained)	Course 1 - $3,500 (p/r) * $4,500 (n/r)** Course 2 - HECS (p/r) $8,500 (n/r) Course 3 - $ 8,400 (p/r) $10,500 (n/r) Course 4 - $ 3,400 (p/r) $5,400 (n/r)
NBNT	no charge	Program 1 – HECS fees Program 2 – No cost
NBWA	$ 85	Determined by university and hospital
NRBNSW	$ 50 (includes 1 year of registration)	$3000
NBT	Full - $530 Modified- $150 (As ANMC do assessments) no charge by Board	HECS fees apply
NBSA	$ 50	$6000
QNC	$ 44	Challenge test $165 Clinical ass $196 (sim) $249 Clinical ass $800/modle (real) Education module
ANMC	Full - $530 Modified - $150	Depending in which state the nurse undertakes program

* p/r permanent resident
** n/r non-resident

Table 6: Assessment and competency based assessment/migrant bridging program costs.

The ANMC standard two, criteria three, indicated that a nurse who had been assessed as not meeting the educational requirements for registration but had worked in either the UK, Ireland, the Republic of South Africa, USA and Canada fulltime for a period of three months and had demonstrated competence to practice, in these countries would be considered as meeting the competence requirements for registration.

In Queensland the QNC would grant a nurse who has meet these requirements, limited registration indicating that the nurse would be required to practice under the supervision of a registered nurse and must notify the Council within twenty-four hours of gaining employment in Queensland and provide a statement of competence within three months to gain full registration.

It appears that the ANMC acknowledges the skills and experience gained by a nurse (educated in a country where the preparation for nursing is not considered able to meet the ANMC competency standards) in an English speaking country where the healthcare system and nursing practice standards are the substantially equivalent to those in Australia. However the QNC believe that while it may appear that these nurses gain the knowledge, attitude and skills, which will enable them to demonstrate the ANMC competencies, the QNC still require an assessment of their competence to practice in order to be granted full registration.

To date no data has been collected by the ANMC or the QNC to indicate that practicing in an English speaking country with similar healthcare systems and nursing practice to that in Australia ensures an overseas-qualified nurses ability to competently practice in Australia. It would appear that a system has been set up by both the ANMC and the QNC, which is not evidence-based and subsequently has not been proven to meet the desired outcome of competence to practice.

Standard 3:   Applicants provide evidence of competence to practice

All Boards require the nurse regulatory authority where the nurse last practiced to provide verification of current registration directly to the Australian nurse regulatory authority. All Boards require a statement of service and/or evidence of experience within the past five years. The statements of service must indicate the capacity in which the nurse was employed, length of employment and the nature of clinical practice. It is not clear whether statements of service are a true indication of a nurse's competence to practice. Personal references from nurses are required by all Boards except the NBV and the NRBNSW who request information indicating type and capacity of a nurse's practice.

The NRBNSW required nurses to supply two character references (no personal references) dated within the past two years, provided by a registered or enrolled nurse who was not related to the applicant and had known the applicant for at least one year. The character reference was to indicate the honesty and trustworthiness of the nurse and whether the nurse was of good character. The Nurses Board of the Australian Capital Territory also requires a character reference. Perhaps other Boards consider that the personal reference gives an indication as to whether the nurse is of good character. However as the NRBNSW require both it appears that the NRBNSW consider a character reference is different to a personal reference.

In summary the evidence obtained from all Boards for determining competence appears to be current registration with a nurse regulatory authority and a professional reference and/or statements of service from the nurse's most recent employer within the past five years.

Standard 4:   Applicant's true identity is established

All Boards required certified documentary evidence of the nurse's full name, previous surnames if applicable and date and place of birth. This proof may be in the form of certified copies of the nurse's passport, birth certificate, driver's licence or Australian citizenship. The ANMC and the NBACT also required a certified passport photograph as proof of identity. However, nurses did not have a face-to-face interview at the ANMC or the NBACT, therefore the photograph supplied was not compared to the nurse. Proof of identity appeared to be similar across all organisations, however it was indicated that proof of identity documents indicated by the Boards were subject to fraud.

Standard 5:   Applicants meet English language proficiency requirements

English speaking countries according to all organisations are the United Kingdom, Ireland and the United States of America. All organisations required overseas-qualified nurses who had either a Non English Speaking Background (NESB) or had English as a second language were required to meet English language proficiency. Table 7 indicates the English language tests accepted as meeting requirements by each organisation.

Six organisations accepted an OET B pass in all four sections or a pass of 6.5 in all four sections with an overall band score of 7 for the IELTS, as meeting English language requirements. However, the NRBNSW accepted a pass of 7 in all four sections with an overall band score of 7 for the IELTS.

Organisation	IELTS*	OET*	ASLPR*	ISLPR*	CULT*
NBACT	6.5 each area overall score 7	-	-	-	
NBV	6.5 each area overall score 7	B pass or above in all sections of test	-	-	
NBNT	6.5 each area overall score 7	B pass or above in all sections of test	-	-	
NBWA	6.5 each area overall score 7	B pass or above in all sections of test	-	-	
NRBNSW	7 each area overall score 7	B pass or above in all sections of test	-	Minimum level 3+	Minimum score 65
NBT	6.5 each area overall score 7	B pass or above in all sections of test	-	-	
NBSA	6.5 each area overall score 7	B pass or above in all sections of test	Minimum level 4	Minimum level 4	
QNC	6.5 each area overall score 7	B pass or above in all sections of test	-	Minimum level 3+ in all components	
ANC	6.5 each area overall score 7	B pass or above in all sections of test	-	-	

*IELTS   International English Language Testing System
*OET   Occupational English Test
*ISLPR   International Second Language Proficiency Rating
*ASLPR   Australian Second Language Proficiency Rating
*CULT   Combined Universities Language Test

Table 7:   English language tests and pass levels

Three Boards also accepted ISLPR as a test for English proficiency, which again had variances of minimum 3+ to a minimum 4+ in the case of the Nurses Board of South Australia. The NBSA was the only Board that accepted ASLPR minimum level 4 as a test of English language proficiency. It was noted by the researcher that the ASLPR had a name change in 1997 to the ISLPR therefore had not existed since that time under the name ASLPR (Wyliek 2002). The NRBNSW accepted CULT if the test is conducted at the University of New South Wales.

The NRBNSW also accepted the following tests, which they equate to the IELTS, overall score 7 or the ISLPR 3+:

- A test conducted by a College of Technical and Further Education (TAFE) in Australia and which is equated to the International Second Language Proficiency Rating (ISLPR) scale at a minimum of level 3+ on each of the four components.

- A test conducted by the New South Wales Adult Migrant English Service (AMES) which is equated to the International Second Language Proficiency Rating (ISLPR) scale at a minimum of level 3+ on each of the four components.

- Combined Universities Language test (CULT) with a minimum score of 65; accepted only if the test is conducted at the University of New South Wales.

- Direct Adaptive ISLPR Test conducted by Griffith University, and which is equated to the International Second Language Proficiency Rating (ISLPR) scale at a minimum of level 3+ on each of the four components.

- The CET Direct Entry Test for entry to the University of Sydney, which is equated to the IELTS test, academic modules, with a minimum of 7.0 on each of the four components.

- Exit Assessment Test for Health Care Workers conducted by the English Language Institute of the Victoria University of Technology and related to the ISLPR, provided that a minimum of level 3+ has been attained on each of the (4) four components of the test.

- English for Academic Purposes Examination conducted by the University of Newcastle and equated to the Academic Modules of the IELTS Test, provided that a minimum of 70% (equivalent to IELTS score 7) has been achieved in each module of the test.
  (Nurses Registration Board of New South Wales 2002, p. 11)

The NRBNSW it appeared was willing to accept a greater range of tests available in Australia than other organisations. The English language requirement may have been waived by the ANMC if the nurse completed their initial nursing education in Canada and gained registration in Canada through an examination conducted in English.

Nurses educated in the Republic of South Africa or Zimbabwe, if their course was taught in English (both theoretical and clinical) and have recent work experience in an English speaking healthcare agency may also have the English language requirements waived.

According to the ANMC, nurses who had undertaken a degree course within the past two years at an Australian university may have had the English language test waived. Also nurses who had successfully undertaken at least one semester full-time equivalent of a post-graduate nursing course as an internal student at an Australian university may have had the English language test waived.

The NBACT indicated that a nurse who had been educated in or practiced for an acceptable period in a country where English was the first language was not required to undertaken an English proficiency test. Also an applicant who had completed one-year full-time equivalent in either an undergraduate or postgraduate course (not necessarily in nursing) as an internal student in an Australian university met the English language requirements. The Nursing Board of Tasmania and the ANMC also waived the English Language test if the applicant had been registered and practicing as a nurse, for a period of three months full time equivalent in the past two years in an English speaking country. What is questionable about these requirements was that there appeared to be an assumption that participating in a university course or practicing in an English speaking environment would automatically increase English fluency to a level where a nurse was able to practice in Australia.

The Queensland Nursing Council indicated that a nurse who has practiced for 3 months within the past five years in an English speaking country would be granted limited registration to work under the supervision of registered nurse. The other provisos with granting limited registration was that the nurse notifies the Council within 24 hours of gaining employment, in Queensland in addition they must provide a statement of competence within three months of employment. This Council also exempts nurses from undertaking the English language test if they had successfully completed post-graduate nursing studies as an internal student in Australia. Again it assumes that a nurse's English level increases when undertaking studies in an English-speaking environment, which may be a questionable assumption. However, the QNC endeavours to monitor whether the nurse is competent or not by granting limited as opposed to full registration. The QNC is the only Board using limited registration in this manner.

The cost to undertake the IELTS test is $A220, the OET, $A440 and the ISLPR, $A125 plus the cost involved in English language lessons which in addition to application fees may be a significant amount of money for some nurses.

What is apparent about the policy instruments is that a nurse from the United Kingdom on a holiday visa (therefore no requirement to be assessed by the ANMC) could have their application processed at the Nursing Board of Victoria for a fee of $80. On the other hand a nurse from the Philippines would be required to pay an $80 application fee, plus up to $10,500 (as indicated in table 6) to undertake a migrant bridging program plus either $220 (IELTS) or $440 (OET) to complete the required English language proficiency test after paying for English language lessons, despite the fact that the nurse's curriculum is taught in English.

It would appear that a nurse from an English speaking country pays significantly less than a nurse from a non-English speaking country.

The policy instruments as indicated by each Board varied in relation to educational, competence and language requirements. What was of interest was why this variation exists given that all Boards are members of the ANMC Collaborative Advisory Panel, whose brief it is to develop consistent standards in the assessment of overseas-qualified nurses. It appeared that some Boards, despite the fact that consistency is paramount to the assessment process in Australia and an underlying principle for the CAP, have adopted the standards and criteria. The next step of the policy cycle is the consultation process, which is discussed in relation to each organisation.

Consultation

Consultation ideally should occur throughout the policy cycle and is a way of soliciting and responding to stakeholder views regarding policy development. Ideally consultation should be a structured process with clear timelines and outcomes (Bridgman & Davis 2000). In order to achieve effective consultation the process should be an open and inclusive process involving identified stakeholders.

In table 8 the groups identified by each organisation as part of the consultation process for developing policy for assessing overseas-qualified nurses are listed.

Organisation	Board / Council	Registration Committee	Board / Council Staff	Collaborative Advisory Panel
NBACT	yes	yes	yes	yes
NBV	yes	no committee	yes	yes
NBNT	yes	no committee	yes	yes
NBWA	yes	yes	yes	yes
NRBNSW	yes	yes	yes	yes
NBT	yes	yes	yes	yes
NBSA	yes	yes	yes	yes
QNC	yes	yes	yes	yes
ANMC	yes	-	yes	yes

Table 8:   Organisation consultation groups

Consultation predominately occurred with the Board members, Registration Advisory Committees or similar, Board staff and the ANMC's Collaborative Advisory Panel. Given the fairly homogenous composition of these groups, consultation appeared to be limited. In the cases of the Nurses Boards of the Northern Territory and Victoria consultation was restricted to Board members and staff. Each Board indicated that membership of the ANMC Collaborative Advisory Panel contributed to knowledge of other Board's policies and processes for assessing overseas-qualified nurses. If consultation involves stakeholders affected by the policy the groups identified in the consultation process by each organisation appeared to be very selective. There was no consultation with overseas-qualified nurses or it appeared a broad range of industry stakeholders. The NBACT was the only organisation as part of quality assurance, had an audit process where questionnaires were forwarded to nurses regarding the registration process when the nurse received their practicing certificate. The questionnaire covers satisfaction/dissatisfaction with service, time taken to register and any other matters deemed important by the Deputy Registrar or Executive Officer (Nurses Board of the Australian Capital Territory 2001). However, there was no indication by the participant that an audit had occurred to date.

Coordination

Coordination of policy development is imperative if policy is to have the desired outcomes for the organisation. An allocated person needs to be responsible for ensuring the issue is identified, policy analysis occurs, policy instruments are developed, adequate consultation is undertaken, policy is developed and a decision made, implemented and most importantly evaluation of the policy takes place. The person allocated to this role does not necessarily need to undertake all phases of the policy cycle, however they do need to ensure all phases occur.

Information provided by participants indicated that the ultimate responsibility for coordinating policy development in all organisations lay with the Executive Officers of each organisation. However, in most cases (NBNSW being the exception) this duty was delegated to the manager responsible for the assessment of overseas-qualified nurses. No organisation had a person or a team with specific skills in policy analysis who were responsible for coordinating the policy cycle on assessing overseas-qualified nurses.

Decision

The person(s) responsible for the decision on whether policy is endorsed or not should do so in an informed manner. Adequate information is vital to decision makers, hence by following a policy framework there is a greater likelihood that policy analysis has occurred based on evidence which would provide the information to make an informed decision.

Data from participants indicated that the decisions on assessment policy for overseas-qualified nurses were made by the Board in all organisations in the study and that briefing papers to the Board were used as the main method of informing the decision making process. Board staff using information based on experience and historical knowledge developed these papers.

Implementation

Implementation of the policy occurs following endorsement by the Board. A process then appears to have been developed or has occurred whereby the processing of the application involves a variety of staff. The application is received by administration staff who determines whether all required documentation was present. If not, the applicant was notified of any additional documentation required before further processing of the application occurred. If the application met policy requirements, in most cases the application was processed without further assessment. If not the application was forwarded to the manager of the registration department who undertook a secondary assessment and determined whether the applicant met requirements or was required to undertake a competency assessment/migrant bridging program. In complex cases outside of organisational policy the nurse's application is referred to the Registration Advisory Committee or to Board for decision. The Queensland Nursing Council was the only Board who described this process in their registration policy. All other Boards discussed the process but were reluctant to supply me with documentation to support this process. The importance of providing this information to applicants and the public is significant in ensuring transparency in the assessment process.

Evaluation

Evaluation is a pivotal step in the policy cycle as this process establishes whether the policy meets the set objectives. The evaluation process also holds accountable persons responsible for implementation of the policy and provides important information as part of the policy analysis in the review of policy in the future (Colebatch 2000).

No evaluation has occurred to date in any Australian nurse regulatory authority on the outcomes of policy decisions in relation to assessing overseas-qualified nurses. Several organisations indicated that the policy was reviewed on either an annual or biennial basis, however no organisation indicated that the policy had actually been evaluated. The lack of evaluation is a concern in that there was no data to date to indicate whether the current policies on the assessment of overseas-qualified nurses ensure that all overseas-qualified nurses were competent to practice and that the process is fair, consistent and transparent for the nurses involved.

Summary

All Australian nurse regulatory authorities and the Australian Nursing and Midwifery Council were participants in the study. Using a framework analysis adapted from Ritchie and Spencer (1999) with Bridgman and Davis' (Bridgman & Davis 2000) policy cycle as the best practice model the findings indicated phases of the policy cycle were achieved by some organisations, while other phases were not achieved.

The areas considered as meeting best practice in policy development were, coordination of policy development and the decision making process.

The other phases of the cycle such as, identifying issues, policy analysis, development of policy instruments, consultation, implementation and evaluation fell short of what is considered best practice in relation to Bridgman and Davis' (2000) policy cycle. The ramifications of these short falls are discussed in chapter seven in relation to policy outcomes and the effect these outcomes may have on the overseas-qualified nurses involved in the assessment process. Underpinning this discussion is the broad social and historical context in which the assessment process for overseas-qualified nurses takes place.

Chapter six presents the analysis of the findings specifically relating to data collected from the four overseas countries in the study.

CHAPTER 6:   DATA ANALYSIS - OVERSEAS

Introduction

In this chapter the analysis of data collected from overseas nurse regulatory authorities is presented. The participating organisations were the College of Nurses Ontario, the Philippine Board of Nursing, the Nursing and Midwifery Council of the United Kingdom and the Board of Registered Nursing California. Framework Analysis was again used as in the case with the Australian organisations presented in chapter five. Framework Analysis involves a process of familiarisation, immersion in the data, identifying a thematic framework, charting, then mapping and interpreting the data. The data from each Board was analysed individually using Framework Analysis.

Data collected included, interview transcripts, organisational policy and procedures, Nurses Acts and annual reports. The face-to-face interviews were conducted at the individual organisations during a three-week time span. The College of Nursing Ontario was the only organisation that provided their registration policy prior to visiting the organisation, allowing me the opportunity to analyse the policy prior to the face-to-face interview.

The Philippine Board of Nursing did not have a specific registration policy and the Nursing and Midwifery Council was not willing to provide their current registration policy as all policies were under review. The Board of Registered Nursing California indicated that the registration policy was an internal policy therefore not available to persons outside the organisation, however they were happy to discuss the policy.

College of Nurses Ontario

Demography

The College of Nursing Ontario (CNO), Canada, is a nurse regulatory authority consisting of a governing body, the Council, comprising thirty nine members, twenty one who were nurses elected by peers and eighteen were government-appointed public members. The work of the Council was supported by seven statutory committees, one of which was the Registration Committee, responsible for developing policy in relation to the registration of nurses. There were nine members on the Registration Committee, five were nurses of whom two were elected by peers, three were Council members and four were government-appointed public members. The chairperson of both the Council and the Registration Committee were nurses, however this was not specified in the *Nurses Act 1991* that the chairperson was required to be a nurse. The two vice-presidents of the Council must be nurses and were elected by the Council membership.

The face-to-face interview was conducted with three staff members identified by the CNO Executive Officer to be those involved in policy development for assessing overseas-qualified nurses. One of the participants was a policy analyst with specific skills in policy development.

The CNO in 2002 had 139,476 nurses on the register and received 2,659 applications from nurses educated in other countries, of those nurses 997 were granted initial registration. No information was available as to why the remaining 1,662 nurses were not granted initial registration. The staff interviewed indicated that 60% of the applications were from the Philippines followed by India, China with a few from, Russia, Poland, United Kingdom, New Zealand, Australia, Cuba and France.

They indicated that in the past five years there had been a 75% increase in overseas-qualified nurses applying for registration, increasing the pressure on staff to complete assessments in a timely manner.

The CNO had a Registration Policy Manual, which stated that 'policies provide a basis for making consistent decisions, for setting guidelines for staff and for communicating rationales to people affected by decisions' (College of Nurses of Ontario 2001, p. 12).

The Registration Policy Manual consisted of policy statements, which included, the name of the policy, date approved, applicable class of registration, applicable regulation, principles, decision rule and rationale (College of Nurses of Ontario 2001). Included in the manual were policy statements relating to the assessment of overseas-qualified nurses. In determining how the CNO practice related to Bridgman and Davis' policy cycle, CNO's policy statements as well as interview transcripts and information available regarding overseas-qualified nurses on the CNO's website were analysed.

The documents that guided policy development and implementation were provided after the interview. The document "Policy at CNO" outlined the role of policy, the policy team and described the process of policy development (College of Nurses of Ontario 2002). This document provided a definition of policy, guiding principles and outlines the five steps in the CNO's policy process.

These steps are:

- Identify the policy problem.

- Policy analysis and formation.

- Policy option identification and evaluation.

- Policy adoption and implementation.

- Policy evaluation.

Analysis of the policy process is presented which specifically examines how the CNO's policy for assessing overseas-qualified nurses relates to Bridgman and Davis' policy cycle previously discussed in chapter five and is used as a benchmark for best practice in policy development (Bridgman & Davis 2000).

Identifying Issues

At CNO, a designated policy team was responsible for identifying and defining the problem and then conducting an environmental scan which included gathering information from staff, internal and external information sources and experts. However, the CNO participants indicated that the primary source of issue identification for the assessment of overseas-qualified nurses was legislation such as the Regulated Health Professions Act 1991, Nurses Act 1991 and Regulations. Another source for identifying issues relating to the assessment of overseas-qualified nurses was the Registration Committee. Information had not been sought from external stakeholders specifically in relation to identifying issues in assessing overseas-qualified nurses other than from the Council members and the Registration Committees.

The environmental scans conducted on a three monthly basis per year, flagged the political and economic issues affecting policy at the CNO. Participants indicated that specific factors relating to the assessment of overseas-qualified nurses identified in these scans were considered in policy development.

Policy Analysis

It is the role of the policy analysts under the direction of the policy team to define/identify the problem, conduct the necessary research and collect relevant information. According to the participants anecdotal evidence and the experience of staff were key sources of information in policy analysis. Environmental scans conducted on a regular basis by the policy team reported trends, events and relationships in CNO's internal and external environment informing policy analysis relating to assessing overseas-qualified nurses. However, the scans had not included soliciting information from overseas-qualified nurses, consumers or employers of overseas-qualified nurses on outcomes of the assessment policies and processes.

Policy Instruments

Participants indicated that the policy instruments used by the CNO were an equivalence assessment of the nurse's academic transcript with a nursing program endorsed by the CNO, a national examination, evidence of recency of practice and an English/French language fluency test.

The CNO required those with essential theory or clinical component deficits to undertake theory and practice in the particular area.

If a nurse had taken additional courses such as midwifery this may have been taken into account if it was not included in the applicant's initial education. This process was undertaken to determine whether the applicant's curriculum was equivalent to a nursing course endorsed by the CNO, therefore determining whether the nurse was eligible to sit the national examination.

A national examination is undertaken by all nurses in Canada in order to initially register with the Council and was non-exemptible. The examination is designed to measure a nurse's ability to meet the essential competencies required for a beginning nurse to provide safe nursing care. The Canadian Nurses Association (a professional organisation for nurses) developed the examination with input from nurse regulatory authorities in all jurisdictions that use the examination. The format of the examination is 240 to 260 multiple-choice questions, half were case-based and the other half was independent questions. The competency categories were data collection, analysis and interpretation, evaluation, collaboration, coordination and professional practice. The examination was administered by the CNO and was held exclusively in Canada four times per year (January, June, August and September). The fee to sit the examination was $A244 plus the application to register fee of $A24.

If any documents required translation, a fee of $A109 was also charged to the nurse. Nurses were required to also provide evidence of recent practice. The nurse's most recent employer must have provided a reference indicating that the nurse had practiced at least three months full-time or 450 hours as a nurse in the previous five years. The employer must have sent this reference directly to the CNO.

The nurse's verification of their current registration was also sent to the CNO directly by the nurse regulatory authority where the nurse was currently registered. In addition the nurse was required to supply verification of original registration directly from the nurse regulatory authority where the nurse originally registered. It was not clear as to why a nurse was required to supply verification of their original registration and supply verification of their current registration.

Participants indicated that there were no memorandums of understanding with any other countries in relation to mutual recognition of qualifications. Another policy instrument used by the CNO were the tests involved in determining language fluency. Canada is a bilingual country of French and English therefore fluency in either of these languages was required.

If a nurse completed their nursing program in English in the countries indicated in table 9 they were deemed to meet the language requirements. It would appear that the countries indicated in table 9 were predominately member countries of the Commonwealth. In other words it would appear that there is English language recognition for nurses who have been educated in Commonwealth countries.

Antigua	Canada	Jamaica	St.Lucia	Uganda
Australia	Cayman Is.	Kenya	St.Vincent	United Kingdom
Bahamas	Dominica	Malawi	Seychelles	United States
Barbados	Ghana	Mauritius	Singapore	Virgin Is.
Bermuda	Grenada	New Zealand	South Africa	Zambia
British Virgin Is.	Guyana	Nigeria	Trinidad & Tobago	Zimbabwe
Cameroon	Ireland	St. Kitts & Nevis		

Table 9: **Countries where nurses meet English language requirements**

French Language fluency in table 10 was also considered to have been met if the nurse completed their nursing program in French in one of the following countries.

Belgium	French Polynesia	Morocco
Burundi	Guadeloupe	Rwanda
Canada	Guinea	Senegal
Chad	Haiti	Switzerland
Congo	Ivory Coast	Zaire
France	Madagascar	
French Guyana	Mali	
	Martinique	

Table 10:   Countries where nurses met French language requirements

Nurses may have also met the language fluency requirement if they were registered and had practiced nursing in one of the countries indicated in tables 9 & 10 using English or French as the primary language of communication in the last five years. However, there was no indication as to how long a nurse was required to have practiced in the above countries for their language level to be considered adequate to meet the language fluency requirements.

Nurses may have also met the language fluency requirements, if they had successfully completed an approved nursing refresher program or total upgrading program in English or French. The Council considered other education courses and programs completed in English or French on a case-by-case basis if the course content and delivery method were sufficient to demonstrate reasonable fluency (College of Nurses of Ontario 2001).

If a nurse undertook their nursing program in a country not identified in tables 9 and 10 they were required to complete and pass one of 3 tests endorsed by the Council.

These tests were the Test of English as a Foreign Language (TOEFL), the Michigan English Language Assessment Battery (MELAB) and the International English Language Testing System (IELTS). Applicants were required to achieve scores in written fluency in English of:

- 203 overall in the computer-based TOEFL (minimum1 9 listening, 20 structure/writing and 20 reading).

- 537 overall in the paper-based TOEFL (minimum 53 listening, 53 structure/writing and 53 reading).

- a minimum score of 75 in the MELAB.

- a minimum score of 6.5 in the IELTS.

Spoken fluency in English requirements were:

- a minimum score of 50 in the Test of Spoken English (TSE).

- a minimum score of 3 in the MELAB.

- a minimum score of 6.5 in the IELTS (overall score of 6.5).

French fluency could be demonstrated by achieving a minimum overall score of 750 in the Test de François International (TFI). The MELAB was held at specific venues in Canada and the USA, however there were 300 MELAB endorsed examiners in various countries who offered individual testing. The cost involved with the MELAB was $A187 to undertake the test.

The paper-based TOEFL was usually held six times per year at various locations in a range of countries and a computer-based TOEFL was available throughout the year at testing centres globally.

The cost of the examination was $A202 whether a computer or paper based test is undertaken. The IELTS offered 48 test dates per year at a range of settings globally. The cost involved was $A220 to sit the test.

In relation to IELTS the policy manual indicated the levels required for written and spoken fluency with no indication of the levels required for listening and reading fluency. The policy did not indicate whether IELTS general or academic version is required.

In determining best practice in selecting policy instruments, one could question the use of a written examination as an appropriate method of assessing competence to practice when there has been no research as to whether overseas-qualified nurses were competent to practice before being required to undertaking the written examination.

Consultation

Consultation involved input from Council staff and the Registration Committee members in policy development. External stakeholders had not been specifically involved in the development of policy relating to overseas-qualified nurses, aside from the Registration Committee and general information gained from the environmental scans conducted by the policy team. It appeared that consultation was limited, in that all stakeholders in the assessment of overseas-qualified nurses were not consulted during the consultation phase of the cycle.

Coordination

The coordination of the policy cycle was the responsibility of the policy team at the CNO in collaboration with the different departments involved in administering the policy. Policy analysts were responsible for undertaking the policy development process. They defined the problem, carried out the necessary research (formal and informal), then prepared a policy options paper with information and recommendations for the Registration Committee. This process of coordination was representative of best practice as there was a specific person responsible for ensuring that all phases of the policy cycle were completed.

Decision

The decisions involving registration policy for assessing overseas-qualified nurses were delegated by the Council under the authority of the Nurses Act to the Registration Committee. This appeared to be limiting in that this committee was also responsible for assessing overseas-qualified nurses, therefore it may have been more appropriate for the Council to make the decision regarding assessment policy on the advice of the registration committee. In others words there would be another set of eyes to view the policy in an objective manner.

Implementation

The registration department consisted of administrators and nurses to implement the policy. The registration and finance department were responsible for the administrative and financial functions involved in the policy. These included processing the fees required in applying for registration and taking the examination.

Administrative staff processed the applications to ensure all required information and criteria had been met. If so, the application was then processed which could take anywhere from six to twelve months. Participants indicated that the requirement for nurses to undertake the examination extended the assessment process from four weeks to twelve months. If criteria had not been met, the application was referred to the Registration Committee for re-assessment.

Evaluation

To date the policy relating to the assessment of overseas-qualified nurses had not been formally evaluated. Participants acknowledged the importance of evaluation but indicated that they did not collect data to determine whether the policy was enabling an accurate assessment of an overseas-qualified nurse's competence to practice.

Summary

The CNO assessed approximately 2,600 overseas nurse applications for registration per year. Nurses applying were from a range of countries, the top three being the Philippines, India and China. There was a Registration Committee Policy Manual containing policy statements used as a guideline for staff in assessing overseas-qualified nurses. This policy manual was developed using a specific policy framework created by the CNO. However, when comparing the policy cycle to what actually happened in practice there were some gaps. These gaps occurred in the consultation process, which were limited to staff and the Registration Committee of the Council. The limited involvement of the Council in policy decisions and the evaluation of the policies did not occur on a formalised basis.

Apart from these three areas, the policy development framework used was comparable to the policy cycle developed by Bridgman and Davis (Bridgman & Davis 2000).

The Nursing and Midwifery Council (UK)

Demography

The Nursing and Midwifery Council (NMC) is a nurse regulatory authority consisting of a governing body called the Council, made up of thirty-five members, eleven public members, twelve nurse/midwives (registrant members) and twelve nurse/midwife alternate members representing each part of the register. Registrant and alternate members (or proxy members) are elected by nurses on the NMC registers. Alternate members attend Council meetings however, are only allowed to vote if the corresponding registrant member is unable to do so. The public members include people from education, employment and consumer groups appointed by the Privy Council. The President of the Council is elected by the members of the Council from the membership and is not required to be a nurse (NMC 2004).

There are four statutory committees of the Council, the Preliminary Proceedings Committee or PPC (investigates allegations of misconduct, unfitness to practice or criminal convictions made against registrants), The Professional Conduct Committee or PCC (considers allegations referred by the Preliminary Proceedings Committee), The Health Committee (deals with allegations of unfitness to practice and reinstatement applications) and the Midwifery Committee (considers any matters affecting midwifery).

The register and maintenance of the register is a major portion of the work of the Council and is it noted that there is no statutory committee specifically designated to address issues relating to this area. There are however, additional committees established by the Council to assist in the day to day functioning of the organisation such as Finance and Business planning, Standards, Communications, Audit, Recruitment and Appointments and Human Resources. Each committee has a maximum of eight people and up to five may be Council members.

In 2001/2002 the Council had 644,024 nurses on the register, of these 21,897 were from overseas which was 3.4% of the register. However, there were 12,236 nurses (1.9%) who were not identified as local or from overseas, hence it was not clear as to whether they were local or overseas-qualified nurses. The number of overseas-qualified nurses admitted to the register in 2001/2002 was 15,064. The top six countries represented in this number were the Philippines (7,235), South Africa (2,114), Australia (1,342), India (994), Zimbabwe (473) and New Zealand (443). While these numbers represent those admitted to the register, there were 41,656 overseas-qualified nurses who applied for registration in the year ending 31 March 2002. The top six countries from which these nurses applied were: Philippines 18,934 (45.5%), India 7,421 (17.8%), South Africa 3,080 (7.4), Nigeria 2,314 (5.6%), Zimbabwe 1,474 (3.5%), Australia 1,418 (3.4%).

Some of these nurses were admitted onto the register without any further requirements, while others were required to undertake further education and clinical experience before meeting the requirements to register. Table 11 provides data on the most common countries where nurses were accepted from, as meeting the requirements to register without having to complete any further requirements.

Country	Number of applicants	Number of applicants accepted with no further requirements	
Australia	1,342	1,133	(84.4%)
Malawi	75	63	(84%)
West Indies	248	204	(82.3%)
USA	122	97	(79.5%)
Botswana	100	77	(77%)
New Zealand	443	332	(74.9%)
South Africa	2,114	1,319	(62.4%)

Table 11:   Most common countries where nurses meet requirements without additional requirements

There is no information available on how many nurses from the Philippines or India were accepted onto the register without further requirements given that they were the top two countries from where nurses had applied.

The NMC did not provide policies in relation to the registration process for overseas-qualified nurses as these policies were currently under review. However, they did provide their current 'policy framework' which indicated what current policies and processes were under review.

The interview took place at the NMC office in London with two staff members. The person initially organised to participate in the interview was unavailable therefore a person involved in the administration of the policy was interviewed initially then a nurse involved in standards development. Due to the fact that the two persons interviewed were not directly involved in policy development relating to the assessment of overseas-qualified nurses further information was sought via email with a person involved in this process.

The organisation's policy cycle is now discussed in detail, using information from the organisation's website and the interview transcript and email responses to further questions from NMC staff.

Identify Issues

Rules established under the Nurses, Midwives and Health Visitors Act 1979, the relevant committee of the Council, applicants, recruiting agencies, employers and Departments of Health were indicated as the sources for identifying issues relating to policies for assessing overseas-qualified nurses. However, there was no formalised process for collecting information from applicants, recruiting agencies, employers and Departments of Health as this information is obtained on an adhoc basis.

Policy Analysis

The newly formed Standards and Registration Directorate has produced the policy framework, which encompasses areas such as applying for registration, review of applications and supervised practice. There does not appear to be any formal policy analysis in relation to assessing overseas-qualified nurses involving stakeholders other than the discussion at Council and Council committees.

Policy Instruments

The policy instruments are an individual, comparable paper-based assessment of the nurse's education/training and post registration experience.

The nurse's education/training program must: Be not less than three years in length, have a demonstrated balance of theoretical and practical instruction of not less than one-third theoretical training and not less than one half clinical/practical training and include theoretical and clinical/practical training and experience in: general and specialist medicine, general and specialist surgery, childcare and paediatrics, maternity care (obstetrics), mental health and psychiatry, care of the elderly and community nursing (NMC 2004).

In addition the nurse must have completed at least six months continuous post registration experience. Each nurse is expected to supply two recent employment references from two senior nurses with whom they had worked closely. Consideration is given in the assessment process to the nurse's post registration experience if the referees identify the experience and meets the organisation's educational requirements. A regulatory authority reference sent directly to the Council is also required from the nurse's home regulatory authority indicating that the nurse's registration is effective and there are no disciplinary issues relating to the nurse's registration.

A nurse may be required to participate in a supervised placement to undertake additional education and clinical practice in order to meet the requirements for registration. The placement must be undertaken at an institution audited by a higher education institution for the purpose of preparing pre-registration nurses in the country for which the nurse is applying for registration. There is no defined time period for the placement, as each nurse is assessed individually therefore may be required to undertake a specific term of placement. This placement may be for a minimum of three to six months or more and the nurse may be paid or unpaid during this time.

It is the nurses' responsibility to secure a position in an organisation in which to undertake the placement.

The requirement for language competency is to complete the General IELTS with a pass of 5.5 in each category with an overall band score of 6.5. However, for writing and speaking the scores can only be a whole number, therefore, are required to be no less than 6.0. IELTS is the only English language test accepted by the NMC.

The United Kingdom is also a member of the European Union therefore has an agreement to accept a nurse's qualification provided they meet the European Union Sectoral Directives. These directives are based on minimum standards of education for registered nurses of the member states of the European Union. In other words a registered nurse from Belgium would have their qualifications recognised if they wish to work in the United Kingdom. The nurse is also required to provide a certificate of good conduct from the police or verification from the nurses' original registering authority. There is a mutual recognition of qualifications in the European Union, therefore nurses are not required to supply an academic transcript. However, there are no memorandums of understanding between the United Kingdom and other countries outside of the European Union. The cost for the assessment of an overseas nurses qualification is $A287, plus English language tests if required. The assessment process takes approximately three months providing the nurse is not required to undertake a clinical placement in which case the process could take nine months.

Consultation

The organisation has a consultation process with stakeholders, however consultation regarding policies relating to overseas-qualified nurses was unable to be determined using the data available.

Coordination

The Standards and Registration Directorate are responsible for coordinating the development of policy. The directorate consists of professional, education and information officers who are responsible to the Director of Standards and Registration.

Decision

The Council is responsible for endorsing policy according to the Nursing and Midwifery Order 2001. The relevant Council committee for endorsement recommends policy however as indicated earlier, there is no designated committee for registration policies.

Implementation

The registration department implement the registration policy under the direction of the Director of Standards and Registration. The registration department is comprised of administrative staff who undertake assessments of nurses applying for general or psychiatric nursing provided the applicants are from certain countries. A professional officer, who is a nurse, assesses any applications received from specialist nurses from other countries.

Evaluation

There was no structured evaluation process for policies relating to the assessment of overseas-qualified nurses. The process presently used is to monitor trends in the countries of initial education of those nurses brought to the Council for misconduct. The current Nursing and Midwifery Order 2001 does not permit the Council to deal with incompetence *per se*, therefore incompetence is dealt with via the professional misconduct route. To date there has been no correlation between nurses reported to the Council for professional misconduct and overseas-qualified nurses. In relation to this phase of the policy cycle the evaluation of policies relating to assessment of overseas-qualified nurses fell short of what was considered best practice.

Summary

The NMC had 41,656 applications for registration from overseas-qualified nurses, of these 15,064 were admitted to the register during the year 2001-2002. The registration policy is currently under extensive review therefore was unavailable for analysis. A framework for the policy analysis was supplied as a list of policies for review. The policy instruments were an individualised paper-based assessment of academic transcript plus assessment of post registration experience and competence. The language requirement is the general IELTS with a pass of 5.5 in each category and an overall band score of 6.5, which is at a lower level than other countries in this study.

It was not clear how consultation occurred with stakeholders in the policy development process. The Standards and Registration Directorate and the Registration team undertook coordination and implementation of policy.

The Council endorses all policy based on recommendations from the Standards Committee (an internal committee). Evaluation of the registration policy related to overseas-qualified nurses has not been achieved on a formal basis. Therefore, as far as the comparison of the NMC's policy cycle and Bridgman and Davis' (2000) policy cycle is concerned there are significant gaps in relation to identifying issues, policy analysis, consultation and evaluation.

The Philippine Board of Nursing

Demography

The Philippine Board of Nursing is a nurse regulatory authority, which is part of a larger organisation, the Republic of the Philippines Professional Regulation Commission (PRC). The PRC is responsible for regulating and supervising the admission to practice of the professions through 42 professional regulatory bodies. The Philippine Board of Nursing (PBN) has a membership of five registered nurses. The Chairperson of the Board is to be the most highly qualified nurse of the membership. There are no other committees of the Board.

Neither the Philippine Board of Nursing nor the PRC were able to supply information in relation to the number of nurses on the register and in particular nurses who have applied for registration from overseas. The participants indicated that nurses from the Philippines apply for registration overseas at a significantly greater rate than overseas-qualified nurses apply to register in the Philippines.

Currently the Philippine Nursing Act of 1991 (Article III section 19) indicates that reciprocity is the only pathway for overseas-qualified nurses to achieve registration with the PBN. Participants indicated that a policy did not exist for assessing overseas-qualified nurses as the Nursing Act prescribed the pathway for registration.

Identify Issues

The issue of qualification assessment is identified in the PRC Modernisation Act of 2000 section 7 (c), which stipulates that the PRC has the power to develop and review policy in relation to the Professional Regulatory Boards. However, in relation to assessing overseas-qualified nurses a policy has not been developed.

Policy Analysis

Participants indicated that due to the Nursing Act clearly indicating that the only way for registration to be achieved by an overseas-qualified nurse is by reciprocity no further policy analysis has been undertaken by the PBN.

Policy Instruments

The instrument for assessing overseas-qualified nurses is registration by reciprocity. This means that a certificate of registration may be issued without examination of a nurse's qualifications if they are registered in a country where the requirements for registration of nurses in that country are substantially the same as those prescribed under the Philippine Nursing Act of 1991 (Article 111 section 19) and that the country grants the same privileges to registered nurses of the Philippines.

At this time there is no reciprocity between the Philippines and any other country, which means there is no ability for a nurse to apply for reciprocal registration from another country.

Consultation

The participants indicated that should there be any policies on the assessment of overseas-qualified nurses that professional organisations would have been involved in developing policy.

Coordination

There has been no specific policy developed for assessing overseas-qualified nurses at this time therefore coordination has not occurred.

Decision

The Government made the decision when the Nursing Act was enacted based on recommendations by the Philippine Board of Nursing and the PRC to use reciprocity as the means to register for overseas-qualified nurses.

Implementation

The section of the Nursing Act has been implemented as part of the proclamation of the Philippine Nursing Act of 1991 (Article III section 19) by PBN staff.

Evaluation

Evaluation of the section of the Nursing Act relating to reciprocity has not occurred to date.

Summary

The Philippine Nursing Act of 1991 (Article III section 19) indicates that overseas-qualified nurses may register by reciprocity. This means that a nurse could register if the country the nurse came from allowed reciprocal registration. There are no countries at present that offer reciprocal registration therefore further policies relating to assessing overseas-qualified nurses have not been further developed. As far as a comparison with the policy cycle at the PCN and Bridgman and Davis' cycle are concerned this has been difficult to achieve given that the participants indicated that a specific policy for assessing overseas-qualified nurses has not been developed.

Board of Registered Nursing California

Demography

The Board of Registered Nursing, California (BRN), is a nurse regulatory authority consisting of nine members of whom three are members of the public, five are registered nurses, and one is a medical practitioner. The BRN is responsible for enacting the state Nursing Practice Act 2000. The five registered nurse Board members include three direct-patient care nurses, a nurse administrator, and a nurse educator. The Governor appoints seven of the members and the state government appoints the two public members. The Board members elect the President and Vice President of the Board, annually.

The Board has the authority to form advisory committees to advise the Board. The current committees are the Administrative, Education/Licensing, Nursing Practice, Legislative and Diversion/Discipline committees. Specific documentation relating to composition of the Education/Licensing committee was not available to me.

In the year 2001/2002 there were 286,845 nurses on the register. Participants indicated that there were approximately 500-600 applications from internationally educated nurses (overseas-qualified) nurses per year. Information was not available as to how many nurses were from other countries however participants indicated that the overseas applications came from the Philippines, India, Canada, South Korea, Australia, United Kingdom and South Africa.

The Nursing Practice Act 2000 was provided during the interview, however not the policies relating to assessing overseas-qualified nurses as participants indicated that they were considered strictly for internal use. The policy development process used by the BRNC is discussed in detail, specifically looking at how the development of policy relates to the policy cycle.

Identify Issues

The Nursing Practice Act 2000, section 2736 (3b), is the principle source for identifying policy development for assessing overseas-qualified nurses. There is also a body called the National Council of State Boards of Nursing (NCSBN) who has no legislative authority, however is the source for identifying policy issues relating to assessing overseas-qualified nurses.

The NCSBN is comprised of member Boards from the various states in the USA and has functions such as performing policy analysis, promoting uniformity in relation to the regulation of nursing practice, disseminating data related to the licensure of nurses, conducting research pertinent to NCSBN's purpose, and serving as a forum for information exchange for members (NCSBN 2003).

Policy Analysis

There are designated persons named education consultants within the BRN whose role it is to evaluate any proposed legislation and the effect it may have on the current policies then make recommendations to Board via the Education/Licensing committee. Participants indicated that there was no research conducted by the licensing section, which is the area responsible for assessing overseas-qualified nurses in relation to policy development. Participants also indicated that the NCSBN may conduct research on a broader basis than the BRN would. However, there did not appear to be a structured process to ensure policy analysis occurred.

Policy Instruments

Each overseas-qualified nurse's application for registration is assessed on an individual basis. Participants indicated that they do not conduct the assessment based on which country the nurse underwent their initial nurse education in, they assess the applicant on what the nurse's initial education comprised of. The nurse's academic transcript is broken down by subject and hours to determine whether there is 1 hour of theory to 3 hours of clinical. The subjects studied are compared to the subjects required by the Board as meeting the requisite subjects for registration.

If the subjects do not meet the Board requirements a nurse must undertake the determined education (theory and/or clinical practice) before applying again to the Board. Participants indicated that work experience and qualifications gained after initial registration were not considered in the assessment process as the assessment is based on initial training not experience. Participants also indicated that a nurse could apply for an interim permit (valid for six months), which would allow the nurse to practice under the supervision of a licensed RN.

Once the nurse has met the educational prerequisites they are then required to undertake the National Council Licensure Examination (NCLEX), which is mandatory for all nurses applying for registration in the USA. The examination was initiated by the NCSBN in 1994 to test knowledge, skills and abilities considered essential for safe and effective practice at entry level for nurses. In 1991 the NCLEX was changed to a computerised adaptive testing (CAT) and is only provided in this format. CAT is a method of administering tests by employing computer technology and measurement theory. Each question is pretested (by a sample group of nurses) and based on a test plan which consists of four categories of client needs such as safe effective care environment, health promotion and maintenance, psychological integrity and physiological integrity (NCSBN 2000). As the nurse answers each question, the computer calculates their competence estimate based on earlier responses then further questions are determined and presented on the computer screen to test the individual's knowledge and skills. The examination continues in this fashion until a pass or fail decision is determined. The nurse has a maximum of five hours to complete the test and must answer a minimum amount of questions.

The NCLEX may be taken at test centres located in the USA, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands. The use of the NCLEX in the above jurisdictions has facilitated mutual recognition between these countries and different states of the USA. Participants indicated that there were no memorandums of understanding with any other country (except the countries where the NCLEX is administered). In relation to the different states of the USA, there was mutual recognition based on verification of a licence from the state the nurse was moving from. However, if an overseas-qualified nurse held a licence in another state in the USA they would still be required to provide an academic transcript of initial nurse education for assessment by the BRNC if applying for a licence with the BRNC.

The cost of assessment of the nurses' academic transcript (which includes the nurses' licence) is $A97, the NCLEX fee is $A259 and if the nurse requires an interim permit another $A39 is paid. In addition each nurse is required to submit a set of their fingerprints which also incurs an $A41fee. The nurses' fingerprints are required to determine whether the nurse has a criminal record, which will be considered in the assessment process.

The English language requirement for nurses from NESB is successful completion of TOEFL. The computer-based TOEFL is a minimum score of 18 listening, 11 structure/writing and 13 reading whereas in the paper-based TOEFL a minimum score of 52 listening, 40 structure/writing and 44 reading is required. There were no other English language tests accepted.

Consultation

The persons consulted in developing assessment policy for overseas-qualified nurses were nursing education consultants (employed at the BRNC), the education/licensing committee and Board members. The education/licensing committee consisted of four members, all nurses and included one Board member and staff liaisons also attend meetings. The BRNC holds four Board meetings per year in different cities in the state of California. There is an open forum as part of the agenda where the public has the ability to attend and to present issues to the Board. Participants indicated that the NCSBN was also a source of consultation given the NCSBN's role in providing information to state boards regarding the NCLEX examination. The BRNC received information from the NCSBN monthly which was used by the nursing education consultants to inform policy development.

Coordination

The Executive Officer was responsible for coordinating the policy development process along with the nursing education consultants. It was not clear whether there was a person responsible for policy development for assessing overseas-qualified nurses.

Decision

The state government of California made the ultimate decisions regarding assessing overseas-qualified nurses by describing specific requirements in the Nursing Practice Act 2000 and regulations. The Board however endorsed internal policies underpinning the assessment process.

Implementation

There were three nurses responsible for implementation of the policy for assessing overseas-qualified nurses. The timeframe for assessment was between four to five months. Participants indicated this was the case because there was a shortage of staff to undertake assessments.

Evaluation

There has been evaluation of the examination process or policy instruments by the NCSBN but not by the Board. Feedback from the NCSBN is provided to the Board on the number of nurses who pass the examination and which countries they originated from. No evaluation has occurred on whether the current policies met the desired outcomes of the Board and other stakeholders.

Summary

There were approximately 500-600 overseas-qualified nurses assessed per year by the Board of Registered Nursing California. Issues relating to policy development stemmed from the Nursing Practice Act 2000 and the NCSBN. Policy analysis was undertaken by education consultants and involved the Board committees. The policy instruments were an initial paper based equivalence assessment of the nurse's academic transcript to determine whether the nurse was eligible to undertake a national examination. The language requirements were successful completion of TOEFL with minimum scores required. The policy was coordinated by the Executive Officer and implemented by an evaluation team of three people.

The Board policies were guided by the Nursing Practice Act 2000 therefore the decision was ultimately made at state government level. The NCSBN developed the examination and has undertaken some formal evaluation of the examination process, however the Board has not evaluated the organisational policies relating to assessing overseas-qualified nurses. In respect to the comparison of the BRN's policy cycle and Bridgman and Davis' policy cycle it would appear that there were gaps in the areas of consultation, policy analysis and evaluation. Consultation was limited to Board committees, while the policy analysis relies on feedback from the NCSBN with limited research or evaluation occurring at Board level.

Summary

The number of nurses applying for registration from overseas destinations varied from approximately 500-600 applicants in California to 41,656 applications in the United Kingdom approximately per year. The Boards and committee compositions were also variable with thirty-nine diverse background members on the College of Ontario Council, to five nurses on the Philippine Board of Nursing.

Establishing how each organisation met the requisites of the policy cycle proved challenging as the information needed to be sought from a number of sources. The identification of issues was similar in that the legislation was the primary source of issue identification. Secondary sources were Board advisory committees, predominately made up of nurses with consumers as a minority representation.

The policy analysis was predominately information obtained internally in each organisation with the exception being the CNO who conducted environmental scans on a regular basis to assist with informing policy development. The policy instruments were reciprocity of qualifications, paper-based assessment based on initial nurse education and the country where that education occurred, plus written examination based on entry-level practice. The other policy instruments were the tests for language fluency. The common test in two organisations was IELTS, however the pass level was higher in one organisation than the other. Other language fluency tests were TOEFL, MELAB and a French language test. It was noted that the BRNC indicated minimum required scores in TOEFL were lower that the minimum scores required by the CNO.

The costs for assessment varied from no cost at the Philippine Board of Nursing to $A287 assessment fee at the NMC. Consultation was limited to internal sources such as Board and Board advisory committees. Coordination of the policy cycle at the CNO and the NMC was a policy or standards team whereas the other two organisations did not have a specific team to coordinate policy development. The CNO was the only Board where the Registration Committee endorsed policy all other organisation's policy endorsement was by the Board.

Implementation was by registration staff in all organisations with complex applications (outside of current policy) referred to Board advisory committees. There was no organisation that evaluated the outcome of their policy on assessing overseas-qualified nurses. Therefore the gaps in the policy cycle in relation to the overseas organisations in the study were, adequate policy analysis, consultation and evaluation.

In the next chapter discussion of the findings, recommendations, limitations of the study, implications and future research are presented.

CHAPTER 7:   DISCUSSION AND RECOMMENDATIONS

Introduction

The main purpose of the study was to conduct a critical analysis of the policies relating to assessment of overseas-qualified nurses in Australia and overseas and to determine how those policies were developed. To achieve this, a critical policy analysis was undertaken. Underpinning the critical policy analysis was Critical Social Theory. This allowed questioning of the status quo, and the ability to move beyond the surface and expose the taken for granted assumptions in the interpretation of policies and procedures used to assess overseas-qualified nurses. The interrogation of policy development using the philosophical underpinning of Critical Social Theory indeed challenged commonly held beliefs of assessors and the false consciousness that existed in the assessment process.

The development of the policies and procedures in the assessment process was evaluated using Bridgman and Davis' policy cycle as the benchmark (Bridgman & Davis 2000). This policy cycle was fundamental to the analysis of the data given that this cycle was considered to reflect how policy should ultimately be developed. The combination of using the policy cycle as a benchmark and Critical Social Theory as the philosophical underpinning led to a critical policy analysis that questioned tradition, values and beliefs of all involved in the decision making process.

This chapter provides a discussion of the findings of the study, recommendations, limitations and suggestions for future research. The findings are presented in the same sequence as the data has been provided using the steps of the policy cycle.

Board and Committee Membership

Board Membership

The findings indicated that the composition of Board membership consisted of either elected or appointed representatives of the profession, government and consumers. All Boards in both Australia and overseas had a majority of nurses in their membership with two of the thirteen organisations specifically stating that the chairperson was to be a nurse.

The Queensland Nursing Council and the College of Nurses Ontario were the only two nurse regulatory authorities where Executive Officers were members of the Board; all other Board Executive Officers were ex officio. The move to include the Executive Officer in Board membership is considered to contribute to openness and transparency in the decision-making process making the Board more accountable for corporate performance (Kiel 2003). However, there is also a view that the Executive Officer should not be a member of a Board as the Board should be independent of management therefore has a strong monitoring role in performance of the organisation (Kiel 2003). There does not appear to be any definitive position in the literature as to whether the Executive Officer should be a Board member or not.

The predominance of nurses in Board membership constitutes enforced self-regulation, where members of the profession who are considered to have a greater level of expertise and knowledge than consumers, determine practice requirements for nurses within the bounds of statute. Self-regulation in this case is likened to a double-edged sword in that the profession, which is regulated, may fund the regulatory authority and provides the expert knowledge about the professions required standards.

In this example self-regulation may be seen in a positive light as expertise and a level of efficiency brought about by low monitoring and enforcement costs enables issues to be dealt with by the Board rather than in the judicial system (Baldwin & Cave 1999). However, there is the potential for professional self-interest and priority conflicts in the regulatory process, which may ultimately overshadow public protection as a Board mandate (Finocchio, Dower, McMahon & Gragnola 1995). This could result in there being significant gaps of knowledge and expertise on a board if over-representation of one interest group occurs (Bryant 2001).

The public/consumer, many of whom are more informed than ever before due to access to a myriad of information available, are demanding regulation developed with public input that is transparent and accountable. One way to address this demand is to include members of the public on professional regulatory Boards. As 'public members are supposed to challenge and complement Board decision-making from a critical, non-professional perspective; they are the social conscience of the Board' (Finocchio et al. 1995, p. 16).

The Nursing and Midwifery Council had the largest consumer participation with 12 professional members and 11 public members. This resulted from the findings of several government reviews conducted in the United Kingdom on the self-regulation of health professionals bought about by greater public concern over the lack of transparency and accountability of professional regulatory bodies (National Consumer Council 1999; Allsop & Saks 2002).

It is considered that the critical mass of individuals on committees, in particular consumer representatives, assists in levelling the potential power disparities between consumers and the professional experts and facilitates participation by all committee members (Martin, Abelson & Singer 2002). The methods used to select members of the Board who participated in this study were election and appointment by government. Elections were predominately nurses voting for nurses while the government appointed other members such as lawyers and consumers. Discussion needs to occur about the most effective method for appointing Board members, in order to serve the public interest and ensure good corporate governance by way of developing carefully crafted policies (Carver & Carver 2003).

The composition of Board members should also reflect the skills needed to regulate the profession in the public interest especially in the area of consumer input. However, consideration needs to be given as to who represents consumers and what skills and knowledge they require to be contributing members of a Board.

In order to ensure that consumers have extensive involvement in professional regulatory activity they need to be in sufficient numbers on a Board to enable them to be a voice for consumers. Therefore the following recommendation is proposed.

Recommendation I: **Board membership consists of equal numbers of members of the profession and consumers.**

In order to influence this recommendation lobbying of politicians is required as in most cases, Board membership was stated in the legislation.

Government Acts are reviewed periodically, therefore it is important to either lobby for an amendment to an Act or lobby politicians when an Act is under review. Consumer groups could also be lobbied to ensure they are aware of the importance of their contribution to professional regulation.

If consumers represent the public interest then this representation should reflect the population composition of Australian society. Results of the 2001 Australian census revealed that 23.1 per cent of the total population were born overseas (Department of Immigration & Multicultural Affairs 2004). This data indicated that nearly a quarter of the Australian population came from different ethnic and cultural backgrounds. The Australian population is inclusive of all Australians including the indigenous. The indigenous Australian was ignored in all but one Board membership. The Nurses Act of the Northern Territory indicated that Board membership was to include a person representative of the indigenous population in Australia.

There was no specific representation in any Board membership in this study of people from different ethnic and cultural backgrounds. Representation of the broader community requires consideration in Board membership of nurse regulatory authorities. Therefore the following recommendation is made.

Recommendation II: **Members from indigenous and different ethnic and cultural backgrounds are appointed as Board members to NMRAs.**

Again this would require lobbying of politicians, representatives of the indigenous population and persons from different ethic backgrounds to push for legislative changes to Board memberships. It may be that a nurse or legal representative is an indigenous person therefore may be cognizant of needs of the indigenous population. However, this should not be relied upon, therefore a strategic approach to determine persons with specific skills is required (Pickin, Popay, Staley, Bruce, Jones & Gowman 2002).

Committee Membership

All but one Board in Australia had designated committees responsible for the development of registration policy. The Nurses Board of Victoria considers that it is the Board's responsibility to develop policy and therefore do not have a registration committee. This is a concern, in that the skills and experience of any Board is limited, by virtue of its membership.

Therefore, committees with the delegation of developing and endorsing policy should have representation of stakeholders to assist in leading policy development in a broader context. The composition of registration committees was limited to Board members, nurses representing stakeholders and consumers. There was no designated representation on any committee of an overseas-qualified nurse. Given that overseas-qualified nurses constitute an increasing number of new registrants with Boards, it would seem prudent that representation by this group could be advantageous in identifying issues in assessment policy and processes. It would also appear that there were no forums available for overseas-qualified nurses to discuss what they considered were barriers to achieving registration in order to practice.

Organisations recognised that nurses had the right to appeal the assessment process but not the decision made. In other words the decision was final and if this decision was based on previous anecdotal experience rather than rigorous policy analysis, the decision may well be fraught.

A study conducted by Omeri and Atkins (2002), highlighted the professional negation experienced by overseas-qualified nurses in the assessment process. Negation meaning, the lack of recognition of skills and absence of value placed on previous experience in the assessment process. They noted that knowing where to find information on how to register was undertaken by word of mouth through friends of the same culture. The usefulness of providing information regarding registration in a nurses' first language was indicated as making the process easier. Nurses from an NESB were a disempowered group purely by virtue of the fact that they are unable to articulate their issues with the same clarity as an English-speaking nurse (Iredale 1987; Menon 1994; Gonda, Hussin, Gaston & Blackman 1995; Teschendorff 1995; Omeri & Atkins 2002). Involvement of overseas-qualified nurses especially from a non-English speaking background in policy development would assist in policies and processes that reflect all stakeholder issues.

The Organisation for Economic Cooperation and Development (OECD) in their

recommendations on improving the quality of government regulation indicated that

public participation, and in this case, participation by overseas-qualified nurses

contributes by:

> (i) bringing into the discussion the expertise, perspectives and ideas for
> alternative actions of those directly affected (ii) helping regulators to
> balance opposing interests (iii) identifying unidentified effects and practical
> problems (iv) providing a quality check on the administration's assessment
> of costs and benefits (v) identifying interactions between regulations from
> various parts of government. Consultation processes can also enhance
> voluntary compliance, reducing reliance on enforcement and sanctions
> (OECD 1995, p. 18)

Given that overseas-qualified nurses are stakeholders in the assessment process it would

be sensible to ensure committees responsible for policy development in this area reflect

a membership inclusive of overseas-qualified nurses. This would allow their views to be

heard regarding current assessment policy and practices and enable them to provide

input into future policy. Specifically, overseas-qualified nurses could identify issues

relating to qualification assessment, language requirements, costs, orientation and

understanding of the Australian the health care system. This input would need to be in a

safe environment, if English is the person's second language they may find it difficult to

articulate their issues in an environment where other members may have English as a

first language. These are issues that require consideration when integrating input from

overseas-qualified nurses. Therefore the following recommendation is made.

Recommendation III: **Registration committees include at least one overseas-
                             qualified nurse in the committee membership.**

By including representatives of different ethnic and cultural backgrounds and overseas-qualified nurses on both the Board and registration committees, issues relating to the assessment process for overseas-qualified nurses have a greater likelihood of being identified. However, issue identification needs to be broader than including overseas-qualified nurses on advisory committees.

Issue Identification

In each state/territory the Board and staff were responsible for identifying the issues in assessing overseas-qualified nurses. The problem with this arrangement, whether a private concern, possibly of a Board staff member, is transformed into a policy issue. For instance participants indicated that policies were based on Board staff's anecdotal experience. This could mean that if a particular staff member had a bad experience for example with nurses from the Philippines that policies may be developed based on this bad experience rather than evidence collected from employers of these nurses. However, there is a need to acknowledge that at times these experiences have been important in highlighting a potential problem. Given that this is the reality of everyday life, that Board members do not always have the ability to be completely objective, mechanisms need to be in place to ensure that subjectivity is limited by adopting processes for identifying issues, which are objective rather than subjective.

Another group that may not be immediately identified as a stakeholder are countries where there are potential trade agreements with Australia. These trade agreements could lead to future mutual recognition agreements between Australia and other countries.

This would mean that overseas-qualified nurses whose qualifications are not currently recognised, as being comparable to the qualifications required of an Australian nurse, may be required to be recognised by NMRAs as dictated by mutual recognition agreements. Identifying this as an issue in the policy development process could lead to NMRAs negotiating with government bodies prior to the signing of mutual recognition agreements. Guidelines have been developed by the World Trade Organisation on mutual recognition agreements, which foster agreements which are based on objective criteria are non-discriminatory and competency based (Ascher 2005).

The ICN urges nurses to stay informed and be involved in trade policy decisions, to provide information on the implications of potential decisions, to influence the direction of these decisions and to be part of the implementation process (ICN 2000). This advice is even more important when considering the implications on policy for assessing nurses from countries involved in trade agreements. Perhaps with the introduction of more trade agreements between Australia and other countries, nurses will ultimately have mutual recognition of qualifications in a number of countries. The only organisation that participated in this study, which had broad mutual recognition, was the United Kingdom as part of the European Union.

The European Union has implemented directives, which allow general nurses to register and practice in countries of the EU without assessment of their qualifications despite the differences in language, culture and healthcare systems. At this time there has been little research to indicate whether the European Union directives have had an impact on patient care.

(Buchan, Parkin & Sochalski 2003) in a study on 'International Nurse Mobility' found that there has been no upward trend in the movement of nurses from EU countries to the UK. Therefore one might conclude that in the most part nurses are self-regulating by not practicing in a country where their native language is not the first language of the country or the healthcare system is different.

The current global nurse shortage has influenced employers to question the assessment process for overseas-qualified nurses as well. Some employers are paying for nurses to migrate to countries such as Australia, therefore are very keen to have these nurses registered as quickly as possible. They are so short staffed that they are unable to wait for nurses to complete bridging programs, therefore are placing pressure on Boards to accept nurses with qualifications not normally recognised as comparable with nursing qualifications in Australia. In other words market forces are now becoming a greater influence in regulatory policy simply by questioning the current assessment processes (Buchan, Parkin & Sochalski 2003).

All stakeholders involved in both the assessment and employment of overseas-qualified nurses should have the ability to bring to the Board's attention any issues relating to the assessment process. For example in Australia, stakeholders would be government bodies such as NOOSR and DIMIA, employers, consumers, overseas-qualified nurses, providers of migrant bridging programs, providers of English language testing, providers of undergraduate and post graduate nursing programs, the ANMC and Board staff responsible for assessment of overseas-qualified nurses.

Identifying the issues could occur in a variety of ways, such as periodic surveys with a focus on identifying issues relevant to the assessment or employment of overseas-qualified nurses, regular meetings with stakeholders initiated by the Board or by identifying a contact person at the Board for stakeholders to notify any relevant issues pertaining to the assessment process. What is important is that there are avenues that regulatory authorities use to ensure that they are cognisant of issues relating to the assessment of overseas-qualified nurses when they occur.

Recommendation IV: **There is a structured process for determining stakeholder issues involving assessment policies and processes for overseas-qualified nurses.**

Identifying stakeholder issues is pivotal when conducting a policy analysis. The next step in the policy cycle is policy analysis.

Policy Analysis

A significant feature of the findings was the limited policy analysis that occurred for all participating organisations. Bridgman and Davis (2000) reinforce why policy analysis is so important.

> Good decision-making about complex issues requires analysis. This is a fundamental stage in the policy cycle, since research and logic are the basis for developing options and making decisions (Bridgman & Davis 2000, p. 46).

Eleven of the participant organisations indicated that policy analysis was carried out through discussions with Board members and relevant Board committees in addition to taking account of historical data and experiential knowledge of staff members.

The Board of Registered Nurses of California had a specific person responsible for analysing any proposed legislation and the effect it would have on current policy. The College of Nurses of Ontario had policy analysts whose brief it was, to conduct policy analysis using a policy analysis framework; however, this had not been applied in its entirety in the case of policy analysis for overseas-qualified nurses. Therefore, no organisation articulated policy analysis in an applied structured framework. This is a major deficit in the policy development process and could be considered a fundamental flaw in the regulation of nurses.

In all states and territories of Australia, current policies/procedures were based on the ANMC standards and criteria for the assessment of the qualifications of overseas-educated nurses and midwives. The ANMC had not conducted a structured policy analysis and it appears that policy analysis is limited, which could have a profound effect on the application of policy and the outcomes expected. This could mean that nurses who are currently competent to practice in Australia from overseas are required to undergo migrant bridging programs unnecessarily, adding extra costs and time to the application process.

Obtaining data is an essential part of conducting a policy analysis. Policy analysis involves observing and describing, analysis, option identification and advice (Potter 2002). While observation and description may have occurred in identifying the policy and process issues then describing these issues, it was not clear from the data that the policy context was identified by measuring the affect these policies have on overseas-qualified nurses, employers and consumers. This information would be difficult to determine given the limited stakeholder involvement in policy development.

One of the most important aspects of policy analysis is to conduct an environmental scan as this involves learning about the political, legal, technological, social and economic influences from both internal and external environments (Choo 1999; Bridgman & Davis 2000; College of Nurses of Ontario 2002). An environmental scan had occurred in only one of the participating organisations. The information collected by organisations was predominately an internal (as in staff members) collection of tacit, explicit and cultural knowledge. Tacit knowledge is gained from the experience of undertaking the task, whereas explicit knowledge is rule based or procedural based and cultural knowledge is the beliefs held based on experience and observation (Choo 2001). Some external information such as information from Board and committee members was obtained based on tacit, explicit and cultural knowledge also. The disadvantage of using this type of information is that it is unanalysable, in other words it is soft information that is not defensible. Therefore it is imperative that environmental scans are conducted using a systematic, documented process which inturn is defensible.

Choo indicates that there are four modes of environmental scanning, undirected viewing, conditioned viewing, informal research and formal research (Choo 1999). Undirected viewing and conditioned viewing are looking at information whereas informal research and formal research are looking for information (see Table 12).

Scanning Modes	Information Need	Information Use	Amt of Targeted Effort	Number of Services	Tactics
Undirected Viewing	General areas of interest; specific need to be revealed	Serendipitous discovery "Sensing"	Minimal Medium	Many	• Scan broadly a diversity of sources, taking advantage of what's easily accessible **"Touring"**
Conditioned Viewing	Able to recognise topics of interest	Increase understanding "Sensemaking"	Low	Few	• Browse in pre-selected sources on pre-specified topics of interest **"Tracking"**
Informal Search	Able to formulate queries	Increase knowledge within narrow limits "Learning"	Medium	Few	• Search is focussed on an issue or event, but a good-enough search is satisfactory **"Satisficing"**
Formal Search	Able to specify targets	Formal use of information for planning, acting "Deciding"	High	Many	• Systematic gathering of information on a target, following some method or procedure **"Retrieving"**

Table 12:   Modes of environment scanning (Choo 1998)

Undirected viewing is a broad scan of the environment without any specific direction. This could be, noting phone calls received or conversations with nurses, employers or government departments. Conditioned viewing is gathering information about specific topics such as overseas-qualified nurses using a minimal amount of resources both financial and physical. An example may be gathering information from Board and registration committee members, or in the case of Australian nurse regulatory authorities gathering information at the Collaborative Advisory Panel meetings.

Informal research is actively looking for information to increase the knowledge and understanding of a specific topic (Choo 1999).

This is usually carried out in a limited and unstructured way such as literature reviews or gathering information informally from Boards in other countries, which is not collated in a formal manner.

Formal research is a deliberate effort to gain specific information using a defined methodology. Formal research may be conducting research either as an individual Board or in collaboration with others. An example of this is the research conducted by the College of Registered Nurses of Nova Scotia, which was a review and synthesis of current policy discourse, trends and prospective directions about implications of globalisation for regulating health professionals (Moore, Picherack & Aherne 2003). Information was gathered from the United Kingdom, Ireland, Canada, Australia, New Zealand and countries of the European Union. The data was collected from nurse, physiotherapy and dentistry regulatory authorities, engineering and accounting professional bodies using a structured questionnaire. The data was collected in a rigorous, structured and consistent manner then collated and analysed. The findings from the research are not yet published. However this is an example of research, which is analysable and able to be repeated in a different environment such as Australia. Information from this research could also be used as part of the environmental scan for developing policy on the assessment of overseas-qualified nurses in Australia.

An environmental scan needs to be a systematic process as illustrated in figure 3. This framework has been adapted from the models developed by Choo (1998) and the CNO (2002).

The reason why this framework has been adapted is that areas such as the political, economic, technological and legal have been specifically identified as areas from where data needs to be collected as each area has the ability to influence policy development. Identifying events and trends from both internal and external environments enables policy to be developed which is responsive to the changing environment.
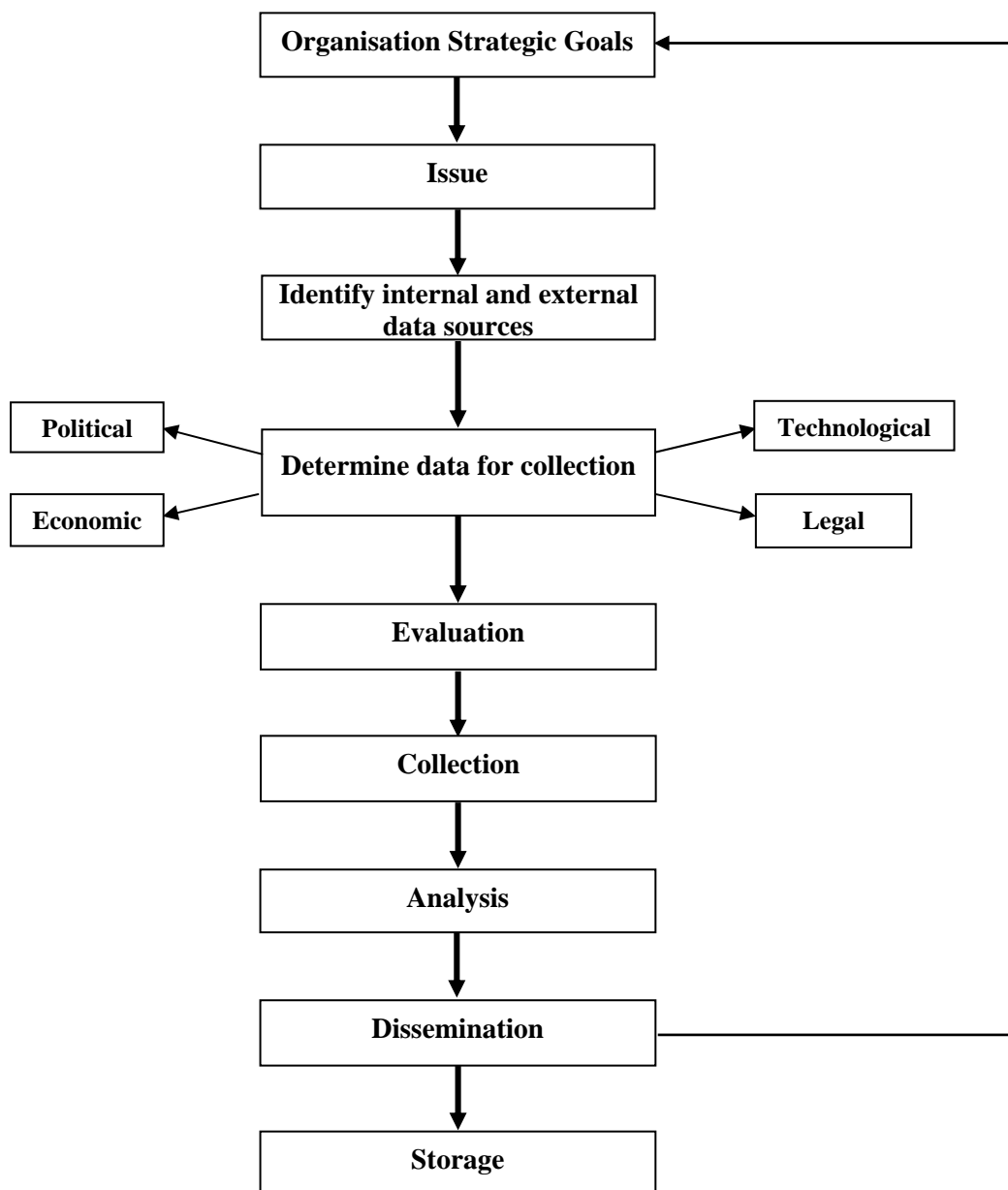
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                    │ Organisation Strategic Goals │◄─────────────┐
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                    │ Identify internal and external │          │
                    │        data sources      │               │
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  ┌───────────┐                ▼                 ┌───────────────┐
  │ Political │◄──────┌────────────────────────┐─────►│ Technological │
  └───────────┘       │ Determine data for collection │      └───────────────┘
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  │ Economic  │                │                       │   Legal   │
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Figure 3:   Environmental scan framework

The framework needs to be inline with the organisations strategic goals, there is no point scanning areas that are outside of the organisations goals. An example would be scanning the regulation of medical practitioners when the organisation is a NMRA responsible for the regulation of nurses.

The implications for not conducting adequate policy analysis mean policy is developed in an uninformed manner (Peiro, Alvarez-Dardet, Plasencia, Borrell, Colmer, Moya, Pararin & Zafra 2002). The danger of uninformed policy means that an organisation may be forced to defend adhoc and incremental decision-making. In relation to overseas-qualified nurses this could come from overseas-qualified nurses, lawyers representing overseas-qualified nurses, migration agents, government ministers and potential employers. Therefore, the importance of adequate policy analysis is imperative in policy development. Analysis provides data presented in an objective and impartial manner that follows an audit trail (Bridgman & Davis 2000). However, the serendipitous nature and ad hocery of policy should not be lost in determining the effects of ad hoc social actions (Ball 1993). In other words, one needs to be careful not to discount adhoc, serendipitous information, but use this information in the context in which it was gathered.

The repercussion of inadequate policy analysis means that information provided to Boards in order to make an informed decision is limited. As shown in figure 3 an environmental scan is a rigorous method of collecting information from both internal and external data sources. This process involves making sure that the issue is inline with the organisational strategic direction, in this case the relevant Nurses Act.

The issue is then clearly identified and articulated. Internal and external data sources involved in the assessment, education and employment of overseas-qualified nurses are identified. Once these sources have been established the data to be collected is determined. Information should include the current processes for assessing overseas-qualified nurses plus the current political, legal, economic and technological factors affecting the assessment policies and processes. The political considerations should include current and potential trade agreements and memorandums of understanding with other countries. Political ideals should be cognisant of issues relating to supply and demand such as the current global shortage of nurses. However, the development of assessment policies and processes while taking account of the global shortage should not be driven by this situation as assessment policy should be fair and equitable no matter what the supply and demand. The economic factors include the actual cost of assessment to the organisation and the nurses. Overseas-qualified nurses should not subsidise an organisation's other work by paying costly assessment fees. Other factors include the cost of conducting research, developing databases on information relating to education, clinical practice and work experience of nurses in other countries.

Legal considerations should include the current Nurses Acts and Regulations and/or any overarching Act such as a Health Professionals Act, plus any deliberation regarding amendments. Other legislation that should also be considered in relation to Australia are the Racial Discrimination Act 1975, the Human Rights and Equal Opportunity Act 1986, the Administrative Appeals Tribunal Act 1975, the Freedom of Information Acts 1982, the Trans-Tasman Mutual Recognition Agreement 1998 and the Mutual Recognition Act 1993.

Information technology has progressed expeditiously in the past five years by nurse regulatory authorities. Many NMRAs have websites providing information relating to registration and education requirements, the number of nurses on the register, investigative procedures and outcomes. However, there is limited information available by way of databases on educational programs for nurses in other countries. This data needs to be collected in a systematic way to ensure consistency of information. Ideally an international database, which regulatory authorities globally could contribute to, would give nurses greater access to information about educational programs. Discussion would need to occur internationally as to what information should be collected and how this could be presented electronically.

Collecting this type of information would be part of an environmental scan, which contributes to the policy analysis process.

Recommendation V: **Environmental scans are conducted as part of rigorous and structured policy analysis.**

Given that the issues regarding the assessment process of overseas-qualified nurses have been identified as similar by NMRAs, an environmental scan conducted by the ANMC for Australian state and territories NMRAs would be practical as the costs are shared. The areas, that are dissimilar, are the different Acts in each state/territory and country however, an environmental scan would identify these differences and the implications discussed on a national level through the ANMC.

Rigorous policy analysis contributes to the development of the instruments that are appropriate, efficient, effective, equitable and practical.

A lack of adequate analysis is highlighted when discussing the policy instruments used by each organisation in the study. Policy instruments are the tools used by Boards to achieve the desired outcome of the policy. In this study, policy instruments were the requirements determined by Boards that overseas-qualified nurses must meet in order to demonstrate the prerequisites for registration. Policy instruments related to language, education, competence of practice, and recency of practice and good character requirements.

Policy Instrument – Language

The significance of the findings in relation to language proficiency related to, who was required to undergo language tests, the variation in tests and pass levels required. Of note is the variation in the countries, which were considered to meet language requirements if the nurses complete their nursing program in English. In the Australian context these countries were the UK, USA, Ireland and Canada. Whereas the CNO indicated that there were thirty-two different countries (see table 9 chapter 6) in which a nurse met English fluency requirements if their initial nursing program was completed in English. Australia has only identified four countries as opposed to thirty-two countries where English is considered an official major language, as identified in the Canadian policy. The impact on nurses from Commonwealth countries would be significant as there would be no requirement to complete an English language test, which would mean fewer costs for these nurses and less requirements in the assessment process.

Further information needs to be obtained from the ANMC to establish what criteria was used to determine why nurses from the UK, USA, Ireland and Canada were the only countries from which nurses came who were considered to meet English language requirements.

Most tests required by organisations were generic English or French (in the case of Canada) tests, used to test language ability of candidates who need English/French as the language of communication to study or work. There was variation in the required pass levels of the generic tests as stated on page 132 in Australian NMRAs and the ANMC also advocated an occupation specific language (OET) test as well as a generic language test (IELTS). No other participants advocated an occupation specific language test. Although the Executive Director of the CNO at the 'Innovations in Regulations' conference held in November 2003 indicated that the CNO was considering using a profession specific language proficiency test.

In Australia the OET (for health professionals) and IELTS were the two most common English language tests used for determining English language proficiency. The pass marks were OET B pass or above in all four sections of the test with an overall pass of B. The IELTS requirements were a minimum score of 6.5 in all four sections of the academic test with an overall band score of not less than 7. Whereas the NMC requirements in relation to IELTS were that nurses must complete the general training test and gain a mark of 5.5 in each category and an overall band score of 6.5.

Information provided in the IELTS handbook indicates that the overall band scores were reported in whole or half bands, whereas writing and speaking band scores are reported as whole bands only (IELTS 2003). It was difficult to determine how an overall band score of 7 could be achieved if the scores did not total a whole number.

The point of interest with language proficiency is why the pass mark varied so much in the countries participating in this study. In the case of IELTS, from a pass mark of 5.5 in all sections in the test and an overall band score of 6.5 to an overall band score of 7 in some countries. At band score 7 the individual was considered to have an operational command of the language, although with occasional inaccuracies, inappropriacies and misunderstandings in some situations, generally handles complex language well and understands detailed reasoning. Whereas a person with a band score of 6 has a generally effective command of the language despite some inaccuracies, inappropriacies and misunderstandings and is able to understand fairly complex language, particularly in familiar situations (IELTS 2003). It is possible that a band 6 would be appropriate for nurses given that it is likely that they will practice in familiar situations such as a healthcare setting from country to country. However, there has been no formal research conducted in a practice environment involving overseas-qualified nurses to determine whether a band 6 or 7 is appropriate. IELTS is currently offered in two formats, an academic or general training test, the academic reading and writing modules assess whether a candidate is able to study in the medium of English at undergraduate or post graduate level and the general training test assesses whether a candidate is able to achieve basic survival skills in a broad social and educational context.

The general training test is suitable for candidates who are going to an English speaking country for work experience or training programs not at degree level.

The difference between Australia requiring the academic test and the NMC requiring the general training test requires further research to ascertain the rationale for the NMC's decision. Given that Australia and the UK are both English speaking countries it would be of interest to determine whether there is a significant difference between the general and academic IELTS test. In other words, do nurses who have completed the general IELTS test demonstrate a greater understanding of the language used in the healthcare environment than nurses who have completed the academic IELTS test?

Hawthorn and McNamara, both identified that generic language testing is a significant issue for NESB nurses where the difficulty for them is more about understanding country specific professional terminology and pharmacological terms, also the local, social and medical idioms which are perceived as fundamental to professional acceptance (Hawthorne 1997; McNamara 1997). One could argue that using a generic English test does not test a nurses ability to understand the slang and idioms of language used in delivery of healthcare in another country. Given that every nurse from NESB countries applying in Australia are required to undertake an English test it would seem relevant to determine which test is the most appropriate to enhance NESB nurses' ability to practice in Australia. This in the long term increases the Board's ability to protect the public by ensuring overseas-qualified nurses are able to communicate with patients/clients and other healthcare workers.

The ANMC English language fluency requirements waive the English language test if an NESB nurse has worked in the UK, Canada, USA or Ireland, full time equivalent, for a period of three months, in the previous two years prior to application to the ANMC.

However, there was no evidence to support why the time period of three months was chosen as indicating that an NESB nurse has reached English language proficiency. There has been no follow up undertaken by the ANMC or any Australian nurse regulatory authority to evaluate whether nurses who have language requirements waived have the English language proficiency required to practice in Australia. The ANMC assessment standards also indicate that nurses from NESB countries such as South Africa and Zimbabwe may have their English language requirements waived if their initial nursing education program was delivered in English. However, nurses from the Philippines do not have their English language requirements waived despite the fact that their initial nursing education is taught in English, as indicated by the Philippine Board of Nursing during the interview for this study. This highlights an inconsistency in the waiving of English language requirements for NESB nurses by the ANMC, which informs nurse regulatory authorities in Australia. Is this evidence of discrimination against NESB nurses, given that there is limited evidence to support this practice?

It would appear that there is a lack of English competence testing in the work environment for NESB nurses. In order to ensure content validity of the English language competence tests, language testing in the workplace environment is essential.

Recommendation VI: **Formal research is undertaken to determine which if any English language fluency tests are valid in relation to nursing practice.**

In 2005, the NMC made a significant policy change to the language requirements of the IELTS overall band score of 6.5 general test to an overall band score of 6.5 academic test. It is believed that this change was bought about following the NMC 'Consultation on the overseas nursing programme for UK registration' conducted in 2004 (Nursing and Midwifery Council). The method used to gain this information was from a number of stakeholders using a questionnaire. The tool used was a closed question requesting a response to the proposed standard stated as:

> **Entry standard A** – Have successfully achieved and provided evidence of an overall score of 6.5 in the International English Language Test (IELT) with no less than 5.5 in listening and reading and no less than 6.0 in writing and speaking (Nursing and Midwifery Council 2004)

Participants were requested to indicate whether they agreed or disagreed with the proposed entry standard or they didn't know. There was a seventy nine percent (79%) agreement with the standard and it would appear that the change to academic IELTS overall score of 6.5 was based on this one question. This is an issue as it is possible that participants did not understand the difference between IELTS general and academic, as there was minimal explanation given indicating the differences in the two tests. Healthcare professionals such as the General Medical Council of the United Kingdom is currently reviewing the IELTS test as a method for testing language skills (The General Medical Council 2005).

The research needs to move from determining how many overseas-qualified professionals pass the test to determining how effective their English language use is in the healthcare environment. It would be prudent to conduct the research relating to the effectiveness of English language tests with the providers of those tests.

However, caution must be exercised as to the ability of providers to critically analyse their own testing system (McNamara 2001). It is for this reason that the research should be commissioned and managed by organisations that have not written or created the tests such as the ANMC or the Department of Linguistics, Macquarie University and funded by a group such as the Commonwealth Government in Australia. Consideration needs to be given as to the language skill level of native English speaking nurses in the Australian healthcare environment. Determining the level of IELTS or OET of nurses educated in Australia would be of interest initially as this would determine the English level in reading, writing, listening and speaking of native speakers. It is possible that the level required of NESB nurses is higher than that demonstrated by native English speakers.

It may be more appropriate to determine nurses' language skills in the workplace environment based on an interview using colloquialisms and contemporary nursing language rather than just a generic written language test held in a classroom.

Recommendation VII: **Research pertaining to language assessment should be conducted in a range of English speaking countries to determine the appropriate method of ascertaining English language skills for use in the practice environment.**

Another policy instrument is the educational requirements of nurses.

Policy Instrument – Educational Requirements

As was the case with language requirements, there was variation in the educational requirements for overseas-qualified nurses.

Most organisations required nurses to have completed a three-year or six semester educational program with an inference that this program was at degree level in all cases. However, variation occurred in relation to the content required by each Board.

In the case of Australia, the curriculum needed to reflect the nurse's ability to demonstrate the ANMC competencies for registered nurses. This would be extremely difficult to determine given the variation in presentation of curriculum details. The requirements of the CNO indicated a minimum of 750 theoretical and 1200 clinical hours with specific content requirements highlights this point. The California Board of Registered Nursing (CBRN) prescribes a ratio of 1 hour of theory to 3 hours of clinical as a curriculum prerequisite for all nurse undergraduate programs. The NMC also prescribe the desired content and the proportion of theoretical to clinical training. All methods relate to a paper based assessment of the nurses ability to practice in another country.

However, the difficulties with using a paper-based assessment are articulated in the report produced by the Australian Committee Inquiry into Recognition of Overseas Qualifications:

> The problems with this method of assessment include the difficulty of obtaining a full description of the scope, intensity and duration of the course of study or training undertaken; the fact that a paper description does not adequately reflect the quality of the course or the students performance; the fact that the attainment of a qualification, particularly some years previous, does not necessarily reflect present competence; and the difficulty of accurately translating technical or other terminology. Also, unless clear criteria are applied and the judgements are open to scrutiny, there may be subjectivity and discrimination even if this is unintentional. (CIROQ 1983, p. 96).

A paper-based assessment of initial qualifications was the preliminary process for all organisations, however some nurses were required to complete a migrant bridging program or a paper based examination. The concern about this process is that there is an assumption that these nurses are incompetent if the curriculum they have undertaken was not deemed as equivalent to the NMRAs benchmark curriculum.

Given the statement by the CIROQ one wonders whether it is reasonable to assume incompetence, rather than competence based on a paper-based assessment. In the case of Australia, it appears to be indirectly discriminatory as to who is required to undertake a migrant bridging program. Nurses who were from developed, English speaking countries were not required to undertake a migrant bridging program. An example of this is that nurses from countries such as the UK, USA, Ireland, Republic of South Africa, Zimbabwe, Canada, Hong Kong, Singapore and the Netherlands were not required to undertake a migrant bridging program. The Queensland Nursing Council is the only Council in Australia that acknowledges nurses from other countries, educated in certain organisations in the Czech Republic, Egypt, Fiji, Ghana and Sri Lanka as meeting the requirements to register without the requirement to undertake a migrant bridging program. The reason why this is the case was not provided by the QNC so it is difficult to make an assumption about why this is the case, except that it may be based on the experiential knowledge of the QNC staff.

It is reasonable to question why nurses from some country's were accepted without further requirements and why others were not, given that all organisations indicated that individual assessments occurred for all applicants.

It can be said that in fact assessments were country based rather than based on individual nurses qualifications and experience. It was indeterminate as to the criteria used by NMRAs to establish from which countries nurses met competence requirements, except that the healthcare and educations systems were considered similar. Using this criterion there is an assumption that nurses who have been educated in a country where the healthcare and education systems are different do not have the ability to learn and adapt to a different healthcare system.

There has been no formal research conducted by any participant organisation, to determine whether nurses from certain countries did not demonstrate competence to practice. Therefore, nurses who are required to undergo a migrant-bridging program are denied natural justice, as they are not given the opportunity to demonstrate competence beforehand. Procedural fairness is about the concept of fairness. Procedural fairness is a combination of a traditional doctrine, natural justice, and a recent innovation, legitimate expectation and the provisions of reasons for the decision (Leaver 2003). Procedural fairness is derived from the tenet that no one should be condemned unheard (Flick 1984). Therefore consideration needs to be given as to whether nurses who are deemed not to meet the requirements for registration and are therefore required to undertake a bridging program are in fact being condemned unheard. The data collected in this study indicates that policies and procedures regarding assessment of overseas-qualified nurses appear to be weighted toward the English-speaking nurse from a developed country. It would seem from the data that the requirements for nurses of NESB are more onerous in relation to having to demonstrate competence as well as language proficiency, as all NESB are required to undertake a migrant-bridging program.

In 1990, section 9(1A) was added to the Australian Racial Discrimination Act to deal with indirect discrimination. According to the Australian Human Rights and Equal Opportunity Commission indirect discrimination happens when:

> A policy that treats everyone in the same way has an unfair effect on more people of a particular race, colour, descent, or national or ethnic origin than others. This is known as indirect discrimination. Unlike direct discrimination, indirect discrimination may be justified if the policy or rule is reasonable and relevant to the particular circumstances (HREOC 2003, p. 1).

In the case of NESB nurses, it could be argued that the current policies may not be justifiable in relation to language and educational requirements. There appears to be no formal evidence to justify the level of English language or level of educational requirements for NESB nurses in the assessment process in any of the organisations in this study. This may be a form of indirect discrimination as there is no evidence to indicate that the policy is reasonable or relevant to the particular circumstance in the situation of a NESB nurse's ability to demonstrate competence to practice in Australia.

The CNO and the NRBC both indicated that every overseas-qualified nurse was required to undertake a generic written examination based on entry level practice. Insisting that *all* overseas-qualified nurses undertake the examination may be considered as fair and equitable. Is seems inappropriate not to acknowledge a nurse's education and post registration experience as an aspect of determining competence rather than how they perform in a one off examination. A survey on the 'Characteristics of Foreign Nurse Graduates conducted by the Commission on Graduates of Foreign Nursing Schools' in 2000-2001, identified issues in relation to educational preparation, employment, nursing environment, satisfaction and US transition (CGFNS 2002).

What was significant in this survey was that nurses identified the need for an in-depth, culturally sensitive orientation to nursing in the USA. The examination has a limited ability to prepare nurses for practice in relation to knowledge of the healthcare system, cultural issues and the language and terminology used in the workplace.

Australia and the NMC do not conduct entrance examinations for overseas-qualified nurses, however there is no evaluation of assessment policies to indicate whether an examination is either required or not. It was difficult to determine which method of assessment was more effective, given the limited evaluation of paper based assessment and assessment by examination.

In relation to paper-based assessment (as is the case in Australia and the UK) further exploration needs to be undertaken in regard to this method of determining a nurse's competency in the practice environment. If paper-based assessment proves to be adequate, there would need to be further questioning of the justification for using a written examination to assess overseas-qualified nurses used in the USA and Canada.

Recommendation VIII: **Research is undertaken to investigate whether a paper-based assessment alone is a reliable and valid indicator of overseas-qualified nurses' competence to practice.**

The paper based assessment in all but one organisation considered only a nurse's undergraduate curriculum. There was no deliberation given to any practice or education a nurse had pursued post-initial registration.

It seems incongruous to think that a nurse's post registration education and experience would not be considered in determining competence to practice. A nurse's competence to practice should indisputably be inclusive of any post registration education and experience as life long learning is the cornerstone of any nurse's practice. The Royal College of Nursing, Australia (a professional body for nurses) has indicated that, ' in the dynamic health environment, there is widespread agreement that nurses must keep themselves up to date in their practice to ensure that they remain competent to practice'(Royal College of Nursing Australia 2004).

The NMC also has an expectation that nurses will pursue lifelong learning as part of the nurse's registration and renewal process (NMC 2002). Therefore, consideration needs to be given to recognition of the concept of life-long learning for nurses in the assessment process.

Recommendation IX: **Nurses post registration education and experience is considered as part of determining a nurse's competence to practice.**

Part of the integration process into another country for overseas-qualified nurses is to understand the culture, healthcare systems, legislation and expectations of their practice. This pertains to all nurses no matter which country they have come from. Therefore, it would seem prudent that all overseas-qualified nurses undertake a learning package relating to the culture, healthcare system, legislation and expectations of practice in the country they choose to practice in. There should not be an assumption that a nurse from the United Kingdom will automatically understand the culture, healthcare system, and legislation and nursing practice in a country like Australia and vice versa.

This learning package could be developed in a nurse's native language as opposed to English as there is a higher likelihood that the content will be understood quicker than reading a package in a second language. These packages could be offered online to maximise accessibility for participants with links to appropriate sources, such as Nurses Acts. However, providing a learning package in a nurse's native language does not negate the fact that a nurse does need to demonstrate language competence in the country they wish to practice. It is preferable that the learning packages are distinguished as an orientation to the healthcare system and expectations of nurses, not as a punitive form of assessment. In other words the assessment of competence is about orientation to a country's systems and expectations rather than about testing nurses ability to practice.

Recommendation X: **All overseas-qualified nurses complete a learning package on the culture, healthcare system, legislation and expectations of practice as part of the assessment process.**

In the interim it would be helpful if educational institutions made available to nurse regulatory authorities information relating to course content of nursing curricula on a secure website (Board password access). This would allow Boards access to information readily and directly. It would also allow for easier updates of information on a regular basis. The difficulty nurses experience accessing academic transcripts would be eliminated.

Recommendation XI: **Educational institutions make available to nurse regulatory authorities, on a secure website, information on the content of courses leading to registration for nurses.**

Education providers supplying passwords to NMRAs in order to access this information online could achieve this. Confidentiality agreements would need to be negotiated between educational institutions and NMRAs to ensure privacy of course content. Processes would need to be implemented by educational institutions to ensure that course curricula were accurate.

What also requires consideration is the concept of an international comprehensive nursing curriculum on which nursing practice is based. This would lead to a greater consistency globally. It is understood that each country's healthcare system, culture and educational requirements are different however, this should not inhibit the development of global education and practice standards. Each country would need to adapt these standards to their specific needs such as legislation affecting nursing practice.

Policy Instruments – Competence to Practice

The primary determination of competence to practice by all participants in the study was based on the nurse's initial education. However, it would appear that other factors considered were the nurse's registration status in the country of origin and last practice date, whether the nurse had post registration experience (not all NMRAs), employment references indicating competence, statements of service from employers, written examination and migrant bridging programs. Recency of practice was also indicated by all but one organisation as a requisite. The requirements for recency varied, from simply practicing within the past five years (all Boards in Australia except NRBNSW) to requirements such as 100 days of practice in past five years or five days of learning activity over last three years.

None of these methods have evidence to indicate that competence to practice is achieved and therefore are questionable in terms of the protective role of the regulatory authority. Participants indicated that they knew of no reason why five years had been chosen as a time limit for demonstrating competence.

Another requisite was the requirement for good character (NSWNRB and NBNT) which according to Chiarella:

> This requirement may seem somewhat old-fashioned, but undoubtedly stems from the fact that the law governing professional regulation is a protective jurisdiction. There have been anecdotal suggestions that this requirement is simply a 'rubber-stamping exercise', which has no relevance to the 'real world' (2001, p. 2).

However, Chiarella goes on to say that the courts take a breach of good character very seriously (Chiarella 2001).

Other Boards in the study appear to address the notion of good character by requesting professional references and asking questions on an application form, such as whether the nurse has been convicted of criminal convictions or ever been de-registered or suspended or had limitations placed on their practice by any Board. The Board of Registered Nursing California requires all nurses to submit a fingerprint card (used to record information of criminal convictions) as part of the application process and to declare any previous criminal convictions.

The character of the nurse is considered an important part of the assessment process and is measured in a range of different ways. Overseas-qualified nurses are treated differently to other nurses applying for registration in this matter.

Although some participants indicated that they had a concern regarding fraud in relation to references received from overseas countries. Which was why it was mandatory, that NMRAs verify a nurse's registration status directly to the Board rather than via the nurse.

Discussion needs to occur to determine whether good character is part of determining competence to practice, or a nurse's fitness to practice. In other words what does good character really mean in the context of assessing an overseas-qualified nurse's ability to practice? It appears that overseas-qualified nurses are required to provide more information in some states than a nurse who has qualified in Australia in relation to good character. Nurses in all but two states in Australia are asked to sign a self-declaration as to their fitness to practice as a requirement for initial registration if educated in Australia. Again there is inconsistency between Australian nurse regulatory authorities and indifference with other countries as to the requirements in determining good character.

Discussion needs to occur nationally and internationally on what are the principles for determining the good character of a nurse. Is it the assessment by a peer that the nurse is of good character, by observing their conduct with patients? Or is it whether a nurse has a police record with no convictions aside from speeding offences?

Recommendation XII: **A consistent approach to determine good character for all nurses is developed internationally.**

Consultation

Consultation in all organisations was through the Board and Board advisory committees. This is a limited consultation process given the tight composition of the Boards and their advisory committees. In the case of the NBACT, all Board members were nurses and the registration committee consisted of 4 Board members. There was no input from any other stakeholder (except the ANMC Collaborative Advisory Panel) in policy development, which in the long term could influence the level of acceptance of policy endorsed by the Board. Consumers in particular could argue that if the Board is there to protect the public where is the public input in Board decision making. It could also be suggested that the Board is protecting the reputation of the profession using hegemonic practices rather than protecting the public by using consultation processes by involving predominately nurses (National Consumer Council 1999).

Seeking a viewpoint from those affected by the policy process is considered by Bridgman and Davis as 'just smart policy making' (Bridgman & Davis 2000, p. 76). While it is acknowledged that the consultation process is both costly in time and money, consultation reflects the values of openness and transparency, which should be pivotal to all groups, involved in the assessment process (International Council of Nurses 2001a). The NMC in December 2003 (post data collection for this study) launched a 'Consultation on the Overseas Nursing Program for UK Registration' (Nursing and Midwifery Council 2004). This consultation related to proposed changes to training and registration of overseas nurses in the UK. A consultation package was sent to thirteen organisations/groups considered to be representative of organisations/groups involved in assessment, employment and consumers of the practice of overseas-qualified nurses.

However, there does not appear to be representatives of overseas-qualified nurses as part of the stakeholder group. Nonetheless the consultation package is available on the NMC website meaning that overseas-qualified nurses could have had access to the consultation package. Although, this is assuming that overseas-qualified nurses access the NMC website. It may have been more appropriate to ensure overseas-qualified nurses were designated as representatives in the stakeholder group, given that the NMC has a database of overseas-qualified nurses. A selected sample of twenty overseas-qualified nurses who applied for registration in the past five years, from both developed and developing countries, English and Non English speaking backgrounds who were successful or unsuccessful in achieving registration would be a reasonable representation of this stakeholder group. Surveys would be a way of collecting data from nurses as there would be an ability to capture data from nurses not in the country.

This may be idealistic, however if information is not gathered from this group of key stakeholders policy analysis may not include information and or comments these nurses have to offer. Information such as nurses' not understanding parts of the application form, not because they could not understand English but because a requirement was worded using a term they were not familiar with or had not been taught.

Consultation needs to be comprehensive including a range of stakeholders in the assessment process such as employers of overseas-qualified nurses, consumers of overseas-qualified nurse's practice and overseas-qualified nurses themselves.

Recommendation XIII: **Consultation in the policy development process includes employers of overseas-qualified nurses, consumers of overseas-qualified nurse's practice and overseas-qualified nurses.**

Focus groups conducted with overseas-qualified nurses in order to determine what requirements they believe are needed to practice competently, would be beneficial to the development of assessment policy. By distributing questionnaires using open-ended questions, to all overseas-qualified nurses (whether successful or unsuccessful in the assessment process) information could be gathered regarding issues encountered during the actual assessment process such understanding the requirements for assessment. It would be worth identifying whether the overseas-qualified nurses believed that the English language requirements if met were adequate as a basis to practice competently.

Coordination

Coordination of the policy process varied from the role being exclusively the Chief Executive Officers of the Board to managers responsible for the assessment process. The CNO and the NMC were the only two organisations that had specific staff allocated to develop policy as their primary role.

Staff in other organisations coordinated policy as one of the many roles they undertook in their day-to-day work. This could prove problematic in relation to staff allocating time to appropriately coordinate policy. The other notable finding was that the CNO was the only organisation that had skilled policy analysts employed to specifically coordinate policy.

The policy team at the CNO were responsible for conducting the environmental scan, developing policy, conducting the consultation process and to act as a resource to the persons responsible for implementing the policy. Therefore, they were remote from the implementation of the policy, which means that had a greater likelihood of remaining objective in the policy development process. It is suggested that many people take part in policy advocacy rather than policy analysis, which produces skewed policy inline with their own preferences (Anderson 2003). This could be the case if staff responsible for the actual implementation of policy are the drivers of policy development.

Recommendation XIV: **Persons will skills in policy development are either employed or consulted in policy development.**

Decision

Responsibility for the decision to endorse policy in all but one organisation (CNO) lay with the Board. The CNO Council has delegated the decision-making role to the Registration Committee for any policy involving registration issues. In order to make informed decisions, analysis needs to occur which identifies or predicts the policy effects on the various recipients of policy in the processes of implementation (Hancock 1999; Steele, Rocchiccioli & Porche 2003). The use of evidence-based policy making advocates consideration of factors such as social, financial and the legal impact that should be taken into account by any Board or committee (Bridgman & Davis 2000). Evidence-based policy's foundation is the combination of experience, judgement and expertise with evidence collected and analysed from systematic research (Davies 1999). However, consideration needs to be given as to what constitutes evidence as it may be described and obtained in a number of different ways and sources.

Examples of evidence are; organisation initiated research, published research, expert knowledge and experience, previous policy evaluations and stakeholder consultation. Evidence in relation to policy used in assessing overseas-qualified nurses appears to be based on expert knowledge and experience with limited stakeholder consultation. The missing links in the evidence chain are research and previous policy evaluations. While expert knowledge and experience are valuable components in the evidence chain, they are rarely detached, value free and neutral (Marston & Watts 2003). NMRA staff while experienced in the assessment process may not be able to detach themselves from their own mental models when involved in the policy development process. If they have never practiced or travelled outside the country in which they have been born and educated they may not have the ability to appreciate how other nurses practice and the different cultural context these nurses would bring to another country. In other words we don't all practice the same way but that does not mean that the practice is not of the same standard or have the same outcomes. It is easy to be judgemental when one does not know what really happens. If NMRA staff have been raised in Australia in a family that firmly believes in the White Australia Policy either overtly or covertly, it may be difficult for them to accept a black nurse from Zimbabwe. It is important to understand that a person's knowledge is not always value free and must be considered in policy analysis.

Likewise caution needs to be exercised when discerning research findings and the weight that should be given to the findings in the context in which the policy is developed. In other words importance needs to be placed on all forms of evidence whether it is research or expert knowledge and experience.

Recommendation XV: **Decisions on the policies for the assessment of overseas-qualified nurses are evidenced-based.**

Another factor that needs consideration in the policy development process is what the future impact of the policy may be. For example in relation to nursing, the vision for the future of the ICN is the introduction of international nurse competencies based on an international curriculum where all nurses undertake similar undergraduate education and clinical practice, could lead to greater mutual recognition of nurses' qualifications between countries in the future. This process will be incremental, occurring over a period of time given the required changes in current thinking and processes. The ICN is attempting to increase debate on the regulation of nurses by placing this on the international agenda by means of the 'Global Nursing Workforce Project' (International Council of Nurses 2005).

In the Australian context the continued discussion relating to the move to a national nurse register as opposed to separate registers in each state is an important consideration for future policy development (Australian Government Productivity Commission 2005). The implications of these issues need to be considered in any policy development involving assessing overseas-qualified nurses in the future and should be identified by an environmental scan in the policy analysis phase of the policy cycle.

Implementation

The implementation phase of the policy cycle again varied in the study group. Predominately the implementation of assessment policy was seen as the role of administrative staff with input from nurses when an application was outside the criteria for registration. Therefore, it was assumed that administrative staff had the ability to determine whether documentation was authentic, to assess a curriculum document and determine whether it was equivalent or comparable to a curriculum used as the benchmark. Board nursing staff would require the same skills however, it appears are also required to have a greater knowledge in assessing curriculum documents and determining post initial registration experience and expertise. In some circumstances an application was referred to the registration committee and or the Board for further assessment and decision. Again both the registration committee and Board required knowledge in undergraduate nursing curricula and what constituted experience and expertise. While this is of interest, information relating to the knowledge of nursing curricula, experience and expertise of Board, administrative and nursing staff was not pursued in this study.

Another factor in the implementation of the policy is the time it takes to assess a nurse's application for registration. This varied in Australia from two days, if the application met the assessment standards and criteria, to two months if the application was referred to the registration committee (due to the committee meeting monthly) and longer if referred to the Board. The overseas countries were similar in that the initial assessments took between three to six months due to the workload of staff. The CNO and BRNC indicated that when the required examination was held, determined how quickly a nurse's application was processed due to examination dates throughout the year.

These timeframes impacted greatly on when a nurse made a decision to apply to practice in another country and when they were eventually able to practice after meeting regulatory requirements (Omeri & Atkins 2002).

The costs involved for overseas-qualified nurses to have their qualifications assessed, varied significantly both in Australia and in the overseas organisations. In Australia the cost ranged from no charge (NBACT), $A44 (QNC) to $A530 (ANMC). The overseas organisations were closer in comparison with costs than Australian in that the CNO was $A244 (examination fee), NMC $A287 and the BRNC $A433 (application and examination fee). However, aside from the examination fees charged by the CNO and BRNC the variation in the actual cost of an assessment is interesting in that if it is cost recovery how can there be a variation from no cost to $A530? How the cost recovery process was determined was not investigated, as part of this study but perhaps requires examination in the future.

Additional considerations in relation to expenses for overseas-qualified nurses were the costs involved in migrant bridging/competency assessment programs and English language tests. The nurses absorb all costs involved in the assessment process when in fact it is the regulatory authorities who have the task of determining whether a nurse is competent to practice or not. The regulatory authorities are the bodies that have been unable to satisfy themselves that nurses who have undertaken undergraduate programs in certain countries are competent to practice. Another way to view this is whether the onus is on the regulatory authority to prove that the nurse is incompetent rather than competent.

This would mean that every nurse applying for a licence to practice would be required to undertake an assessment either clinical or written or both at the Board's expense. Governments or employers may agree to fund such assessments during a nursing shortage however, I would imagine would be very reluctant to when there was a glut of nurses.

Evaluation

> Evaluation is the point in the cycle when the utility of policy must be questioned, and a new cycle of analysis and adjustment, confirmation or abandonment begins (Bridgman & Davis 2000, p. 126)

Evaluation usually occurs when a policy has been implemented to test for efficiency and importantly, effectiveness (Bridgman & Davis 2000). Therefore, it was surprising to discover that no organisation had formally evaluated their policy on the assessment of overseas-qualified nurses. It would appear by the following comments from participants when asked about evaluation that evaluation occurs in an informal and adhoc manner. Whilst these comments are raw data they have been included in this chapter again to reinforce the significance of the comments.

Comments in relation to evaluation were:

> There has not been any done in this office that's for sure I know (12: p20 L9).
>
> I think we have done it mostly from the number of people that have come in by the college, follow them through we have the numbers of how many pass how many have been recommended for retraining how many have been recommended for a lesser. We draw these statistics yearly (7: p24L 22).
>
> We don't have to because we don't do the assessments (4:p19L14).
>
> No not really. We have got some stuff from the ANMC, we have not done any (10:p13L14).

> No but I think suffice to say because we keep the information on previous decisions that the decisions are based on those decisions (11:p11L5).
>
> And one of the things that we don't do in the policy process is evaluate enough. Because that is one of the things that falls off at the end that is usually step 5 in the policy process is evaluation (1: p36L35).

Evaluation of the policies on the assessment of overseas-qualified nurses appears to be limited to an internal perspective. The focus is on whether decisions have been consistent, which is valuable however the decisions need to be accurate in order to protect the public and ensure that the nurse has a fair assessment. Also noted is the importance placed on whether overseas-qualified nurses were reported to the Board for professional misconduct. While this is important data, it should not be the only data used to evaluate the effectiveness and efficiency of assessment policy. The process for determining accuracy of decisions should be to pursue feedback from employers of overseas-qualified nurses assessed as competent to practice to indicate whether in fact they were. This of course would not address overseas-qualified nurses who have been assessed as not eligible to register or nurses that self regulate and decide not to practice if they believe they are incompetent.

The most significant finding of the study was the lack of evaluation of policies used in the assessment of overseas-qualified nurses by each organisation. While it is acknowledged that policies were reviewed, it was noted that there had been no evaluation as to how effective and efficient the current or previous policies were in relation to assessing overseas-qualified nurses.

Evaluation needs to include determinations as to whether the policies are transparent, consistent, fair and equitable and the outcome is that overseas-qualified nurses are competent to practice in the country they have applied to practice. Therefore the next recommendation relates to policy evaluation.

Recommendation XVI: **All policies pertaining to the assessment of overseas-qualified nurses are evaluated in relation to effectiveness in determining competence to practice.**

This evaluation could occur in a number of ways such as conducting focus groups with employers of overseas-qualified nurses to determine whether these nurses are competent at the expected level of practice. Given that most overseas-qualified nurses prior to assessment, have been registered for an average of five to ten years there would be an expectation that they would be practicing using a higher level of expertise than a graduate nurse. However, it may be apparent after evaluation that overseas-qualified nurses practice at the level of a graduate nurse hence require supervision not required of a nurses of five years experience. If this is the case, then the orientation of overseas-qualified nurses may need to be evaluated to determine why nurses are not practicing at the required level.

Consumers of the care provided by overseas-qualified nurses are another source of information in the evaluation process. Determining any issues experienced by consumers could influence policy, such as language requirements. If consumers are indicating that overseas-qualified nurses with English as a second language are too hard to understand then the level of English may need review.

The next recommendation relates to how the Australian assessment process fits in the global picture. During this study it became obvious that there were many similarities in the issues relating to assessing overseas-qualified nurses by nurse regulatory authorities. Therefore it would seem prudent to suggest that the notion of assessing nurses from other countries be addressed at an international level in the long term.

This may appear again to be idealistic, however in the current global environment information technology is progressing rapidly meaning this may not seem so idealistic in the future. Consequently this recommendation relates to instigating an international working party initiated by the International Council of Nurses to determine best practice principles in assessing overseas-qualified nurses.

Recommendation XVII: **An international working party is established to develop best practice principles in assessing nurses from other countries.**

If this issue is not addressed internationally, or at the very least nationally, there will continue to be inequities in assessment policies, such as, some countries acknowledging nurses from certain countries as competent to practice while nurses from this country are not recognised as competent in the reciprocating country. The issue of memorandums of understandings or agreements between countries could also be explored by an international working party, given the current and pending trade agreements between countries. The model used by the European Union could be discussed as this involves currently, twenty-five countries with different education and healthcare systems.

The study revealed that policy in relation to the assessment of overseas-qualified nurses was undertaken in an adhoc manner and not evidence-based, therefore the final recommendation relates to policy development.

Recommendation XVIII: **Policy development is undertaken using a policy framework such as Bridgman and Davis' policy cycle.**

The recommendations from this study will change the current process for assessing overseas-qualified nurses if NMRAs in Australia take the initiative and adopt them. However there were some limitations to the study that require comment.

Limitations of the Study

The major limitation of the study was the availability of policy documents as indicated in the findings. Most organisations were not prepared to provide policy documents therefore analysis of some policies relied on the participants' verbal understanding of the policy and information available on the organisation's website. This was a limitation in most cases as part of the study design was to critically analyse the policy documents prior to conducting the face-to-face interviews. It has become apparent as I am now employed at an Australian nurse regulatory authority that more information was available exclusively to staff in relation to policy used for assessing overseas-qualified nurses.

Distance may also be considered a limitation as, in order to conduct face-to-face interviews with participants it was necessary to travel extensive distances in some cases.

If distance was not an issue the sample size could have been larger, and may have brought forth different information in relation to the study. The time it took to access the appropriate person to interview took a period of eight months in one case. This meant that I was unable to book airline flights until all interview dates and times were established. Even though appointments for interviews were confirmed, one participant at the last minute was unavailable which meant the person interviewed acknowledged that limited information was provided.

Follow-up with the appropriate person was by email, which I believe limited, the interaction that could have occurred should a face-to-face interview have been conducted. The use of a focus group involving all Australian nurse regulatory authorities was a consideration, however the logistical and financial implications of achieving a meeting of participants from every state/territory in Australia was a major influence in deciding not to pursue focus groups.

The fact that the study related only to nurse regulatory authorities could be seen as a limitation as other overseas-qualified healthcare professionals such as medical practitioners, pharmacists and physiotherapist assess overseas-qualified applicants also. However, the study was about nurse and midwifery regulatory authorities hence focused on nurses/midwives.

The use of Bridgman and Davis' (2000) policy cycle as the benchmark used for a policy framework could be seen as a limitation as there are other policy frameworks advocated by policy researchers. However, I believed that Bridgman and Davis' policy cycle was both practical and comprehensive as a benchmark for policy development.

Implications for the Future

Many issues have been raised in this study that question current policy relating to the assessment of overseas-qualified nurses. It is anticipated that by raising an awareness of how inconsistent and adhoc policy development and policy is in the assessment of overseas-qualified nurses that this will stimulate further discussion which may lead to change in the assessment process.

Overseas-qualified nurses deserve and are entitled to a fair, equitable and transparent process when it comes to assessing their ability to practice in another country. The current global shortage of nurses has no doubt raised an awareness of the qualification assessment processes however there has been minimal dialogue internationally on developing underlying principles for assessment. Statements have been produced by various nursing bodies on poaching nurses from developing countries to developed countries however, these same bodies have been silent until very recently on working towards consistency and transparency of qualification assessment policies.

Publishing the findings of this study is imperative to enure that the issues about assessment polices become agenda items in both Australia and at an international level. Also presenting the findings of the study at conferences on the regulation of professions and trades is crucial to stimulate debate in order to change the current policies on assessing a person's ability to practice in another country. Ensuring that government bodies involved in migration and employment of overseas-qualified persons have copies of the publications produced from this study is an important part of influencing policy change.

However, the primary aim is to promote the use of a policy framework in policy development, influence policy change at an international level by encouraging debate on mutual recognition of qualifications and research on the current policies and processes.
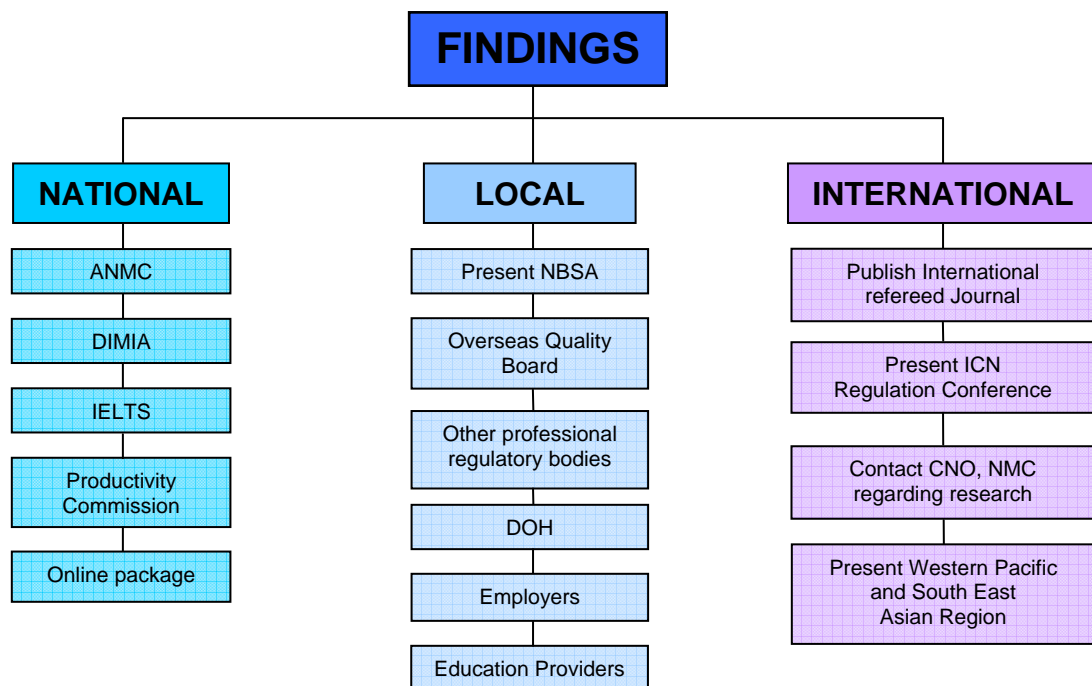
Action Plan to disseminate findings

FINDINGS		
NATIONAL	**LOCAL**	**INTERNATIONAL**
ANMC	Present NBSA	Publish International refereed Journal
DIMIA	Overseas Quality Board	Present ICN Regulation Conference
IELTS	Other professional regulatory bodies	Contact CNO, NMC regarding research
Productivity Commission	DOH	Present Western Pacific and South East Asian Region
Online package	Employers	
	Education Providers	

Figure 4 Action Plan

Local dissemination of findings

The Nurses Board of South Australia embraced Bridgman and Davis' policy cycle as the framework for policy development at the NBSA in 2004 as a result of the influence inherent in my current role. All policies are now developed using this framework.

The findings will be provided to the NBSA and presented to Board members. Policy analysis will be undertaken using the findings of this study in the review of all policies

and procedures for the assessment of overseas-qualified nurses. The findings will also be provided to the Department of Health who are involved in the recruitment of overseas-qualified nurses and employers in the private health care sector. Education providers will be provided with the findings especially those involved in offering migrant bridging programs or competence assessment.

The 'Overseas Qualifications Reference Group' (OQRG) is a reference group to the Government of South Australian and is responsible for identifying barriers to the recognition of skills and qualifications gained overseas, inquiring into and analysis of issues identified and developing innovative solutions to overcome these barriers. The OQRG also provides advice to the 'Training and Skills Commission' and will be provided a report of the findings. The 'Medical Board of South Australia' and the 'Teachers Board of South Australia' will be provided with the findings with the aim of collaborating in research in the future on competence and English language assessment.

National dissemination of findings

The findings will be provided to the ANMC and all NMRAs in Australia and the New Zealand. Nursing and Midwifery Councils. As a member of the ANMC Collaborative Advisory Panel I have and continue to encourage the ANMC to use a policy framework when developing criteria for assessment of overseas-qualified nurses. Meetings will be organised with the Department of Immigration and Multicultural and Indigenous Affairs to discuss the current process for assessment leading to migration for overseas-qualified nurses.

Presenting the findings to managing groups of IELTS and OET to discuss testing in the clinical setting as to the efficacy of the IELTS and OET for health professionals. is paramount in encouraging debate on the language test used.

Information was provided orally to the Australian Health Workforce Productivity Commission prior to the presentation of the position paper in September 2005. The findings will be provided to the Commission. Discussion has been pursued with a provider of e-learning packages on the development of a learning package for health professionals from other countries.

This package will be available online and in the native language of the overseas applicant. The content will be on the Australian healthcare system and expectations of health professionals within that system. Funding is currently being sought to develop the package.

International dissemination of findings

Initially submission for publication of a paper on the findings in an international refereed journal will be a priority. Also submission of papers for presentation at the next International Council of Nursing Conference in Japan in 2007 and the next Western Pacific and South East Asian Region Conference.

Finally to be involved in the future research as suggested below is a vital step in ensuring these research findings do not sit frozen in time.

Future Research

The literature review revealed a lack of research on the policies pertaining to the assessment of overseas-qualified nurses. This study highlights the fact that the process of how nurses are assessed to meet the requirements for registration in another country is an unexplored area in the nursing research schema. Consequently, the following recommendations are made for future research in this area:

- As there is limited data available on the range of assessment policies and processes used by nurse regulatory authorities globally, research by the International Council of Nurses to determine this range with a view to determining generic policies and processes would be beneficial given the current and possible future trade agreements between countries.

- A comparative analysis of nurse regulatory authority's policies with other health professional regulatory authority's policies on the assessment of overseas-qualified professionals is conducted to determine whether there are different methods to determine competence to practice.

- Research on the language level of native speaking nurses to determine what the benchmark should be for overseas-qualified nurses to practice.

- A determination of the language proficiency of nurses and other health professionals once in the workplace who have completed language tests such as the IELTS and OET.

- Research on the entry and exit competence of overseas-qualified nurses completing bridging programs or competence assessment programs. This would determine whether nurses who were incorrectly assessed on paper as being incompetent in fact were not.

- Equally a study into the competence of nurses who have been assessed as eligible to practice in a country without undertaking a bridging program or competence assessment prior to obtaining registration would be of interest, in determining whether in fact they were competent to practice.

Conclusion

The aim of this study was to critically analyse policy development and policies for assessing overseas-qualified nurses in Australia and from selected overseas countries. The aim was underpinned by a belief that polices and processes used to assess overseas-qualified nurses were not evidence-based but rather were based purely on experiential knowledge and adhoc decisions by NMRA staff.

In order to determine whether this was in fact the case, policy development and policies from Australia and overseas were collected and analysed using Bridgman and Davis' (2000) policy cycle. The data and subsequent analysis indicated that policy was developed in an adhoc manner with no NMRAs meeting the minimum requirements of a policy cycle. The most profound finding was the lack of evaluation of the policies developed by all participants in the study. This was significant as evaluation is a means of determining whether the objectives (nurses are competent to practice) of the policy were in fact being met. For overseas-qualified nurses, decisions are being made by NMRAs that may or may not necessarily reflect whether a nurse is competent to practice. In other words there are many assumptions made, based on the experience of persons who have completed assessments of overseas-qualified nurses as to the predictability of a nurses ability to practice in a different country.

The concern with using this method is that this approach could admit or equally exclude nurses that may or may not be competent to practice. Given the public, government and professions expectations, evidenced-based policies and procedures need to be developed. The utilisation of a policy framework is recommended as a means of using a systematic approach to policy development.

Further research is suggested on a national and international basis to determine the most effective method for assessing a nurse's ability to practice in another country. Other health professionals could be part of this research, which determines competence to practice, as it appears that the principles of assessment would be the same across other professions. Any future policies regarding overseas-qualified nurses need to be evidenced-based, fair, consistent and transparent for all nurses applying to have their qualifications assessed.

APPENDIX 1: ETHICS APPROVAL

ROYAL ADELAIDE HOSPITAL
Medical Administration & Services

8222 4139

1 August 2001

Level 3,
Margaret Graham Building
TELEPHONE
(08) 8222 5345
FACSIMILE
(08) 8222 5936
WEBSITE
http://www.rah.sa.gov.au

Ms D J Wickett
DEPT OF CLINICAL NURSING
ROYAL ADELAIDE HOSPITAL

Dear Ms Wickett,

Re: "A critical analysis of the assessment process involving overseas qualified nurses."
RAH Protocol No: 010801

I am writing to advise that ethical approval has been given to the above project. Please note that the approval is ethical only, and does not imply an approval for funding of the project.

Human Ethics Committee deliberations are guided by the Declaration of Helsinki and N.H. and M.R.C. Guidelines on Human Experimentation. Copies of these can be forwarded at your request.

Adequate record-keeping is important and you should retain <u>at least</u> the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them if necessary, in the future. The Committee will seek a progress report on this project at regular intervals and would like a brief report upon its conclusion.

If the results of your project are to be published, an appropriate acknowledgment of the Hospital should be contained in the article.

Yours sincerely,

Dr M James
Chairman
RESEARCH ETHICS COMMITTEE

ROYAL ADELAIDE HOSPITAL · NORTH TERRACE, ADELAIDE, SOUTH AUSTRALIA 5000
TELEPHONE +61 8 8222 4000 · FACSIMILE +61 8 8222 5170 · ABN 80 230 154 545
www.rah.sa.gov.au

APPENDIX 2:   LETTER TO PARTICIPANTS

4 October 2001

Australian Nursing Council Inc
Ms
Chief Executive Officer
PO Box 873
Dickson ACT 2602

Dear Ms

Re: Assessment of overseas-qualified nurses

I am currently a student undertaking a PhD at Adelaide University in Australia. The title of my research is, a "Critical Analysis of the Assessment Process of Overseas Qualified Nurses'. The following aims are the basis for the research in this area:

To critically analyse qualification assessment of overseas qualified nurses in Australia and overseas.

To assess the significance of English language assessment of nurses qualified in a country where English is the second language.

To compare the Australian assessment process of overseas qualified nurses with that of other countries.

To develop a model for assessment of overseas qualified nurses that will have worldwide significance.

A range of eight countries has been selected for the comparative analysis. These countries include the United Kingdom, Sweden, the United States, Canada, the Philippines, Hong Kong, Saudi Arabia and Australia. The comparative analysis will consist of:

1. Analysing each country's policies and procedures on assessment of overseas-qualified nurses.
2. Face-to-face interviews with persons responsible for assessment of overseas-qualified nurses to further explore the processes involved in qualification assessment.
3. Collection of some demographic data relating to the number of nurses assessed per year from overseas.

I therefore seek permission to obtain your organizations policies and procedures on the assessment of overseas-qualified nurses and to conduct an interview with appropriate staff at a time to be negotiated.

Your willingness to participate in this valuable study is greatly appreciated. Should you require any further information please do not hesitate in contacting either my supervisor, or myself Dr Helen McCutcheon at the address indicated on this letter.

Yours sincerely

Diane Wickett
PhD Student
Adelaide University

APPENDIX 3:   INTERVIEW QUESTIONS

INTERVIEW QUESTIONS – NURSE REGULATORY BODIES

Personal information - What is your name and position in the organisation?

How are you involved in the assessment of overseas/foreign-qualified nurses?

How many overseas/foreign-qualified nurses are assessed by your organisation per year?

From which countries are these nurses from?

What does the term policy mean to you?

Could you give me an overview of the policies relating to assessment of overseas/foreign-qualified nurses?

What is the process for policy development relating to the assessment process?

Who is involved in the process?

What are the policies relating to language requirements?

What are the policies outlining how qualifications are assessed i.e. equivalence or comparability?

What memorandums of understandings or mutual recognition do you have with other countries?

If so, how were policies developed in relation to the memorandums or mutual recognition?

What research have you conducted on whether assessment of nurses qualifications are accurate i.e. are any nurses from overseas reported for incompetence?

How often are policies relating to the assessment process reviewed?

Under what circumstances would you consider accepting any other countries registration of a nurse without any further assessment?

In an ideal world, what would you like to see happen to make the global movement of nurses transparent and easy?

Are there costs involved for applicants to have their qualifications assessed?

What is the timeframe for an application to be processed?

Would you be willing to supply me with a copy of your policies and processes on qualification assessment?

Would you also be willing to participate in a further telephone interview to clarify any issues relating to the assessment policies and processes?

Is there any further information you'd like to share with me?

APPENDIX 4: INDIVIDUAL THEMATIC CHART

(10)

Thematic framework	Source	Indexes
Identify Issues 1. How was the issue of qualification assessment for overseas-qualified nurses identified and by whom? 2. Who was responsible for identifying the need for a policy to be developed?	**Registration Policy** **Registration Policy**	The policies stated in this document are derived from the *Nursing Act 1992*, the *Nursing By-Law 1993* and from mutual recognition principles. In addition, consideration has been given to the provisions of other relevant legislation. **Registration Policy Part 1 Identification of Relevant legislation 2. p 1** As a regulatory authority, the Council has a mandate to ensure, as far as possible, that all individuals authorised to practise nursing are safe and competent to do so. To this end, as part of its multiple functions, the Council is responsible for the initial and ongoing licensure of nurses and the maintenance of a Register and a Roll. Council recognises that in undertaking this function it must establish an appropriate balance between the legislative requirement to protect the public from unsafe and incompetent care and the provision of a client service to applicants seeking an authorisation to practise nursing. **Registration Policy Part 1. Philosophy p 1**

Thematic framework	Source	Indexes
3. How was the need for a policy on qualification assessment bought to the attention of the regulatory authority?	**Registration Policy**	The Registration Committee of the Council is established to consider matters relevant to nurse registration and to make appropriate recommendations to Council. The Terms of Reference and membership of the Committee are set out in *Appendix B*. **Registration Policy Part 1. Registration Committee p 1**
Policy Analysis 1. What research was conducted to identify the appropriate policy instrument for qualification assessment?	**Interview**	No. Not really. We have got some stuff from the ANC. We have not done any. **P: 13 L 14**
2. Was research conducted to determine whether nurses who had previously been assessed as competent to practice were in fact competent to practice?	**Interview**	The only thing that we have done is sent some people to Papua New Guinea to see what was happening there because we have a few nurses here. As far as I can think we have not really done any. **P: 13 L 14-17**

Thematic framework	Source	Indexes
3. Were industry asked to give feedback on the assessment process and the outcomes of assessment?	**Interview**	Not apparent.
4. How were the current policies developed and by whom and when were they last reviewed?	**Interview**	Yes, it could be generated from a variety of sources, but it would usually come to me to put a briefing paper up to the committee (registration) than they would make a recommendation to the council. P: 8 L 10-12 It had a minor review annually that's mainly, to make sure its' quite frequently amended annual review is to make sure amendments have been applied consistently across the whole policy and to look at any major things that may need to be changed but I think the plan is five years and major review. P: 14 L 1-4
5. What were the costs of the assessment process to both regulatory authorities and overseas-qualified nurses?	**Interview**	The challenge test the theoretical part is $169, the clinical they can do in a real environment or a simulated environment and I think the whole thing costs between $350- $400. The educational modules they are $800.I don't know the costs of the course I just know it is very expensive for overseas nurses. **P: 12 L 21-23**

Thematic framework	Source	Indexes
Policy Instruments 1. What were the policy instruments	**Interview**	We look at their transcript which is all they can mostly all they can provide us we look at the content , we do compare it with something from … at the time and we don't have a document of a course that's where we use the knowledge of the person from the university , um we look at things like the number of hours we use that as a guide um we also use as a guide the age of the person, when they commenced the course, for example people from Bosnia do a course which is actually a four course, but a secondary vocational course it is not a pre registration course, so I can give you, It's in our registration policy which is on the web that our committee use to make decision . I have to say in relation to that sometimes I feel that the decision was made that the person can proceed but we always have the backstop that we are going to require them to demonstrate competence anyway. **P: 10 L 1-12.**
2. Were they a paper-based assessment or a written exam both for determining competence in English language and skills?	**Interview**	As above IELTS overall score 7, OET B pass Waived if undertaken at Australian University on campus degree in past 2 years. Completes post grad course at Australian university on campus not less than 1 semester FTE In special circumstances. **Policy November 2002**

Thematic framework	Source	Indexes
3. Who determined which policy instrument was to be used and how often was this instrument reviewed?	**Registration Policy**	The Registration Committee of the Council is established to consider matters relevant to nurse registration and to make appropriate recommendations to Council. Policy: Registration committee p1 This Policy, its Appendices and associated Information and Procedures Manuals will be subject to continuing review and enhancement. Processes will be in place to ensure that the Policy reflects at all times, decisions made by the Registrations Committee and Council. Amendments may be proposed by staff or by the Registrations Committee. Proposed amendments will be discussed in a consultative process and forwarded to the Registrations Committee for recommendation to Council. All amendments will be made through a formal change process which will include advice to all relevant staff. A full review and evaluation of the policy will take place annually and will include consultation with staff and clients. Responsibility for the maintenance of this Policy and associated documents lies with the Registrations Manager. Policy : Review and Evaluation of policy p 40
4. How was the policy instrument developed?	**Interview**	It could be generated from a variety of sources, but it would usually come to me to put a briefing paper up to the committee than they would make a recommendation to the council. **P: 8 L 10-12**

Thematic framework	Source	Indexes
5. Did the policy instrument acknowledge a nurse's experience and continuing education?	**Interview**	But under our act we have to base our recommendations on pre registration course that the person has done , and we can't consider post registration experience or qualifications. **P: 2 L 21-23**
6. What were the underlying assumptions in the policy process?	**Interview**	That competence to practice could be demonstrated by a nurses based on a paper based assessment of undergraduate academic transcript no consideration is given to post grad experience or education.
7. Were there memorandums of understanding with any other countries in relation to mutual recognition of qualifications?	**Interview**	I know that some years ago there was some talk about that and I know J took or was going to take it to the ICN conference but nothing ever came of that. **P: 5 L 10-12**

Thematic framework	Source	Indexes
Consultation		
1. Who had been consulted in the policy development process?	**Registration Policy**	The Registration Committee: Two Council members, one of whom will be Chairperson, Three nurses, one of whom may be an enrolled nurse, Director, Nursing Program Registration Manager (Convenor),Executive Officer of Council or a delegated nominee Registration Officer, Chairperson of the Council (ex officio member). Registration Committee: Appendix B
2. Had all stakeholders been identified and included in the policy cycle?		Only members of Registration Committee others not apparent.
3. Were industry and overseas-qualified nurses considered as stakeholders?		Not apparent.
4. Has feedback from consultation been incorporated into policy advice?		Not apparent.

Thematic framework	Source	Indexes
Coordination 1. Who was responsible for coordinating the policy cycle?	**Interview**	It would usually come to me to put a briefing paper up to the committee than they would make recommendation to the council. **P: 8 L 10-12**
2. Who was accountable for the policy outcomes?	**Interview**	The Council, by virtue of the legislation.
3. Who was responsible for the administrative and financial outcomes of the policy?	**Interview**	My position is that I am responsible for everything that happens in the registration area. **P: 1 L 12-13**
4. Was the policy applied consistently and equitably?	**Registration Policy**	Assessment of applications and all other decisions made by Council staff will reflect qualities of consistency and equity and be clearly derived from the legislation and policy. The principles of natural justice will be applied to all decisions. These require that a person be given an adequate opportunity of presenting their case and that the body making decisions on the matter will be unbiased. Clients will be advised of decisions promptly and an explanation of the decision will be provided. **Rights and Responsibility of Clients: Decision Making. p3**

Thematic framework	Source	Indexes
Decision		
1. Who authorised the policy for assessment of an overseas nurses qualification?	**Registration Policy**	The Council.
2. Who was involved in the decision process?	**Registration Policy**	The registration Committee and the Council. **Policy: Registration committee p1**
3. How did the policy relate to the regulatory authorities legislation?	**Registration Policy**	This policy is developed in the context of the following standards which are derived from Section54, *Nursing Act 1992* and from the Council's Client Services and Communications Standards: **Preliminary: Standards and Criteria p 1**

Thematic framework	Source	Indexes
Implementation		
1 Who was responsible for implementation of the policy?	**Interview**	My position is that I am responsible for everything that happens in the registration area. **P: 1 L 12-13**
2 Was the assigned agency the most appropriate to implement the policy?	**Registration Policy**	As a regulatory authority, the Council has a mandate to ensure, as far as possible, that all individuals authorised to practise nursing are safe and competent to do so. To this end, as part of its multiple functions, the Council is responsible for the initial and ongoing licensure of nurses and the maintenance of a Register and a Roll. **Preliminary: Philosophy p1**
3 What resources were identified as necessary for implementation of the policy?	**Interview**	Until 18 months ago I was responsible for actually assessing or processing the overseas applications and that involves you know looking at the documents that we need. Whether there is any particular policy on applications from that country forwarding to the registration working party for the actual assessment. Advising the working party and the registrations committee on applications. Discussing applications with the actual nurses. Really involved in the whole process. About 18 months ago we created a new position here particularly to deal with overseas applicants and re-entry people and so on. So now my role is I am still a member of the working party and I am actually convenor of it. And I am also convenor of the registration committee. So what happens is the working party makes recommendations to the registrations committee. **P: 1 L 13-23**

Thematic framework	Source	Indexes
4 How will the polices effect be communicated to staff and clients?	**Website**	Registration Policy available on website. **Accessed : 23 /06/03**
5 Was the policy enforceable ?	**Registration Policy**	This policy is developed in the context of the following standards which are derived from Section 54, *Nursing Act 1992* and from the Council's *Client Services and Communications Standards:* **Preliminary: Standards and Criteria p1**
6 Has an evaluation strategy been included in the implementation plan?	**Registration Policy**	Yes. This Policy, its Appendices and associated Information and Procedures Manuals will be subject to continuing review and enhancement. Processes will be in place to ensure that the Policy reflects at all times, decisions made by the Registrations Committee and Council. Amendments may be proposed by staff or by the Registrations Committee. Proposed amendments will be discussed in a consultative process and forwarded to the Registrations Committee for recommendation to Council. All amendments will be made through a formal change process, which will include advice to all relevant staff. A full review and evaluation of the policy will take place annually and will include consultation with staff and clients. Responsibility for the maintenance of this Policy and associated documents lies with the Registrations Manager. **Policy : Review and Evaluation of policy p 40**

Thematic framework	Source	Indexes
Evaluation		
1 How was the policy evaluated?		Not apparent.
2 Were all stakeholders involved in the evaluation process?		Not apparent.
3 How often was policy evaluated?	**Registration Policy**	A full review and evaluation of the policy will take place annually and will include consultation with staff and clients. Responsibility for the maintenance of this Policy and associated documents lies with the Registrations Manager. **Policy: Review and Evaluation of policy p 40**
4 Was the performance of the policy monitored?		Not apparent.
5 Have performance indicators been developed?		Not apparent.
6 Was research conducted on outcomes of the assessment process as part of the evaluation process?	**Interview**	No not really. We have got some stuff from the ANC. We have not done any. The only thing that we have done is sent some people to Papua New Guinea to see what was happening there because we have a few nurses here. As far as I can think we have not really done any. **P: 13 L 14-17**

APPENDIX 5:   COLLATED THEMATIC CHART

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
1	Yes	Yes	Policy analyst identifies issue defines problem identified by the legislation.	Policies developed by policy analyst. No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript National exam. No acknowledgement of a nurses post-registration experience **Language** TOFEL MELAB IELTS	Consultation not apparent outside of board.
2	No	No	Unable to obtain information.	Unable to obtain information.	**Competence** Initial comparable assessment of academic transcript. National exam. **Language** IELTS overall 6.5	Unable to obtain information.

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
3	No	No	The Board identify issue from legislation	No policy.	No policy.	No policy.
4	No	No	Manager of assessments Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post registration experience. **Language** • OET B pass • IELTS overall 7	No consultation apparent outside of Board and ANC.
5	No	No	Manager of assessments Registration committee Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post registration experience.	No consultation apparent outside of Board, Board Committees.

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
					Language • OET B pass • IELTS overall 7	
6	Yes	No	Manager of assessments Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post-registration experience. **Language** • OET B pass • IELTS overall 7 (*Nurses Act - ACT* 1988)	No consultation apparent outside of Board, Board Committees and ANC .

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
7	Yes	No	Nursing officers Registration committee Legislation	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgment of a nurses post registration experience. **Language** • OET B pass • IELTS overall 7 • ISLPR Level +3	No consultation apparent outside of Board, Board committees and ANC.
8	Yes	Yes	Manager of assessments Standards Committee Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post - registration experience.	No consultation apparent outside of Board, Board committees and ANC.

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
					Language • OET B pass IELTS overall 7	
9	Yes	Yes	Department of immigration CAP Manager of assessments	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post-registration experience. **Language** • OET B pass IELTS overall 7	Consultation with regulatory authorities.
10	Yes	Yes on website	Manager of assessments Standards Committee Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript.	No consultation apparent outside of Board, Board committees and ANC.

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
					No acknowledgement of a nurses post-registration experience. **Language** • OET B pass IELTS overall 7	
11	Yes	No	Any staff member of Board Standards Committee Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post - registration experience. **Language** • OET B pass IELTS overall 7	No consultation apparent outside of Board, Board committees and ANC.

Organisation	Policy	Accessible	Identify issues	Policy analysis	Policy instrument/s	Consultation
12	Yes	Yes on Website	Manager of assessments Standards/Policy Committee Identified by legislation ANC	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post-registration experience. **Language** • OET B pass IELTS overall 7	No consultation apparent outside of Board, Board committees and ANC.
13	Yes	No	Licensing analyst Education consultant Identified by legislation	No formal research conducted. Anecdotal evidence and experience of staff used for analysis.	**Competence** Initial comparable assessment of academic transcript. No acknowledgement of a nurses post - registration experience. National exam **Language** TOFEL	Consultation with National Board who develop exam. No other apparent consultation outside of Board.

Organisation	Coordination	Decision	Implementation	Evaluation
1	• Policy analysts	• Registration Committee delegated via Board from Nurses Act	• Registration department consisting of administrators and nurses • Policy is consistent as all nurses have a paper based assessment and sit exam	• Policy reviewed on an adhoc basis • Policy not evaluated at this stage
2	• Director of Policy and Standards	• The Council	• Registration department consisting of administrators and nurses • Policy varies depending on whether English is the nurses first language they may be required to undertake a bridging program (countries of the EU are exempt)	• Policy not evaluated at this stage
3	• No policy	• N/A	• N/A	• N/A
4	• Policy research officer	• The Board	• Assessments undertaken by ANC • Endorsed by policy research officer	• Policy reviewed on an adhoc basis • Policy not evaluated at this stage

Organisation	Coordination	Decision	Implementation	Evaluation
			• Policy varies depending on whether English is the nurses first language they may be required to undertake a bridging program	
5	• Manager Registration	• The Board	• Assessments undertaken by registration staff (non nurses) • Complex cases are referred to nursing officer • Policy varies depending on whether English is the nurses first language they may be required to undertake a bridging program	• Policy reviewed on an adhoc basis • Policy not evaluated at this stage
6	• Nurse advisor education and registration	• The Board	• Assessments undertaken by Registration coordinator and customer service officers (non nurses) • Complex cases are referred to nursing officer	• Policies reviewed yearly or as necessary • Policy not evaluated at this stage

Organisation	Coordination	Decision	Implementation	Evaluation
			• Policy varies depending on whether English is the nurses first language they may be required to undertake a bridging program	
7	• Executive Director	• The Board	• Administrative Staff and nursing officers process applications • Complex cases are referred to Executive director • Policy varies depending on whether English is the nurses first language they may be required to undertake a bridging program	• Policies reviewed on a regular basis • Policy not evaluated at this stage
8	• The Senior nursing Advisor	• The Board	• The Senior Nursing officer • Policy varies depending on whether English is the nurses first language are required to undertake a bridging program	• Policies reviewed every 3 years or as necessary • Policy not evaluated at this stage

Organisation	Coordination	Decision	Implementation	Evaluation
9	• Overseas assessment manager	• The Council by unanimous decision from the regulatory authorities	• Overseas assessment manager • Policy varies depending on whether English is the nurses first language they may be recommended to undertake a bridging program	• Policies reviewed every 1-2 years or as necessary • Policy not evaluated at this stage
10	• Registrations Manager	• The Council	• Applications processed by administrative staff • Endorsed by Registration committee • Policy varies depending on whether English is the nurses first language are required to undertake a bridging program	• Minor review annually, major review 5 yearly or as necessary • Policy not evaluated at this stage
11	• Manager Registration and practice standards	• The Board	• Registration staff process applications • Complex cases are referred to nursing officer • Policy varies depending on whether English is the nurses first language are required to undertake a bridging program	• Policies reviewed every 2 years or as necessary • Policy not evaluated at this stage

Organisation	Coordination	Decision	Implementation	Evaluation
12	• Business Manager	• The Board	• Deputy registrar assesses all applications • Policy varies depending on whether English is the nurses first language are required to undertake a bridging program	• Policies reviewed 2 yearly or as necessary • Policy not evaluated at this stage
13	• Executive Officer	• The Board	• Registration department consisting of administrators and nurses • Policy is consistent as all nurses have a paper based assessment and sit exam	• Policy reviewed on an adhoc basis • Policy not evaluated at this stage

APPENDIX 6:   ANCI STANDARDS AND CRITERIA

ANC

AUSTRALIAN NURSING COUNCIL INC

AUSTRALIAN NURSING COUNCIL INC.

ANCI STANDARDS AND CRITERIA FOR THE

ASSESSMENT OF THE QUALIFICATIONS

OF OVERSEAS-EDUCATED NURSES AND MIDWIVES.

February 2002

Australian Nursing Council Inc (2002)
ANCI Guidelines for the assessment of the qualifications of overseas-educated nurses
and midwives

**APPENDIX 7: ANC COMPETENCY BASED ASSESSMENT PROGRAMS
FOR OVERSEAS NURSES**

ANC
**Australian Nursing Council
A.R.B.N. 061 504 407, Incorporated in the ACT,
Limited Liability**

MIGRANT BRIDGING PROGRAMS / COMPETENCY BASED ASSESSMENT PROGRAMS / PRE-REGISTRATION PROGRAMS FOR OVERSEAS NURSES

November 2002

Australian Nursing Council Inc (2002)
Migrant bridging programs/competency based assessment programs/pre-registration
programs for overseas nurses.

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