Chapter 3

Obtaining a Nursing Job in Australia and New Zealand: A Case Study of Migrant Nurses Trained in India

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July 2023

This chapter should be cited as
Tsujita, Y., H. Oda and S.I. Rajan (2023), 'Obtaining a Nursing Job in Australia and New Zealand: A Case Study of Migrant Nurses Trained in India', in Tsujita, Y. and T. Kato (eds.), *Human Resource Development, Employment, and International Migration of Nurses and Caregivers in Asia and the Pacific Region*. ERIA Research Project Report FY2023 No. 07, Jakarta: ERIA, pp.47-69.

Chapter 3
Obtaining a Nursing Job in Australia and New Zealand: A Case Study of Migrant Nurses Trained in India

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Many developed countries face a shortage of nurses and open their labour markets to foreign-trained nurses, adopting different recruitment methods. The literature mainly discussed the recruitment of foreign-trained nurses from the nurse-receiving country's point of view and paid little attention to that of the recruited. This chapter demonstrates how foreign-trained nurses, focusing on India-trained migrant nurses, obtain nursing jobs in Australia and New Zealand, and some issues and problems from migrant nurses' point of view, based on semi-structured interviews.

In both countries, the percentage of foreign-trained nurses is on the rise because of the shortage of nursing professionals, and the growing ageing population. To migrate to Australia or New Zealand and practice nursing, foreign nurses must be registered with the countries' nursing boards. Registration is required to complete a nursing board–approved bridging programme for those who study nursing in most Asian countries, including India.

From the Indian nurses' point of view, application and assessment are more complicated in Australia than in New Zealand. Both countries have changed their assessment and immigration systems, which is mainly why foreign-trained nurses rely on recruitment agents, raising the cost of migration. Nurse-sending families are well-off. It is a household strategy to send a nurse to Australia and New Zealand. Once the sampled nurses were registered, they sent for their families. Marrying a man off to a migrating nurse is a strategy for the man's family to have access to developed countries. But finding a reasonably good job for the spouse is not easy, particularly in New Zealand.

The overwhelming majority of the sampled nurses chose New Zealand because their English scores met its requirements. Some foreign-trained nurses regard New Zealand as a steppingstone to Australia. The Trans-Tasman Mutual Recognition Agreement is a double-edged sword. Through it, New Zealand attracts those who would like to go to Australia, and they might leave for Australia after some time. Some policy implications are discussed based on our findings.

[1] We would like to thank Dr Dharmalingham Arnachalam, Dr Allegra Schermuly, and Dr Priya Mohan for their collaboration in our research. We are also grateful to Ms Shizuka Ishida for her excellent research assistance. Any errors remain solely our responsibility.

1. Introduction

Many developed countries face a shortage of nurses because of the ageing population, growing demand for better health services, the shift of family or home care to institutional care, the turnover and ageing of local nurses, and the promotion of medical tourism, amongst other reasons. Most developed countries open their labour markets to foreign-trained nurses to fill such shortages. On average, 14.5% of the nursing workforce was born abroad in Organisation for Economic Co-operation Development (OECD) member countries (OECD, 2015). International migration has accelerated through a wide range of recruitment methods.

Traditionally, those who have an overseas nursing qualification are often required to be assessed by the authority in the destination country (Kingma, 2006). One assessment method is taking the licensing or qualification exam in the destination country. The method is still valid but some countries hold exams in another country. For example, the United States (US) National Council of State Boards of Nursing registered nurses exam can be taken outside the US, including in Hong Kong, India, Japan, the Philippines, and Taiwan. The other method is the conduct of a series of assessments by the nursing authority and/or nursing authority–accredited institutions in some nurse-receiving countries. Some nurses are easily recognised as a registered nurse in the destination country based on their qualifications in the place of origin, but others are required to take training courses, so-called bridge courses, to register as a nurse.

Besides the traditional assessment methods, nurses are recruited through a multinational, regional, or bilateral trade agreement. Free trade agreements increasingly include labour-related clauses (Yeats and Pillinger, 2019). Mutual recognition agreements (MRAs) allow qualified nurses to practice in other countries through mutual recognition of their qualifications. MRAs, however, do not mean automatic recognition by all states joining such MRAs, and the practical application of MRAs varies from one state to another. The Caribbean Community (CARICOM) has unified the nursing education curriculum and qualifications. Thus, nurses in CARICOM countries may work in any participating country without additional qualifications or assessments. The Trans-Tasman MRA of 1997 enables Australian nurses to work in New Zealand and vice versa, although they do not have the same nursing curriculum and have separate registration systems. The Association of Southeast Asian Nations (ASEAN) MRA on nursing services, which was signed and came into force in December 2012, has facilitated nurses' mobility to only a few countries. Trade agreements may include a clause on mobility of people, allowing preferential access to one country (or more than one country) for some nationals. For example, Japan's economic partnership agreements allow Japan-qualified nurses and care workers from the Philippines, Indonesia, and Viet Nam to practice in Japan and work and reside there without limitation. Under the Triple Win project, Germany employs nurses from Serbia, Bosnia and Herzegovina, the Philippines, Indian state of Kerala, Tunisia, Indonesia and Jordan through employment agencies. Many nurse-receiving countries adopt different recruitment methods for foreign-trained nurses.

The literature mainly discussed recruitment of nurses from the point of view of nurse-receiving countries and not the recruited. This chapter demonstrates how foreign-trained nurses, with a focus on India-trained migrant nurses, get nursing jobs in Australia and New Zealand. It shows

some issues and problems from migrant nurses' point of view, based on semi-structured interviews. The proportion of foreign-trained nurses in the nurse workforce is high: 18.4% in Australia and 26.4% in New Zealand (Organisation for Economic Co-operation and Development), which employ assessment systems.

Indian migrant nurses are defined as registered nurses in Australia or New Zealand, who were born in India, studied nursing there, and had or have a nursing license there. We conducted semi-structured interviews with India-trained migrant nurses from September 2019 to March 2020. The questions included personal background, educational experience, clinical experience in India, job history, migration to Australia or New Zealand, the process of becoming a registered nurse, current problems faced in the destination country, and so on. We employed the snowball sampling method because we lacked access to nursing registrars in both countries. The survey had 14 participants in Melbourne, Australia, and 13 in Christchurch, New Zealand, all female. They were usually interviewed at home, in English, for about 60 minutes on average. The interviews were audio-recorded and transcribed. This chapter focuses on registered nurses, although nurses in both countries include registered nurses, enrolled nurses, and nursing practitioners. The description in this chapter is confined to the period prior to the COVID-19 pandemic.

2. Australia

2.1. Overview of Nurse Migration to Australia

Australia has been a major destination country for migrants such as nurses because of its relatively open immigration policy, moderate climate, and better working environment. Demand is rising for skilled workers. Like other developed countries, Australia has a shortage of nurses, particularly in critical care, midwifery, aged care, and mental health. Health Workforce Australia (HWA) (2014) projected a shortfall of 85,000 registered and enrolled nurses by 2025, estimated to increase to 123,000 by 2030. Migrant nurses from overseas have been important in filling the shortage.

OECD reports statistics on health professionals in its member countries, including foreign-trained nurses in destination countries. Caution is necessary in interpreting the figures, as there are two categories of foreign-trained nurses: foreign-trained foreign-born nurses, and foreign-trained native-born nurses.[2] Except in a few countries such as Israel and Norway, foreign-trained native-born nurses are far fewer than foreign-trained foreign-born nurses. In this chapter, for simplicity, all foreign-trained nurses are considered trained and born abroad. As of 2017, Australia had 52,860 foreign nurses. Amongst 21 OECD countries, Australia has the third-largest population of foreign nurses after the United Kingdom (UK) (103,671) and Germany (71,000) (OECD). The proportion of foreign nurses in Australia was 14.5% in 2007, increasing to 18.4% in 2017, the

[2] Some nurses were born abroad and trained in the receiving country. They are not categorised as foreign trained.

third largest amongst OECD countries after New Zealand (26.0%) and Switzerland (25.9%).

In 2017, nurses from the UK formed the largest group of foreign nurses in Australia (14,370, 27.2%), followed by nurses from India (10,052, 19.0%) and the Philippines (7,835, 14.8%) (Table 3.1). New Zealand has provided a stable source of nurses for Australia. Whilst the population of UK-trained nurses is the largest, it has generally remained constant. However, the numbers of Indian and Filipino nurses are quickly increasing. From 2013 to 2017, Indian nurses increased by more than 60% and Filipinos by close to 70%. The trend seems to be continuing.

Table 3.1: Stock Foreign-trained Nurses in Australia

Year	2007	2008	2009	2013	2014	2015	2016	2017
Country of origin								
Canada	..	..	..	452	514	502	530	539
China	..	..	..	1063	1228	1283	1328	1397
India	..	..	..	6237	7713	8468	9169	10052
Ireland	..	..	..	1847	2039	2090	2088	2108
Malaysia	..	..	..	200	202	177	177	183
New Zealand	5248	5691	5834	6404	6491	6398	6915	6847
Philippines	..	..	..	4628	5734	6235	6941	7835
South Africa	..	..	..	1725	1879	1884	1871	1813
Sri Lanka	..	..	..	65	83	84	85	86
United Kingdom	..	..	..	14009	14916	14562	14452	14370
United States	..	..	..	459	543	515	548	547
Zimbabwe	..	..	..	1149	1276	1288	1322	1344
Others (not elsewhere classified)	32860	31958	33141	6045	5915	5640	5754	5739
Total	38108	37649	38975	44283	48533	49126	51180	52860

Data extracted on 22 Feb 2020 11:05 UTC (GMT) from OECD.Stat

Source: Organisation for Economic Co-operation and Development statistics (accessed 22 February 2020).

2.2. Factors Influencing Nurse Shortages

Multiple factors have caused the shortage of nurses in Australia. Demographic changes are a major one. First, Australia's population is ageing. The ratio of the population aged 65 and above to the total was 12.3% in 1999, increasing to 15.9% in 2018 (Australia Bureau of Statistics), and expected to grow to 22% by 2056 (Government of Australia). Second, the population was growing at 1.5% in 2019, high amongst developed countries. The country's growing ageing population demands more health professionals, including nurses.

At the same time, the nursing occupation is undergoing a demographic change. Whilst the average age of nurses marginally increased from 44.3 in 2009 to 44.6 in 2012, the ratio of aged nurses increased. The proportion of nurses aged 55 and over in Australia was 19.8% in 2009, rising to 23.1% in 2012 (HWA, 2014). This ageing trend is reported to continue and indicates the imminent retirement of experienced and skilled older nurses, which will impact not only quantity but also the overall quality of nursing professionals.

High turnover rates amongst nurses contribute to shortages. Because nursing jobs are physically and mentally demanding, high turnover is not particular to Australia, where it has been reported

at about 30% (Commonwealth of Australian, 2002).

From our interviews with nurses in Australia, we concluded that the shortage might be a consequence of Australians' way of life. Australians usually work a maximum of 40 hours per week. One reason is that they value work–life balance and health. Another is that they simply want to avoid the higher tax rate imposed on additional work hours because their net-income increase is marginal.

Rising demand for and declining supply of nurses have caused the nursing shortage.

2.3. Pathway for Foreign Nurses to Become a Registered Nurse in Australia

To mitigate the negative economic and social impacts of skilled-labour shortages, the government initiated the General Skilled Migration (GSM) Programme to expand immigration policies and improve the workforce. The GSM is a visa-issuing programme that prioritises skilled workers willing to migrate to Australia. The GSM lists 512 types of jobs as 'skilled occupations' that are in demand and includes 20 nursing and midwifery occupations such as midwife, registered nurse for aged care, and registered nurse for critical care and emergency (see the Appendix for the complete list of nursing and midwifery occupations and Australian Government (not dated) for the complete list of skilled occupations).

To apply for a skill-migration visa specified under the GSM, nurses must be registered with the Nursing and Midwifery Board of Australia (NMBA), which is the formal association of nurses and midwives in Australia. Then they must be skill-assessed by the Australian Nursing and Midwifery Accreditation Council (ANMAC), an independent body gazetted by the minister for immigration. The Australian Health Practitioner Regulation Agency (AHPRA) works with 15 national boards of health professionals to maintain quality health services and assesses registration applications from overseas nurses and midwives on behalf of the NMBA. ANMAC assesses skills of nurses migrating to Australia under the GSM programme and determines if their qualifications and experience are sufficient for permanent migration. AHPRA assesses nurses for registration and ANMAC assesses them for potential immigration.

Registering with the NMBA is the most important step in migrating to Australia. ANMAC's role is not clear. One migrant nurse from the UK we interviewed did not know that her qualifications and experience had been assessed by ANMAC after registration; she did not even know what ANMAC was. Other migrant nurses talked about their dealings with AHPRA and the NMBA for registration but almost nobody mentioned ANMAC's skills assessments. We never met nurses who had registered but failed to pass ANMAC's skills assessment. Thus, ANMAC's function in the migration procedure is not visible.

2.4. Qualified Nurses from New Zealand and English-speaking Countries

The nurse-registration procedure is not the same for everyone and depends on where the migrating nurses come from and their qualifications. There are three pathways to

registration in Australia: for nurses registered in New Zealand, nurses registered in specified English-speaking countries, and the rest.

Registration with the NMBA is simple for nurses registered with the Nursing Council of New Zealand or the Midwifery Council of New Zealand, as nurse certification between the two countries is transferrable because of the Trans-Tasman MRA. This simple procedure may encourage New Zealand–registered nurses to practice in Australia; New Zealand, therefore, has provided a stable source of nurses to Australia.

Nurses trained in five English-speaking countries—the US, the UK, Ireland, Canada, and Hong Kong—enjoy a fast track to nursing registration in Australia, although not as simple as the process for New Zealand–registered nurses. Although a more detailed skills assessment by ANMAC may be required, it is not complicated for nurses with bachelor of science (BSc) degrees from those countries to register as long as they satisfy all of AHPRA's registration standards. These are composed of four categories: criminal history, English-language skills, recency of practice, and professional indemnity insurance arrangement, since the NMBA considers nursing qualifications issued by education institutions in the five countries to be *likely* to meet the requirements for quality assurance and accreditation.[3]

2.5. Nurses from Countries Other than New Zealand and English-speaking Countries

Most nurses migrating from abroad fall into this category, including India- and Philippines-trained nurses, who are rapidly increasing their presence in Australia. Since the programme offered in educational institutes in countries other than New Zealand and the five mentioned English-speaking countries are not likely to meet the criteria set by the NMBA, nurses with a BSc in nursing and those registered as nurses in those countries follow a different path (Figure 3.1). Until the end of 2019, nurses from those countries who applied to AHPRA for registration were directed to take an NMBA-approved bridging programme to become eligible.

The bridging programmes are Initial Registration of Overseas Nurses (IRON) or Entry Program for Internationally Qualified Nurses (EPIC), depending on their location. They usually last 12–24 weeks, costing at least AUD12,000. After completing a bridging programme, a nurse is qualified for registration. Subsequently, his or her skills are assessed by ANMAC for immigration. Nurses with diplomas are not admitted to bridging programmes and must take undergraduate courses from an Australian university for 1–2 years before applying to AHPRA and bridging programmes.

A major problem facing nurses from non–English-speaking countries is their English-language skills. To apply for registration, an applicant must satisfy the registration standard, which includes

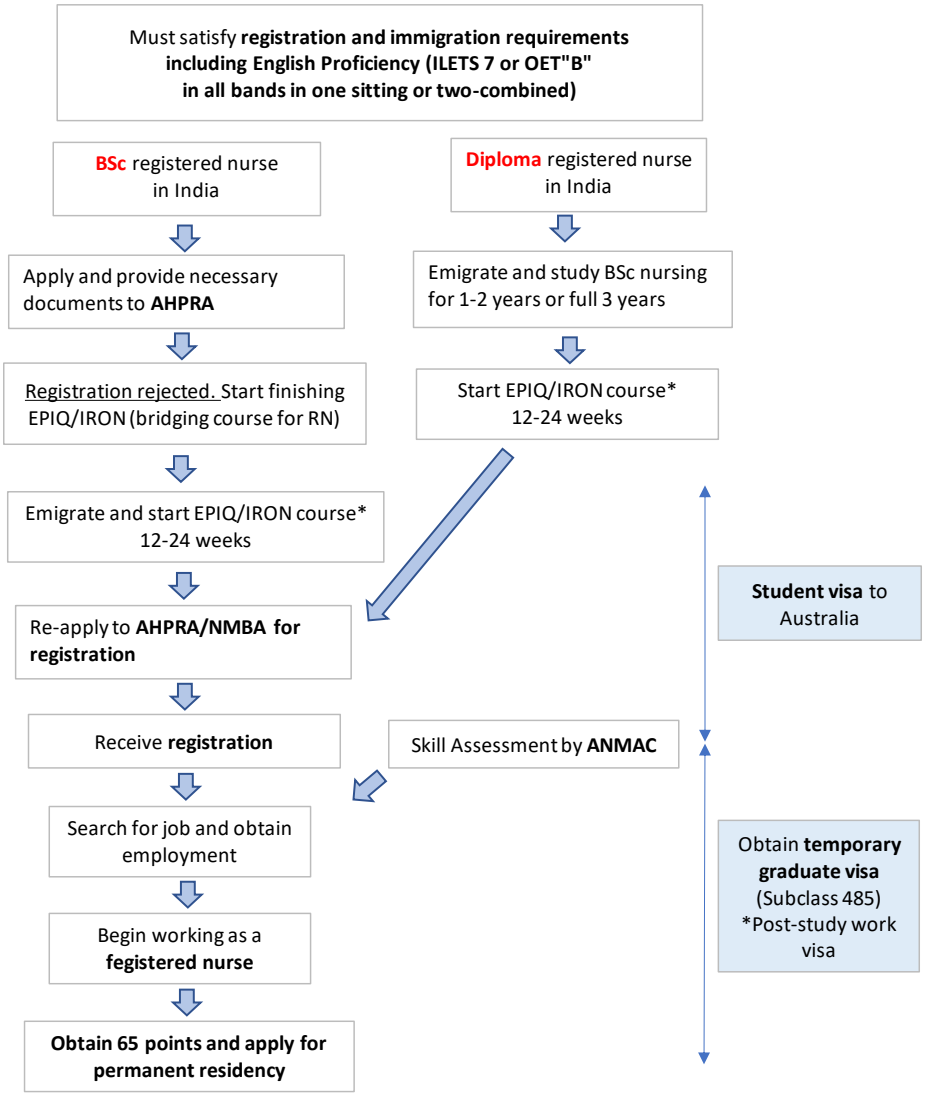
[3] The NMBA has found that nursing qualifications issued by education institutions in Belgium Flanders, Chile, Pakistan, Papua New Guinea, and Singapore *may* meet the requirements for quality assurance and accreditation.

English-language skills. The minimum level of English is at least 7.0 in all four bands (listening, reading, writing, and speaking) of IELTS or at least B in all modules of the Occupational English Test (OET). The scores have been clubbed since 2016; that is, satisfactory scores can be achieved over two test sittings. However, the minimum overall score of at least 7.0 must be maintained, both tests must be taken within 6 months of each other, and no module score must be below 6.5 across both sittings. Many Indian nurses have difficulty obtaining 7.0 in writing. Before 2016, a score of at least 7.0 in all four modules on one test was required. This strict rule discouraged foreign nurses from non–English-speaking countries from applying to Australia. They chose instead to migrate to New Zealand, which accepted clubbed scores.

Another issue is that seats for IRON and EPIC bridging programmes are limited. Bridging programmes offered in cities and convenient locations quickly fill up. Therefore, nurses must wait a long time to enrol, in addition to the waiting period during the initial application procedure to AHPRA. After registration is complete, potential migrants must wait about 2 months to receive their ANMAC skills assessments to qualify for a visa. The duration from the migrant's initial application to his or her ANMAC skills assessment could be significant.

The registration procedure has undergone major changes since mid-March 2020. It is in transition for a couple of years. Bridging programmes are being replaced by a new scheme. Those currently enrolled or those who have been accepted and are expecting to enrol, however, are on the old track to nurse registration. Details on the new scheme have not been revealed as of this writing.

Figure 3.1. Steps for Nurse Registration until the End of 2019



AHPRA = Australian Health Practitioner Regulation Authority, ANMAC = Australian Nursing and Midwifery Accreditation Council, EPIQ = Gradate Certificate in Australian Nursing, IELTS = International English Language Testing System, IRON = Initial Registration for Overseas Nurses, NMBA = Nursing and Midwifery Board of Australia, OET = Occupational English Test, RN = Registered nurse.
Source: Authors.

2.5. Characteristics of India-trained Nurses in Australia

Table 3.2 shows a brief profile of four survey participants, three from Kerala and one from Karnataka, southern India. Kerala has traditionally been a major source of nurses. In the Greater Melbourne area, about 60% of India-trained nurses migrated from Kerala and are mostly

Christian.[5] The four were registered nurses in India. Except for Nurse 3, who had completed a diploma in nursing, the nurses have a BSc in nursing. Nurse 3 had to take undergraduate courses in nursing in Australia and spent a longer period in a bridging programme to become a registered nurse. The others went through 3-month bridging courses, either in Australia or New Zealand. Nursing certifications in New Zealand are easily transferrable to Australia under the Trans-Tasman MRA.

The cost of migration is high for those who take bridging courses in Australia, about INR1.1 million or US$14,000, more than half spent on course fees. For example, the fee for an IRON course starts from AUD12,000 or US$7,500. The cost of migration is financed by nurses' own savings, a bank loan,[6] or support from the spouse's family. India-trained nurses migrating to Australia seem to have access to financial resources and are generally from well-off families.

The husbands of two nurses did not have full-time jobs; they worked part-time or as temporary workers, a situation observed amongst interviewed nurses from India living in New Zealand or the US (George, 2005). The husbands worked full-time before coming to Australia, but when their wives migrated, they followed. Typically, wives migrated first, then husbands arrived later on spouse visas after their wives completed their bridging programmes, registered as nurses, and found employment. The husbands faced difficulties finding jobs without any qualifications recognised in Australia. They worked part-time or full-time but not in the fields or jobs they enjoyed working in before coming to Australia. In some cases, they became 'househusbands', taking care of household duties and driving their children to school.

For the husbands' families, arranging marriages between their sons and migrating nurses provides them with access to a developed country. The husbands' families are happy to pay the fees for the bridging course that nurses (such as Nurse 4) must take to become registered. One study argued that the possible opportunity of overseas migration gave nurses a higher value in the marriage market (Percot and Irudaya Rajan, 2007).

[5] According to the 2016 Census, there are 3,312 nurses in the Greater Melbourne area who speak an Indian language other than English at home: Malayalam (1,919, 57.9%), Punjabi (597, 18.0%), Hindi (422, 12.7%), Tamil (218, 6.6%), and other languages (156, 4.7%).

[6] Indian banks issue loans to nurses to pay for a bridging course. Indian nurses who took out such loans said banks were willing to lend money to migrating nurses.

Table 3.2. Brief Profiles and Characteristics of Sampled Nurses

All nurses are RN

	Nurse #1	Nurse #2	Nurse #3	Nurse #4
Type of Workplace	Public hospital	Public hospital	Public hospital	Public hospital
State of origin in India	Kerala	Kerala	Karnataka	Kerala
Religion	Christian	Christian	Christian	Christian
Gender	Male	Female	Female	Female
Degree	BSc	BSc	Diploma	BSc
Marital status	Married	Married	Married	Married
Spouse's work (full/part time)	Part-time	Part-time	Full	Part-time
Previous migraiton	None	Dubai, NZ	None	None
Nurses in family	Yes	No	No	Yes
If yes above, Is s/he abroad?	Yes	No	No	n/a
Is Australia the first choice?	No (US)	No	No (parents migration)	Yes
Bridging course	Yes-3months	No (Did it in NZ)	Yes-6months/Undergrad nursing	Yes-3monts
Cost of migration	INR 1million	AUD 5000	n/a	INR 1.1million
Financing migration	Own saving and Bank	Own saving	N/A	Parents in Law
Use of Recruitment Agent	Yes	No	No	Yes
VISA type when arrived	Tourist	Skilled Permanent (Ind)	Family visa	Student visa
Advantages	Salary,	Employment, Job satisfaction	Job flexible	Career development, flexible hours
Disadvantages	Stress, Workload, bullying	Discrimination	Bullying, Exclusion	Stress, high physical involvement

AUD = Australian dollars, BSc = Bachelor of Science, INR = Indian rupees, NZ = New Zealand.
Source: Authors.

3. New Zealand

3.1. Overview of Foreign-trained Nurses

In New Zealand, demand for nurses has been increasing. One main reason is the ageing population. The proportion of those aged 65 plus was 9.9% in 1981, 14.3% in 2013, and projected to be 26.7% by 2063 (Statistics New Zealand, 2015). The population grew by 14.5% between 2011 and 2019, higher than the 11.4% between 1991 and 2001, and 12.3% between 2001 and 2011 (Statistics New Zealand, 2020), because more migrants had entered the country. It is predicted that 25,000 more nurses will be required by 2030 (Hancock, 2019). The supply of home-grown nurses does not meet growing demand, mainly for three reasons.[7] Firstly, the number of local nursing students is not enough. The number of new graduates who passed the Nursing Council's state exam increased from 1,321 in 2010 to 1,817 in 2013 (Ministry of Health, 2014). However, the entire new potential workforce neither gains employment nor stays in the country. Secondly, the workforce is decreasing and ageing. The Ministry of Health (2016) reported that the average age of nurses is 46.3 years, and 45.2% of nurses are over 50. A large part of the present workforce will reach retirement age within the next 10–15 years (Clendon and Walker, 2012: 4). Thirdly, because of the Trans-Tasman MRA, more nurses migrate from New Zealand to Australia than the other way around. In 2017, there were 652 Australian nurses in

[7] New Zealanders work up to 40 hours per week. Nurses can decide how many hours per week they work, which may contribute to the nurse shortage.

New Zealand and 6,847 New Zealand nurses in Australia (Tables 3.1 and 3.3). All these factors lead to recruitment of more nurses from overseas.

The Ministry of Health (2014: 2–3) reports: 'Locally trained doctors and nurses are leaving to work overseas, and there is a heavy reliance on highly mobile locums and overseas-trained health professionals to fill the vacancies'. New overseas registrations nearly equal or exceed the number of new home-trained registrations every year (Walker and Clendon, 2015). Some schemes have been introduced to resolve, in the medium to long term, recruitment, retention, and distribution issues of home-grown nurses. For example, the Voluntary Bonding Scheme encourages nurses to work in difficult places and specialties so they can earn as much as they can to pay off student loans. The Advanced Trainee Fellowship Scheme enables nurses to undertake advanced training or study in New Zealand or overseas in a shortage-specialty area. Whilst 2,413 nurses had used the Voluntary Bond Scheme as of 2014, only one had used the Advanced Trainee Fellowship Scheme (Ministry of Health, 2014)

Immigration policy has clearly tackled the shortage of registered nurses and placed registered nurses in skill-shortage lists. Although the categories or names of the lists have changed, a wide range of registered nurses, including those who are specialised in mental health; aged care; clinical care; and emergency, medical, and perioperative care have been listed as priority occupations for immigrants from the early 2000s (North, 2007) to February 2017. All registered nurse categories were removed in 2017.[8] The Long-term Skill Shortage List (New Zealand Immigration, 2019)[9] and Regional Skill Shortage List include registered nurses (aged care) because the aged care association lobbied to add them (Jackson, 2019).

Nurses, if their occupation is in the skill shortage list, can gain bonus points to obtain various visas, including reside to work, work visa, resident visa, and others. Employers need not go through the formal labour recruitment to prove that they cannot find a local person for the job. Even if registered nurses are not listed in the skill shortage category, employers may hire foreign-trained nurses.

Table 3.3 shows that the number of foreign-trained nurses increased from 8,931 in 2008 to 13,115 in 2018. The countries of origin changed during this period. In 2008, 4,169 (46.7%) foreign-trained nurses came from the UK, followed by 672 (7.5%) from Australia, and 645 (7.2%) from South Africa. In 2018, 4,282 (32.6%) were from the Philippines, followed by 3,380 (25.8%) from the UK and 2,369 (18.1%) from India. Clearly, more foreign-trained nurses are recruited from Asian countries, especially the Philippines and India.

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[8] The New Zealand Nurses Organization (NZNO), the largest nurse labour union and professional organisation for nurses, midwives, and caregivers, along with other national nursing organisations, recommended that all nursing categories be removed from the list (NZNO, 2017). They said that long-term health-work planning is required rather than reliance on recruitment of nurses from overseas (NZNO, 2017).

[9] The list, generally reviewed every 6 months, identifies occupations that have a sustained and ongoing shortage of highly skilled workers, globally and throughout New Zealand.

Table 3.3: Foreign-trained Nurses and Country of Origin in New Zealand

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Australia	672	648	657	740	675	639	636	652	698	652	698
China	71	70	118	125	130	134	143	99	145	142	147
Fiji	-	-	-	452	441	436	424	421	434	409	402
India	563	666	882	1200	1457	1526	1697	2076	2373	2330	2369
Philippines	-	-	-	1694	2009	2234	2498	2975	3684	3924	4282
South Africa	645	672	695	712	649	656	627	607	595	558	571
United Kingdom	4169	4301	4303	4036	3925	3831	3759	3695	3545	3415	3380
Total	8931	9298	10115	10532	10764	10885	11170	11972	12894	12680	13115

Source: Organisation for Economic Co-operation and Development.

3.2. Characteristics of Asian Nurses

Asian, including Indian, nurses have three main characteristics. Firstly, foreign-trained nurses are significantly younger than home-trained nurses (Walker and Clendon, 2015; Nursing Council of New Zealand, 2020). Age is related to willingness to work abroad and immigration policies in receiving countries. Younger nurses from India tend to be more likely to go abroad (Oda, Tsujita, and Irudaya Rajan, 2018). In New Zealand, the younger the nurses are, the more points they earn to work, reside, and achieve permanent residency. Secondly, foreign-trained nurses concentrate in Auckland, where 36.7% of the overall nursing workforce is foreign trained, a far higher proportion than in other regions (the national average is 26.6%) (Nursing Council of New Zealand, 2020).[10] Thirdly, Asia-trained migrant nurses tend to work in aged care (Walker and Clendon, 2015; Nursing Council of New Zealand, 2020). In New Zealand, aged care services are largely privatised, whilst the district health boards, which are fully funded by the government, mainly provide health and medical services. Nurses in aged care are paid much less, NZD5 per hour, than those working in the public sector (Wallance, 2019), which is why home-trained nurses prefer not to work in the aged care sector.

3.3. Pathway to Become a Registered Nurse

In New Zealand, those who complete a 3-year BSc programme leading to registration as a nurse are required to sit and pass the Nursing Council State final examination. In the case of foreign-trained nurses (New Zealand Nursing Council, undated), the process of registration is different for those registered in Australia and those registered in other countries. Those registered in Australia are registered in New Zealand through the Trans-Tasman MRA, but those registered in other countries are required to send documents to the Credentials Verification Services for the Nursing Council of New Zealand (CVS-NCNZ) at Comission on Grants of Foreign Nursing Schools (CGFNS) International Inc. The documents include IDs, employment history, nursing education history, license validation, and language proficiency.[11] Once CGFNS completes the verification process, the Nursing Council decides on each registration. Foreign-trained nurses from Asian countries are often required to take a bridging course called the Competency Assessment Programme (CAP).

The CAP, stipulated by the Health Practitioners Competence Assurance Act 2003, is a bridging course for foreign-trained nurses and for local nurses who have been away from practice for more than 5 years. The CAP is provided by the Nursing Council's accredited providers, 20 institutions as of July 2019. The course consists of theory and clinical practice over 5–12 weeks (Table 3.4), during which the candidates are continuously assessed and can be dropped out. Those who complete the CAP successfully are officially recognised as registered nurses.

[10] The government discourages foreign-trained nurses from working in Auckland. Our interviews with Indian migrant nurses found that those who work outside Auckland can earn higher points to obtain permanent residency and those who take a nursing bridge course outside Auckland are given a longer post-study visa.

[11] Language proficiency is waived for those who registered in the UK, Ireland, Canada, and the US.

Institutions admit more international than local students, partly because international students pay much higher fees than local nurses, and partly because demand for international students is higher than for local nurses who have been away from nursing. Admission to the CAP is highly competitive for international students, and we came across Indian migrant nurses studying nursing in a 1-year graduate diploma course in combination with the CAP, as the validity of the English proficiency test expires if they wait to be admitted to the short-term CAP course.

Table 3.4: Competency Assessment Programmes

	Length	Basic fees for International students (NZD)	Basic fees for Domestic students (NZD)
1	9 weeks (full-time)	6,720	1,530-1,940
2	First 3 weeks for theory and following 5 weeks (200 hours) for clinical practice	10,000	10,000
3	Not applicable	NA	NA
4	Full-time 7 weeks (2 weeks theory and 5 weeks clinical placement)	8,000	2,400
5	2 weeks in school and 6 weeks in clinical placement.	11,550	NA
6	Full-time (2 weeks theory and 6 weeks clinical)	10,000 (approx.)	2,000 (approx.)
7	12 weeks (150 total student learning hours, maximum of 300 clinical practice hours)	9,750+	2,382
8	Minimum 8 weeks	Price on application	1,991
9	6 weeks training, with 10 classroom days and 20 clinical duties at private hospital sites	8,250+	7,800+
10	Full-time 5–8 weeks (Face-to-face and online learning, 10 days of theoretical skill-based study, plus a minimum of 120 hours clinical practice)	9,035	1,663 (with ID); 1,648 (without ID)
11	6 weeks: Classroom-based teaching (theory and written assessments for 60 hours and clinical placement for 4 weeks (20 clinical shifts, 160 hours)	10,500	10,500
12	7 weeks	8,700	NA
13	Not applicable	NA	NA
14	Full-time (12 weeks)	8,900	1,845
15	Full-time (12 weeks)	10,000	2,418
16	Lecture format (first 5–6 weeks part-time) and clinical placement	9,180	1,838

17	Full-time (6–12 weeks)	NA	2,500
18	Complete within 8–12 weeks of the start date	NA	NA
19	9 weeks	15,000	2,500
20	8 weeks	NA	3,007

Source: New Zealand Nursing Council (2019).

3.4. Indian Migrant Nurses

Why do Indian migrant nurses prefer New Zealand? Mainly, according to our interviews, because it allows foreign-trained nurses to combine all the English test scores taken over 12 months. The current requirement to apply for nursing registration is a minimum score of 7.0 in the International English Language Testing System (ILETS) and B in the OET for every band: reading, listening, writing, and speaking. If a candidate cannot achieve the minimum score in any band in either the ILETS or OET sitting, they can take the exam until they fulfil the requirement for the next 12 months. Such flexibility was not found in other English-speaking countries such as Australia, the UK, and Ireland until recently. Only one nurse, whose husband was working in New Zealand, was decisive about New Zealand as her preferred migration destination. Otherwise, 12 of the sampled nurses came to New Zealand mainly because of their English proficiency score. For example, 'I would like to go to Australia but could not obtain the minimum score in one test, so I came to New Zealand' (New Zealand participant 4). Similarly, 'My English score only matched the New Zealand requirements when I investigated the requirement of the other English-speaking countries' (New Zealand participant 13). Most of the nurses said Australia was their first preferred destination before arriving in New Zealand. Another example was a nurse we interviewed who took a bridge course in Melbourne, Australia, because her relatives lived there. But she could not find a job there, which is why she came to New Zealand.

We found from interviews that the cost of migrating to New Zealand, except for English tests, is high, INR800,000–INR1,000,000 (US$10,800–US$13,500). Those migrating to Australia pay about that much, which is at least 10 times more expensive than the cost of migration to the Gulf countries from India, as per our previous survey. Most of the sampled nurses earned several thousand Indian rupees monthly in private hospitals in India before they arrived in New Zealand. They had to finance the cost of migration somehow and seem to come from well-off families.

Some of the sampled nurses had worked in other countries such as Saudi Arabia, Qatar, or Ireland and could finance the cost of migrating to New Zealand on their own. The rest of the sampled nurses, however, had to borrow money either as an education loan under their own name, or other loans from their father, husband, or father-in-law. Going to New Zealand as a nurse is a once-in-a-lifetime opportunity that benefits the entire family. Thus, it is the household's strategy and the reason it can be financed by the in-laws. Except for one nurse, whose husband was working in New Zealand, the other 11 married nurses (1 was divorced) came to New Zealand alone. Their spouses (and children) joined from India or from the first migration destination country.

New Zealand reportedly has a high turnover of foreign-trained nurses, particularly because they can move directly to Australia once they register under the MRA (Walker, 2008; New Zealand Nurse Organization, 2018). Asked if they intended to migrate to Australia or elsewhere, the nurses gave mixed answers. Those thinking of going to Australia said: 'A lot of friends have already left for Australia. In Australia, nurses are better paid, the cost of living is lower than here. In particular, the rent is very expensive here, and the houses are smaller than those in Australia' (New Zealand participant 7). 'It is not only better paid in Australia but also closer to India, and more flight options are available. We cannot go home easily from here in case of an emergency

back home' (New Zealand participant 10). Importantly, 3 out of 14 of the sampled nurses in Australia had formerly worked in New Zealand. One said, 'My husband is educated but could not find a job in Auckland. That is the main reason why we came to Australia' (Australia participant 5). Many of the nurses' husbands seemed to be engaged in unskilled jobs or were self-employed, as finding a reasonably good job is not easy in New Zealand. Some nurses confessed that they were professionally satisfied in a smaller town's public hospital in New Zealand, but because of job opportunities for the husband, they came to Christchurch, a larger town (New Zealand participants 4, 12, and 13).

Some nurses were willing to stay in New Zealand. One told us: 'A lot of friends left for Australia, and they told us to come. However, I am not interested in going there now. I heard that racial discrimination is more severe in Australia than here' (New Zealand participant 3). 'We have settled down and our children go to school here. Besides that, I heard there are a lot of snakes in Australia. There are no snakes in New Zealand' (New Zealand participant 5).[12] Whether or not the sampled nurses were willing to move to Australia, their decision was based not only on economic reasons but also on household and personal ones.

The nurse-receiving countries ease the qualification standards for foreign-trained nurses when they suffer from a shortage of nurses, whilst they tighten requirements when they have enough nurses. Work experience, language proficiency, and educational background are common criteria that nurse-receiving countries adjust from time to time. New Zealand changes the standard qualifications for registered nurses from abroad from time to time, as well. Some India-trained migrant nurses cannot meet the educational criteria set by the Nursing Council. New Zealand used to allow graduates of India's 3-year nursing diploma to register but now requires a BSc nursing degree. New Zealand participant 7 said: 'Since my brother settled in Australia, I was planning to go there but it was difficult to find a nursing job in 2012. So I came to New Zealand without knowing that India's nursing diploma qualification was not qualified to join the CAP course. I ended up doing a BSc in nursing in this country'.

Although it is outside the scope of this chapter, we came across some caregivers in New Zealand who had completed a diploma in nursing and had a nursing license in India. They did not know that their educational qualification did not meet the minimum criteria to become a registered nurse in New Zealand. They came to New Zealand to study any health-related course. The sampled Indian nurses used an agent in India and/or an Indian agent in New Zealand, because immigration processes are complicated and may change at any time, and because they were busy working in India. The caregivers told us that the recruitment agent in India did not inform them of the minimum requirements to become a registered nurse, and they were optimistic about becoming registered nurses in the destination country. They are struggling to find a way to become registered nurses.

[12] In India, a snakebite is still fatal. The World Health Organization estimated that India sees 2.8 million snake bites and 50,000 deaths a year (Ray, 2019).

4. Conclusions

This chapter demonstrates how foreign-trained nurses, with a focus on India-trained migrant nurses, became registered nurses in Australia and New Zealand. It shows issues and problems from the migrant nurses' point of view, based on our semi-structured interviews with them.

In both countries, the percentage of foreign-trained nurses is on the rise because of the shortage of nursing professionals and the growing ageing population. For foreign nurses to migrate to Australia or New Zealand and practice nursing, they must be registered with the county's nursing board. For Indian migrant nurses, the first hurdle is that they need to meet the requirements, particularly English proficiency. The second hurdle is to complete a nursing board–approved bridging programme.

For Indian nurses, the application and assessment are more complicated in Australia than in New Zealand. Both countries can change the assessment system as well as immigration system at any time, which is one reason why foreign-trained nurses rely on recruitment agents, which raises the cost of migration. Families sending nurses to either country are well-off. It is a household strategy to send a nurse to those countries. Once the sampled nurses became registered, they sent for their families. Marrying a man off to a migrating nurse is a strategy for the man's family to have access to developed countries. Finding a reasonably good job, however, is not easy for the spouse, particularly in New Zealand.

The overwhelming majority of the sampled nurses chose New Zealand because their English score met the specified requirements. Some foreign-trained nurses regard New Zealand as a steppingstone to Australia. The MRA is a double-edged sword; through it, New Zealand attracts those who would like to go to Australia and who might leave for Australia after some time. This implies that the ASEAN MRA on nursing services, which allows registered or licensed nurses to practice nursing in host countries, might have the same consequences. ASEAN nurses might aim to work in a country that offers better pay, more training opportunities, and a higher standard of living. In the European Union, where the health workforce has freedom of mobility, wealthier member states receive more benefits from health workforce mobility at the expense of less wealthy ones (Ginos, 2015). ASEAN may need to adopt the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel.

An implication for India is that the 3-year diploma course is no longer accepted for working in Australia, New Zealand, and some other nurse-receiving countries. Those who would like to go abroad should know about the requirements in overseas labour markets. Governments should provide information on the overseas labour markets and regulate domestic recruitment agents.

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Appendix:

Table 3A.1. Skilled Occupations for Midwifery and Nursing Professionals

(Australian Standard Classification of Occupations: Minor Group 254/Midwifery and Nursing Professionals of Sub-Major Group 25/Health Professionals in Major Group 2/ Professionals)

Occupation	Code	List	Visa subclasses (streams or type)	Assessing Authority
Enrolled Nurse	411411	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Midwife	254111	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Nurse Educator	254211	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Nurse Manager	254311	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Nurse Practitioner	254411	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Nurse Researcher	254212	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Nursing Clinical Director	134212	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Aged Care)	254412	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Child and Family Health)	254413	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Community Health)	254414	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Critical Care and Emergency)	254415	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Developmental Disability)	254416	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Disability and Rehabilitation)	254417	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Medical Practice)	254421	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Medical)	254418	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Mental Health)	254422	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Paediatrics)	254425	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Perioperative)	254423	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Surgical)	254424	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurses nec	254499	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC

ANMAC = Australia Nursing and Midwifery Accreditation Council, F=Family nominated, GW=Graduate Work, M=MLTSSL = Medium and Long-term Strategic Skills List, PT=Point-tested, S/T=State or Territory nominated, TSS=Temporary Skill Shortage.

Source: Government of Australia, Department of Home Affairs (