A MIXED PICTURE: THE EXPERIENCES OF OVERSEAS TRAINED NURSES IN NEW ZEALAND

LÉONIE WALKER

New Zealand Nurses Organisation
PO Box 2128, Wellington 6140

Abstract

There has long been information that some migrant nurses (especially those from developing countries and those for whom English is a second language) report significant hardship and distress linked to difficulties experienced with migration and employment as Registered Nurses in New Zealand. There has been much anecdotal evidence of individual exploitation linked to overseas emigration advisers, immigration advisors and employment agencies based in New Zealand, and of employers in New Zealand requiring binding contracts obliging nurses to work as Care Givers or Care Assistants with terms and conditions and rates of pay far below those they had been led to expect. A project is currently being undertaken by the New Zealand Organisation of Nurses in two separate parts. This paper outlines the results and implications of the first part of the study: an anonymous survey of overseas trained nurses examining the issues, and mapping the extent of the experiences reported anecdotally. The results are presented in the context of other information on the international migration of nurses, and in particular, the implications for the health care services of New Zealand.

Background

The health workforce in New Zealand is amongst the most mobile in the developed world, with one of highest proportion of migrant nurses of all the OECD countries, along with high emigration rates of NZ trained nurses to other OECD countries (Zurn and Dumont 2007) Though **exact** numbers are hard to define, estimates of overseas trained nurses working as *registered nurses* in New Zealand range from 7,698 out of 33,123 (or 23.2%) as defined by New Zealand Census of Populations and Dwellings (NZ Census 2006) to 11,319 out of 41276 (or 27.%) of total registered nurses (Nursing Council of NZ 2007) Nicola North's paper in 2007 describes the changing patterns of nurse emmigration and imigration, highlighting the large changes in the origins, destinations and numbers of migrating nurses that New Zealand has experienced over the last decade in particular. Despite nearly a decade of calls for better workforce data (Hawthorne, 2001) both internationally and nationally, information systems are inadequate for policy analysis and decision making. In the face of rapid change: such deficits may make work force planning complex and inadequate.

Department of Labour figures (Department of Labour, May 2007) showing nurse migration are shown in table 1. There are acknowledged difficulties in tracking these workers, due to the visas used on first entry to New Zealand. Only Skilled migrant or General Work Permit arrivals would be counted on entry into these figures.

Table 1. Temporary work applications, by Title and Year

NZSCO occupation	02/03	03/04	04/05	05/06	06/07	07/08
Care Giver Total	50	189	257	527	901	1227
Health Assistant Total	11	20	33	47	98	71
Registered Nurse Total	578	1352	1116	918	876	65

The Nursing Council of New Zealand is responsible for the registration and regulation of all registered nurses, and their figures show 1465 new registrations from overseas – mainly UK and Philippines in 2007 alone. As registration is mandatory under the HCPA act, it can be argued that Nursing Council data for new migrants working as registered nurses is likely to be the more robust.

The issue for the current study however, concerned the migration experiences of nurses trained overseas, many of whom are not registered by the Nursing Council (for a variety of reasons). They nevertheless comprise a significant proportion of health care workforce, particularly in the Aged Care sector. From table 1, and from information from the Department of Labour, it can be inferred that increasingly, many are brought in by employers to work as care givers.

Numbers for specific nationalities of interest are also hard to establish: figures from the recent OECD report, (cited in Dumont 2007) are given in Table 2.

Table 2. Main Countries of birth of immigrant nurses working in New Zealand 2001

Source: New Zealand Census of Population and Dwellings,

Country of birth*	Number	Country of birth	Number
UK	3291	Philippines	**426**
Australia	615	Netherlands	**309**
South Africa	432	China	**177**
Fiji	405	Malaysia	**138**
Samoa	285	India	**114**
Ireland	186	Germany	**111**
Tonga	171		
Canada	135	**Total foreign born**	**7698**
USA	105	**Total native born**	**25425**

*** Nurses from these countries were not targeted for questionnaire**

It is even harder to gain meaningful data on the total numbers of nurses working in all sectors of the health economy here. If they are not registered with the Nursing Council, (Health Care Assistants and Care Givers are not regulated), unless people arrive with skilled migrant visas or general work permits related to nursing, the census is the only way of ascertaining where people are working. When this is combined with fears related to uncertain legal status of visas and work permits, undercounting is a real likelihood.

New Zealand Nurses Organisation is a union and professional organisation representing some 42,000 nurses, midwives and care givers in New Zealand. Its members are both registered nurses and unregulated health care workers, particularly in the Aged Care sector (Brown and Duncan 2001) The NZNO membership data base does not record the country or origin or of nursing training of their membership. However, NZNO and other union organisers and delegates have consistently reported migrant nurses experiencing significant hardship and distress linked to difficulties in migration and obtaining registration with the NZ Nursing Council. Anecdotal evidence has also existed for some time of individual exploitation linked to emigration advisers in some home countries (especially the Philippines), immigration advisors and employment agencies based in New Zealand, and of employers in New Zealand requiring binding contracts obliging the nurses to work as Care Givers or Care Assistants with terms and conditions and rates of pay far below those they had been led to expect (Manchester, 2005) NZNO lawyers have acted (with mixed success) for NZNO members seeking to exit from legal contracts signed in ignorance or under duress. These concerns had been widely publicised (O'Connor 2005 and 2008) and escalated to the departments of Labour and Immigration, to the Nursing Council and to the Ministry of Health. All required hard evidence of the scale of the problem, and responsibility for the plight of the migrant nurses was hard to apportion. A project exploring the issue was therefore sanctioned by the Management Team of NZNO, and ethical approval for the first part of the project, a scoping survey, was obtained from the Multi-Regional Ethics Committee.

Method

A questionnaire was developed based on information received by NZNO, at a group pinoy with Filipino nurses, and following consultation with appropriate representatives from the Department of Labour and the Ministry of Health. The questionnaire was reviewed and revised by the Chair of the Filipino Nurse Association (FNA) of New Zealand, and by a small group of mixed overseas nursing students from Massey University**.**

The questionnaire was disseminated (along with a Freepost envelope in which to return the form to the researcher) via NZNO organisers and delegates. The target population were defined as people who had trained as nurses overseas, English not their first language, and excluding Pacific Island nurses, for whom many of the immigration issues were felt to be different. A small feature regarding the survey was placed in Kai Tiaki (the Journal produced by NZNO) which resulted in several direct contacts being made to the researcher offering to help disseminate the questionnaire, and requesting copies of the questionnaire for themselves or for colleagues. It was also sent to NZNO nurse members at DHB hospitals, the Filipina Nurse Association, and to Service & Food Workers Union delegates in aged care settings. It was made available at a Philippine Migranté rally in Auckland. Requests for assistance were also made to all the 13 nursing and language schools known to NZNO who prepare overseas trained nurses for Competency Assessments and the IELTS and OET language tests required by the New Zealand Nursing Council for registration and to the college's Immigration Support Services. One college agreed to disseminate questionnaires. A request was also made to the Nursing Council for the questionnaire to be mailed to a selection of overseas trained nurses who were registered with the council, but this was not able to be accommodated within the time scale of the project.

The quantitative data were analysed using descriptive statistics and appropriate computer software. The free text responses were grouped thematically using NVivo 8 software.

Results

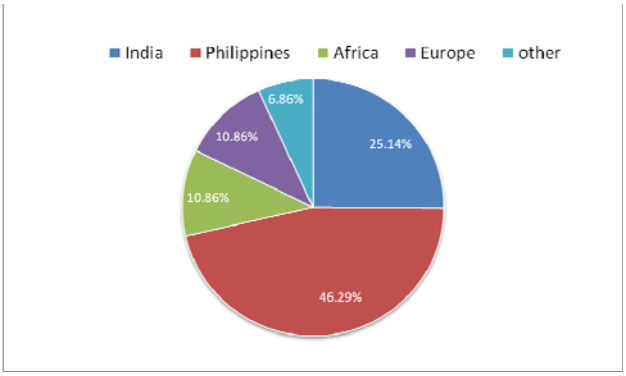
A total of 600 questionnaires were sent out, and 175 returned within the cut-off time.

1) Origin

Table 3. Country of Origin

Country	No.	Country	No.
Chile	1	Romania	1
China	1	Russia	4
Germany	7	Sierra Leone	1
Ghana	3	South Korea	1
India	47	Sri Lanka	2
Israel	1	Thailand	3
Japan	3	The Netherlands	7
Malta	1	Uganda	3
Malaysia	2	Zimbabwe	9
Philippines	78	Total	175

Graph 1: Origin of respondents, percentages

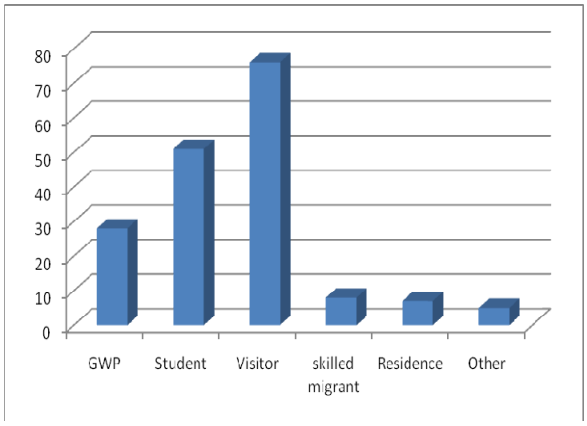


This survey excluded those from English language speaking countries & Pacific Islands. (This decision was made as the issues of use of agents, and of language barriers / cultural issues were felt to be different) The Nursing Council report that migrants comprise only 27% of the total nursing workforce (2001), the OECD report above (Dumont 2007) indicates that those who came from these countries totalled 5625, or 73% of all migrant nurses. Overseas trained nurses comprised 59% of new registrations with the Nursing council in 2007. Migrants therefore represent a significant contribution to the New Zealand nursing workforce. The higher proportions of nurses from India and the Philippines who responded to the survey compared to the 2001 proportions reported from the census, and the lower proportions of Chinese and Dutch nurses will be discussed later.

The average number of years respondents had worked post qualification as nurses in their own countries was 7.9 years (+/- 5.4 years) ranging from six months to 21 years.

2) Visas held

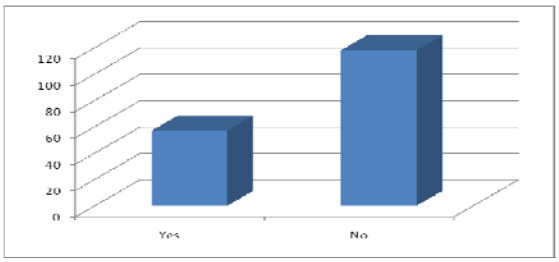
Graph 2: Visas at time of entry to the country (numbers of respondents)



This graph illustrates clearly the reasons for data mismatches between Immigration, Labour and Nursing council: Students and Visitors would not be counted as nurses until and if they reported their occupation under a census, or gained registration.

3) Use of Agents

Graph 3: Agents used (number of respondents)



57 respondents had signed with agents, mostly in their home countries. Of these, 27 (51%) had been required to sign a bond committing the nurse to work for the agent, for between six months and 3 years. 20 of the 25 were from the Philippines, the rest from African countries. The fees to exit from the bonds ranged from $12K to zero, with a mean release fee of $8K. Responses to the question about what they expected from their agents included help finding work, accommodation, air fares, training, and help with visas. Emigration advisors had been used by 68 (43%), almost all who had used advisors came from India and the Philippines.

4) Costs of migration

Of the 152 respondents who identified their total migration costs, the mean cost was $9,788 with the range from $25,000 to $500. These sums represent a considerable investment by these overseas trained nurses, especially relative to wages in their home countries. The main costs identified were study fees for Competency Assessment Programmes (CAP) and language training and exams (mainly IELTS). 100 took additional competency or conversion training (additional to language testing) ranging from one year to eight weeks. Pre 2004, a number of nurses had demonstrated competence by working without wages in DHB hospitals, but this would no longer be acceptable under the recent legislation related to nurse registration (HPCA 2003) Of

the 163 required to take language tests, 147 had taken IELTS, with 61 passing first time, and the most number of fails **by an individual** reported being 10. Many of these had also attempted the OET test. Results from the language questions are shown in table 4. A number of respondents had not yet undertaken CAP, nor registered with the Nursing Council as they were still attempting language tests. One anomaly highlighted by a number of nurses was that those from Zimbabwe were not required to take language tests. Indian nurses in particular felt that as all their schooling and college teaching had been in English (which equated to their Zimbabwean colleagues) many of whom had languages other than English (Shona and Ndebele) as a first language. Of the 41 who had not yet passed the language test, most were working as care givers in the Aged Care sector. Only 9 who had not passed the language test were registered with the Nursing Council – all of these nurses had arrived in New Zealand before 2004 and with either a General Work permit or as skilled migrants. 8 were from India, 1 from Malaysia.

Registration with the Nursing Council

126 out of 175 respondents were registered with the Nursing Council. 115 had worked as registered nurses, 92 of whom had worked in the DHB sector. Most had worked in aged care while awaiting registration, while 19 had remained in the Aged care sector as registered nurses. All had worked as registered nurses in their home countries prior to moving to New Zealand.

Table 4. Language Testing

Test taken	Number of respondents	percentage
IELTS only	127	78
OET only	5	3
Both OET and IELTS	20	12
Other	3	2
Not Stated	8	5
TOTAL	163	100

A very large proportion of the free text comments concerned the language requirements for registration. Inevitably, those who had struggled to meet the required score of 7.0 across all four elements (reading, writing, speaking and comprehension) felt the cost and standard was too high. In particular, Indian nurses who had taken and passed the one year long NZ Nursing conversion course (BNRN), taught in English, felt this extra hurdle to be unreasonable. Suggestions regarding statement on their communication skills as observed by registered nurses, or of more occupation specific language tests were made. The OET course was much less commonly taken. There may be several reasons for this: the test is not available in all centres in NZ, OET costs 4 times the IELTS in fees, and is only run two or three times per year in NZ. Additionally, as a qualification, it would only have currency for working as a nurse in Australia, although all except one nurse who took OET listed working as a nurse in New Zealand as their longer term aim. The longer term plans reported by the respondents are shown in graph 4.

Graph 4: Longer term plans of the respondents

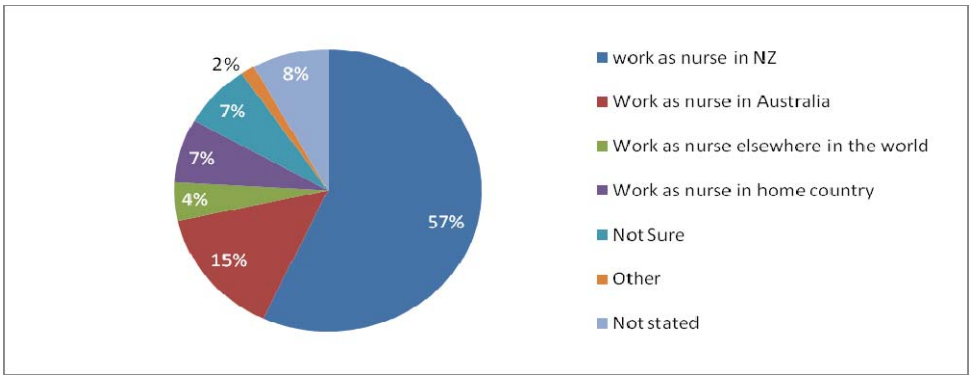


Table 5. Intentions by country of origin

Country	Number	% total	Contemplating move	% from each country
India	44	25.29	5	11
Philippines	68	47.7	34	50
Africa	18	10.34	9	50
Europe	19	10.92	10	53
other	10	5.75	5	50
Totals	159	100	63	39

Anecdotally, it has long been claimed that due to the perceived relative ease of migration to New Zealand compared to Australia, to higher wages in Australia and to the Trans Tasman agreement between the Nursing Councils in NZ and Australia, that migrant nurses were treating New Zealand as a "revolving door" with Australia the ultimate destination of choice. Only 15% of respondents reported this as a longer term aim in this survey, though 39% had longer term plans that included options **other than** working as a nurse in New Zealand. It can be seen that proportionately, the number of Indian graduates contemplating a further move was low. This might be reflective of a longer history of Indian migration to New Zealand for permanent residence with their families, compared to migration for economic reasons including sending remittances for workers from the Philippines. The loss of New Zealand-trained nurses however is a real issue, with numbers corresponding to a quarter of all new graduates moving to Australia or the UK every year (Dumont 2007).

5) Union membership

A majority of respondents reported belonging to a union: with 116 belonging to NZNO. A further 5 belong to the SFWU, and 15 reported also belonging to the Nursing Council. 5 reported belonging to either country-specific or speciality specific nursing organisations. NZNO currently has approximately 41,000 members: most being registered nurses or care givers. The NZNO origin of the survey, and the main dissemination strategy is likely to have influenced this aspect of the responders. Verbal warnings from the Filipina Nurse Association regarding expectations of low response rates due to fears of their members related to their immigration status and the fact that union membership is illegal and therefore almost unknown in the Philippines proved unfounded. Well over half of the respondents (including a high proportion from the Philippines) gave their contact details, and indicated that they would be prepared to help with the more in-depth second part of the survey. NZNO provides independent indemnity insurance in addition to its other union services (education, legal advice, a journal, colleges and sections). Despite all members having indemnity insurance as part of their membership, the following table shows that less than half who indicated union membership are aware of this union function.

Table 5: Insurance knowledge

NZNO Membership	Number replying	Yes (%)	No (%)	Not Sure (%)	(blank)
NZNO	116	41	29	28	1
Not NZNO	55	4	64	31	1
All	175	28.5	41	29	2

Concern must also exist that if knowledge about insurance cover is so widespread, what are the levels of understanding about the legal issues, of rights and mechanisms for reporting or responding to professional issues? Anecdotal evidence from Nursing Council (2008) indicates that a disproportionate number of overseas trained nurses become subject to competency review, this may in part be related to lack of knowledge and understanding of these systems and the support available.

6) Qualitative data

An additional 112 free text coments were provided, and these were analysed thematically and grouped into 8 main themes. Counts of phrases relating to each theme and percentages of words coded (to show frequency and relative importance to respondents, together with exemplar quotes are presented in table 6.

Table 6: Qualitative data

Theme	**Count** % words coded*	Exemplars (2 representative quotes from different respondents)
Language Testing	**34** 43.2%	*IELTS is not a suitable test* *IELTS is not relevant to working as a nurse and the score to be achieved is too high*
Requests for help	**15** 11.8%	*Please help us in our struggle here in NZ* *If possible I'd like English coaching classes.....* *I miss my children so much*
Agents	**9** 9.8%	*care givers feel exploited, abused and neglected by no less than our own people* *Agencies are robbing nurses by making false claims*
Nursing Council	**9** 8.3%	*I experienced NC as bureaucratic and unwilling to help, they are very slow, very disappointing* *NC should get real about English – for some of us English is a fifth language*
Delays & Costs	**16** 12.2%	*It will take 2 years to process our papers* *Major delays with Nursing Council were caused by them using the wrong address* *It is too expensive to come here – I paid $5000 in fees for training and lodging I didn't need.*
Racism	**5** 7.3%	*I still feel discriminated against and belittled just because I am from overseas.* *I was bullied for the first time in my life, and Kiwis called us refugees which is not true. For 7 years in NZ it was hard work, pain, racism and fighting for my rights*
Working conditions	**7** 7.2%	*No staff, no protective clothing, harsh working conditions, poor pay.* *My salary as a care giver is low, and the work is really hard*
Visas	**7** 6.2%	*Immigration wont give me a visa as a care giver, as I am overqualified* *It would be better if Immigration / Labour gave us work visa rather than visitors visas*

***Some passages are coded against 2 sections (e.g. cost of agents, delays with Nursing Council)**

The qualitative data reflect the frustrations experienced by migrant nurses with their experiences with agencies, bureaucracy delay and costs, particularly of gaining registration with the Nursing Council. Very few references were made about the delays, bureacracy or costs of migration *per se*, or with the immigration service itself.

Discussion

By far the biggest issue for migrant nurses relates to registration with the Nursing Council – and the biggest hurdle to registration is the language competency test . An unintended outcome of the publicity generated about the IELTS test (O'Connor 2008) has been that the requirement to pass the test will be extended to all nurses who have trained overseas from January 2009. (Until recently, nurses from some Pacific Islands, and from the UK and Ireland) did not have to take IELTS. While this has an element of fairness about it (and is a reciprocal requirement of New Zealand nurses by the Nursing and Midwifery Council in the UK), in the context of the OECD report (Dumont 2007) and of the UK currently being by far the largest provider of nurses to the New Zealand nursing workforce, a further expense and barrier to nurse migration from this source may prove short sighted. More information for potential migrants about language requirement prior to emigration, together with extra support with language skills is clearly required to speed the process of registration of suitably qualified nurses. In an increasingly diverse population / patient population, the extra languages these migrant health workers bring with them is an asset (AUT 2008).

The second barrier to registration relates to the accreditation of the various nursing schools in the Philipines, and the acceptability of the curriculum studied compared to that required for registration. Due to the sudden increase in such colleges (the numbers have risen 10 fold over the last five years, Kingma, 2006 a) many nurses registered in the Philipines are finding their qualifications are not deemed adequate in New Zealand, and their choice is to undertake a further 3 year degree course (with the expense entailed) or to work as unregulated care givers in the Aged Care sector. The delays and frustrations related to their registration

reported by many respondents to the survey are evidence that the Nursing Council, in common with many National regulatory bodies, is struggling to keep up with the workloads caused by the dramatic increases in nurses both arriving (seeking registration) and leaving (seeking proof of registration) Kingma (2006) b.

The issue of whether overseas trained nurses plan to work in New Zealand long term, or to move to another country or back home is therefore important. While the results of this small survey are mixed, significant numbers of those responding (with the exception of Indian nurses) are considering further moves to other countries, especially Australia. Reluctance to disclose these plans might be expected especially as one motivation for filling in the questionnaire might have been to provide help to migrants, so the numbers may prove an underestimate. As James Buchan reported from a similar survey in the UK in 2005, "the fact that these nurses have made at least one international move means they are likely to have the propensity to do so again."

Other evidence exists that nurse migrants do not settle long term - some estimates that around 50% of skilled migrants return to their home countries on average after 5 years (Lowell and Findlay 2002), one wonders whether adequate consideration has been given to the succession planning for both nurse leadership and nurse education. It would be interesting and important to find out if these figure also apply to the very much larger population of UK trained nurses currently working in New Zealand.

Caution with interpretation: though the number of questionnaires returned was small, the different mechanisms of distribution helped ensure that a wide range of experiences have been captured. The relative over-representation compared to figures available of potential respondents of nurses from the Philippines and India could be due either to recent changes in migration numbers from these two countries, or to the specific help that was received with dissemination from one particular nurse competency assessment course provider (who *specifically* recruit Indian nurses) and to the publicity that related to the plight of Fillipina nurses had received in Kai Tiaki. The under representation of Chinese nurses was despite attempts to reach them via Chinese associations, and nurses from the Netherlands had very recently been approached for a similar survey of Dutch nurses by a Dutch researcher at Victoria University, which may have impacted on the numbers. An alternative explanation might be that ethnically, nurses from the Netherlands are less distinguishable from the dominant ethnic group in New Zealand, and that due to the long history of Chinese settlement, nurses and delegates might have been reluctant to approach people of Chinese decent in case thay had been born and trained in New Zealand and been insulted. The small numbers, and the discrepancies in official migrant numbers precluded more complex statistical analysis.

With any anonymous survey concerning contentious issues, there is the possibility that some respondents who feel very passionately about the issues may have responded more than once. The questionnaires were carefully scrutinised by the researcher, and there was no evidence that this had ocurred. Additionally, more than 65% of respondents gave their contact details as being prepared to take part in further research on the issue.

More accurate and up to date information is required about the number and skill mix of nurses in New Zealand, and specifically about the employment of migrant nurses in unregulated care settings. Where migrants enter as visitors and students, there appears no current mechanism by which workforce planners have access to data that would allow policy or work force development to be truly evidence based. The deficit in adequate data has been highlighted previously, notaby by Buchan and Sochaslski in 2004, and it could be argued that the requirement is even more acute given the recent speed of changes. North (2007) highlighted rapid and large variation in the sources, destinations and numbers of migrating nurses as measured by the registrations with the Nursing Council. These changes may have been driven by differing regulatory requirements, domestic and overseas policy changes, and changes in relative wages particularly in English-speaking countries – but unravelling such a complex and evolving picture may make work force planning difficult and inadequate. With over half of all new New Zealand nurse registrations being overseas trained nurses, even small changes could have potentially drastic effects. This survey has confirmed that the unregulated nature of the aged care sector, together with the difficulties many migrant nurses experience becoming registered with the nursing council, means many such nurses work (at least temporarily) as care givers in aged care. This survey, due to the methods used to disseminate it, will by definition, have reached migrants who have found work in the DHB and Aged Care sectors. Less successful migrants will be less likely to be represented in the results. Shortage relates not just to absolute numbers, but to skill mix, experience and how health systems function to enable nurses to use their skills effectively. Skill shortages in aged care have been documented (Department of Laour, 2005) though these have been described as recruitment and selection difficulties, where enough skilled nurses exist, they are not prepared to work as nurse under the pay and conditios on offer. It is too early to tell if the pay increase won in 2004 will change this situation, but in aged care, employers depend increasingly on overseas migrants. If this supply dries up in the face of changing patterns and increased global competition, it is clear there would be important implications for the sector, and for society.

On a humanitatrian level, further evidence has been collected that supports the anecdotal stories that migrant nurses (particularly from India and the Philipines) in New Zealand have experienced delay, dismay, expense, disrupted careers, dislocated family life, and racism. While the numbers of nurses reporting discrimination and racism are low, there is evidence from elsewhere that tolerance of migrant nurses falls when numbers increase dramatically, especially if national nurses perceive extra support given to migrants as reverse discrimination, or where they are asked to orientate the newcomers, or to take additional duties (Payne 2003) This may require skilled and determined nursing leadership to address

potential issues at source if the proportions of overseas trained nurses (particulalry non-English speakers) continues to rise at the current rate.

It is hoped that dissemination of the findings will highlight the issues and prompt appropriate action by all the authorities concerned. Deeper exploration of these experiences, using in depth qualitative methodology is warranted.

Acknowledgement

The author would particularly like to acknowledge the help she received from NZNO and SFWU workers, members and delegates with dissemination of the questionnaire.

References

Auckland University of Technology, (AUT). (2008). NZ Diversity Forum: Capitalising on a Diverse Workforce, accessed at http://www.aut.ac.nz/research/research_institutes/niphmhr/centre_for_asian_and_migrant_health_research/health_pra_forum.htm.

Brown, E. and Duncan A. (2001). *The Aged Care sector: an inter-union perspective.* NZNO and SFWU, Wellington

Buchan, J. and Sochalski, J. (2004). The migration of nurses: trends and policies. *Bulletin on the World Health Organisation*, **82** (8), 587-594

Buchan, J., Jobanputra, R., Gough, P. and Hutt, R. (2005). *Internationally recruited nurses in London: profile and implications for policy*. King's Fund, accessed at www.kingsfund.org.uk/publications.

Department of Labour. (2005). Registered Nurse: Occupational skill shortage assessment, accessed at www.dol.govt.nz/PDFs/professional-report-registered-nurse.pdf.

Hawthorne, L. (2001). The globalisation of the nursing workforce: Barriers confronting overseas nurses in Australia. *Nursing Inquiry,* **8** (4), 213-29.

HPCA. (2003). Health Practitioners Competency Act accessed at www.moh.govt.nz/hpca.

Kingma, M. (2006). a *Nurses on the move, Migration and the Global Health Care Economy*, ILR Press, Ithaca and London, 21-2.

Kingma, M. (2006). b *Nurses on the move, Migration and the Global Health Care Economy*, ILR Press, Ithaca and London, 217.

Lowell, B. L. and Findlay and A. (2002). Migration of highly skilled Persons from developing countries: impact and policy responses – Synthesis report While International Migration Papers no. 4. Geneva: ILO.

Manchester, A. (2005). Filipino nurses suffer abuse and exploitation. *Kai Tiaki Nursing New Zealand*, 11(4): 12-2.

North, N. (2007). International Nurse Migration: Impacts on New Zealand. Policy, Politics & Nursing Practice

Nursing Council of New Zealand. (2007). Workforce statistics update, Nursing Council of New Zealand, Wellington

Nursing Council of New Zealand. (2008). Personal communication, 16.09.08 joint NCNZ/NZNO meeting.

New Zealand Census. (2006). Accessed at http://www.stats.govt.nz/census/census-outputs/default.htm

Department of Labour. (2007). Occupations in Shortage in New Zealand: 2006, DoL, Wellington, accessed at http://www.dol.govt.nz/PDFs/jvm-shortage2006.pdf.

O'Connor, T. (2005). Embarrassed to be a New Zealander: a NZ nurse shares her shame about the treatment of Filipino nurses in this country. *Kai Tiaki Nursing New Zealand*, 11(4):14-1.

O'Connor, T. (2008). Language requirements exclude overseas nurses from practice. *Kai Tiaki Nursing New Zealand*, 14(6): 16-3.

Payne, L. (2003). Differing viewpoints on the issue of Overseas nurses Nursing times, **99**, (13): 15.

Zurn, P. and Dumont, J-C. (2008). Health workforce and international migration: can New Zealand compete? OECD Working Papers 33. Paris: OECD and WHO.