Hardships and Hurdles: the experiences of migrant nurses in New Zealand

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Background: The New Zealand nursing workforce is increasingly made up of overseas trained nurses. There is an extensive literature from elsewhere in the world on the impacts of international nurse recruitment and migration on individual nurses, on health services and evidence of abuse and exploitation, yet few studies are available relating to the experiences of migrant nurses in New Zealand.

Aim: To carry out a survey of overseas trained nurses in New Zealand; specifically, to focus on those nurses for whom English was not their first language.

Method: A paper based questionnaire was developed, piloted and distributed widely**.**

Findings: 175 completed questionnaires from nurses from nineteen non-English speaking countries were received and analysed. While many were registered with the Nursing Council and able to work as Registered Nurses, many others had failed to gain registration, and were working as care givers in aged care. Particular difficulties with English language proficiency tests, recognition of prior qualifications, perceived racism and poor experiences with overseas agencies caused hardship and distress for some.

Recommendations: Given the importance to the New Zealand workforce of overseas trained nurses, more warnings and advice regarding agencies, information about nursing in New Zealand and the Nursing Council requirements for registration should be made available to nurses prior to their migration. Support is also needed for those nurses who experience difficulties once here, and nursing leadership should be particularly alert to any evidence of bullying or discrimination based on race or overseas origin.

Key Words: International nurse recruitment, nurse migration, New Zealand.

Introduction:

The health workforce in New Zealand is amongst the most mobile in the developed world (Zurn and Dumont, 2008), with one of highest proportion of of migrant nurses, (23%) of all the Organisation for Economic Co-operation and Development (OECD) countries. (Nursing Council of New Zealand, 2007) There are also high emigration rates of New Zealand trained nurses to other OECD countries, especially Australia. (Hawthorne, 2001) The ethics of international nurse migration has been the subject of much debate, with different stakeholders at individual, institutional, national and international levels, and overlapping, different and often conflicting interests. (Xu & Zhang, 2005 and Walker, 2009). While much of the nurse migration into New Zealand has been from countries such as the UK, and is largely the result of personal choice, many others come from poorer countries, and their migration is often driven by economic necessity (Brush & Vasupuram, 2006). Changing patterns of nurse emigration and imigration, highlighting the large recent changes in the origins, destinations and numbers of migrating nurses that New Zealand has experienced over the last decade have been described. (North, 2007) Filipino nurses in particular have experienced hardship and exploitation in many countries (Kingma, 2008) and form a significant group of the New Zealand nursing workforce. (Nursing Council New Zealand, 2008)

Given the scale of nurse migration to and from New Zealand, it is important to understand the experiences, and factors affecting migrant nurses (Buchan & Sochalski, 2004), and to have systems in place to reduce exploitation and diminish threats of shortages to the New Zealand nursing workforce.

Method:

A pragmatic, mixed method survey design was used

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Questionnaire development:

A questionnaire was developed based on information received by NZNO organisers and delegates, a group pinoy with **Filipino** nurses, and 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**.** It explored the origins, qualifications, Nursing Council registration, language testing, workplaces, use of agents, plans and experiences of overseas trained nurses working in New Zealand. It was intentionally kept to a short (four page) and simple format, to encourage return, and is available in full from the author.

Inclusion / Exclusion criteria:

The target population were defined as people who had trained as nurses overseas, and for whom English was not their first language. Pacific Island nurses were excluded, as immigration and employment issues were felt to be different.

Dissemination strategy:

The questionnaire (along with a Freepost envelope in which to return the form) was widely disseminated. The dissemination strategy was a pragmatic, snowball sampling strategy. A feature regarding the survey placed in KaiTiaki, Nursing New Zealand (the Journal produced by NZNO) resulted in several direct contacts being made to the researcher offering to help disseminate the questionnaire, and to requests for copies of the questionnaire for themselves or for colleagues. The questionnaire was also sent to NZNO organisers, delegates, nurse members at District Health Board hospitals, the Filipino Nurse Association, and to Service & Food Workers Union delegates in aged care settings. It was also made available to nurses at a Philippine Migranté rally in Auckland. Requests for assistance with dissemination were made to all the 13 nursing and language schools known to NZNO who prepare overseas trained nurses for Competency Assessments and the two language tests accepted by the New Zealand Nursing Council for registration and to the college's Immigration Support Services. Only one such college responded to the request.

Analysis:

The questionnaires were collated. The quantitative data were analysed using basic descriptive statistics (sums, means, standard deviation, percentages) and Microsoft Excel software. The free text responses were qualitatively analysed, with free text comments grouped using NVivo 8 software. Statements were coded thematically and iteratively into nodes, and counts and word percentages recorded.

Ethical Approval:

Ethical approval for the survey was obtained from the Multi-Regional Ethics Committee.

Results:

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

1) Origin

Table 1: Country of Origin

Country	**number**	**Country**	**number**
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

2) Nursing qualifications and experience

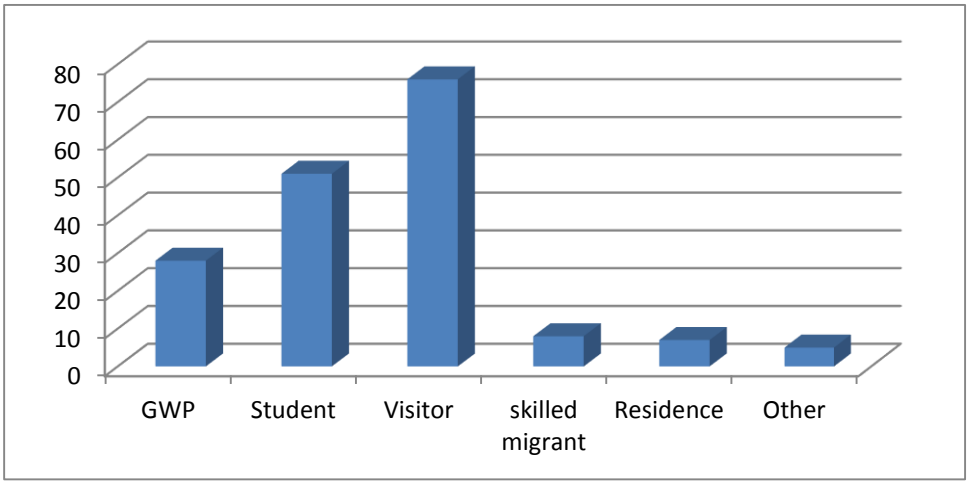
More than half had completed degree level nursing courses, or nursing and midwifery courses. The rest had diplomas in nursing and/or midwifery. The average number of years respondents had worked post qualification *as registered nurses* in their own countries was 7.9 years (+/- 5.4 years) ranging from six months to 21 years.

3) Registration with the Nursing Council of New Zealand

80/157 respondents were registered with the Nursing Council. Of these, 91% were working as registered nurses, 80% of these working in sectors other than aged care. Of the 77 who were not being registered with the Nursing Council of New Zealand, 71% were working as caregivers in the aged-care sector. Free text comments reported difficulties gaining registration, related to language tests (see later section), validation of overseas Schools of Nursing, access to Competency Assessment Programmes (CAP), and Immigration / visa difficulties.

4) Visas held

Graph 1: Visas at time of entry to the country (numbers of respondents)



The implications of these visa categories are explored in the discussion section.

5) Use of Agents

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 27 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. Dissatisfaction with agents was common, with many expressing a belief they had been, or were being financially and legally exploited.

6) Costs of migration and language testing

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 were reported as representing 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 and language training and exams (mainly the International English Language Test, IELTS). 100 took additional competency or conversion training (additional to language testing) ranging from one year to eight weeks. A few who had arrived prior to 2004, had demonstrated competence by

working without wages in DHB hospitals. This is no longer acceptable under the legislation related to nurse registration. (HPCA, 2003). Of the 163 required to take language tests, 147 had taken IELTS, with 61 passing first time, many taking the tests numerous times. The highest number of fails reported by an individual was 10. Many had also attempted the Occupational English Test (OET). The language tests used are shown in table 2. 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) yet were not at that point required to pass IELTS. 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 with either a General Work Permit or as Skilled Migrants. 8 of these were from India, and 1 from Malaysia.

Table 2: English Language Competency Testing.

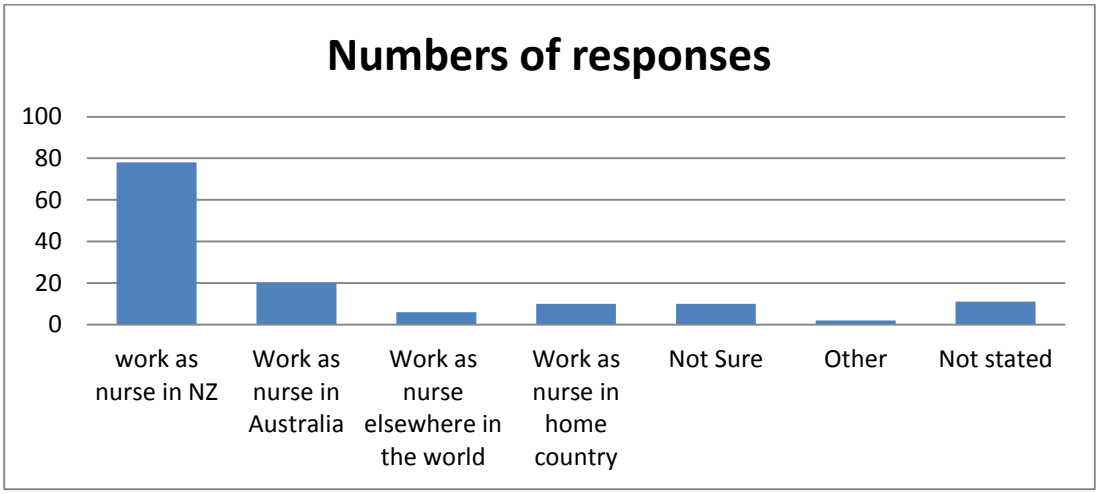
Test taken	Number of respondents	percentage
IELTS only	127	78
OET only	5	3
Both OET and IELTS	20	12
Other	3	2
Not Stated	8	5
TOTAL	163	100

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 statements about their communication skills as observed by registered nurses, or of more occupation specific language tests were made. The OET test 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 or New Zealand, although all except one

nurse who took OET listed working as a nurse in New Zealand as their longer term aim.

7) Longer term plans

Graph 2: Longer term plans of the respondents



8) Union membership

A majority of respondents reported belonging to a union: with 116 belonging to NZNO. A further 5 belong to the SFWU. 5 reported belonging to either country-specific or speciality specific nursing organisations. Of the NZNO members, only 42% were aware that indemnity insurance was provided with their membership. Many were members of various NZNO professional nursing colleges and sections.

Qualitative data

An additional 112 free text coments were provided, and these were analysed thematically and grouped into 8 main themes. Counts of numbers of individual respondents using phrases relating to each theme, and percentages of words coded to each theme (to show frequency and relative importance to respondents) together with exemplar quotes are presented in table 3. Only themes represented by three or more respondents are shown for brevity, but all data are available from the author.

Table 3: 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.....*
Abuse by 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.* *Major delays with Nursing Council were caused by them rejecting transcripts from my school*
Delays & Costs	**16** 12.2%	*It will take 2 years to process our papers* *It is too expensive to come here – I paid $5000 in fees for training and lodging I didn't need.*
Racism, discrimination and hardship	**7** 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*
Poor 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*
Difficulties with 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*

The qualitative data particularly illustrate the frustrations experienced by migrant nurses in 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. Additionally, while some expressed grattitude at being in New Zealand, and were enjoying their work, others were finding the work challenging and different from their expectations, and expressed dissatisfaction and distress related to working as care givers rather than nurses, low pay, hard work and perceived racism.

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 . Two outcomes of the publicity generated about the IELTS test (O'Connor 2008) have 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 recent 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. A recent development is that the Nursing Council has now removed the requirement to obtain a score of 7 at all four sections of the IELTS to be passed at the same sitting, these may now be acquired within one year (Nursing Council New Zealand, 2008) While an acceptable standard of English is a reasonable requirement for safe practice, 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. It could be argued that in an increasingly diverse population / patient population, the extra languages these migrant health workers bring with them is an asset. (AUT, 2008)

A second barrier to registration related to the accreditation of the various nursing schools in the Philippines, and the acceptability of the curriculum studied compared to that required for registration. Nursing Council of New Zealand (2008) acknowledged difficulties with this issues, and in particular credentialling combined degrees from the Philippines. There has been an increase in nursing colleges (the numbers have risen 10 fold over the last five years, (Kingma, 2006) [a], many nurses registered in the Philippines 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 (Kingma, 2006 [b]) is struggling to keep up with the

workloads caused by the increases in nurses. Graph 1, illustrating Visas held at entry illustrates clearly possible 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. Skilled migrant or working permit visa cannot be issued until registration with the Nursing Council is obtained, but delays can mean visa conditions are exceeded, and as care giving is not a skill shortage occupation, those awaiting registration with the Nursing Council risk deportation.

Whether overseas trained nurses plan to work in New Zealand long term, or to move to another country or back home is also important. It has long been claimed that due to the perceived relative ease of migration to New Zealand compared to Australia, the 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. (Marion Clark, 2008, communication to NZNO) 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. 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.

While the results of this small survey are mixed, not insignificant numbers of those responding (with the exception of Indian nurses) are considering further moves to other countries, especially Australia. As reported in a similar survey in the UK: “the fact that these nurses have made at least one international move means they are likely to have the propensity to do so again.” (Buchan, 2005)

Other international evidence exists that nurse migrants do not settle long term. Studies show that around 50% of skilled migrants return to their home countries after 5 years on average (Lowell and Findlay, 2002), and it is important that this information is used in the succession planning for both nurse leadership and nurse education.It would be interesting and important to find out if these figures also apply to the very much larger population of UK trained nurses currently working in New Zealand.

A third barrier to nurse registration is the access to and costs associated with cultural competence assessment programmes. Some overseas nurses are currently waiting for over a year to get places on these courses, and risk loosing their Immigration status if they do not become registered nurses within the two years. It should be noted that in the Philippines, arrangements for aged care are very different, and the training that nurses get of relevance to working in aged care may not be comparable or relevant.

Caution is required with interpretation of the current survey: the numbers of questionnaires returned was small, though the different mechanisms of distribution helped ensure that a wide range of experiences have been captured. The relative over-representation of potential respondents of nurses from the Philippines and India could be due either to the 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 significant publicity that related to the plight of Filipino nurses had received in KaiTiaki.

More accurate and up to date information is required about the number and skill mix of nurses in New Zealand. 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 (Buchan and Sochaslski 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, but unravelling such a complex and evolving picture may make work force planning difficult and inadequate. (Hawthorne, 2001) With over half of all *new* New Zealand nurse registrations being to overseas trained nurses, even small changes could have potentially drastic effects. This survey has confirmed that 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 Labour, 2005) though these have been described as recruitment and selection difficulties. It is too early to tell if the current global recession will change this situation, but in aged care especially, employers depend increasingly on overseas migrants. If this supply dries up in the face of changing regulations, patterns and increased global competition, there will be important implications for the sector, and for society.

NZNO currently has approximately 44,000: 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. NZNO provides independent indemnity insurance in addition to its other union services (education, professional practice advice, legal advice, a journal, colleges and sections) Despite all members having indemnity insurance as part of their membership, less than half who indicated union membership were aware of this union function. Concern must exist that if knowledge about insurance cover is so lacking, the levels of understanding about the legal issues, of rights and mechanisms for reporting or responding to professional issues may also be low There is an important role for Unions in supporting and protecting their migrant members from exploitation. Anecdotal evidence from Nursing Council 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. (P. Cook, Personal Communication)

On a humanitatrian level, further evidence has been collected that supports previous anecdotal stories that migrant nurses, particularly from India and the Philippines, in New Zealand have experienced delay, dismay, expense, disrupted careers, dislocated family life, and racism (Manchester, 2005). 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 home country nurses percieve 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.

In summary:

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

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