19 May 2010

Hon Tony Ryall
Minister of Health
Parliament
WELLINGTON

Tēnā koe

Legislative Barriers to Workforce Innovation

Thank you for the opportunity for the New Zealand Nurses Organisation (NZNO) to comment on the legislative barriers to workforce innovation. We have discussed these extensively with staff, members and other professional nursing groups and are confident that there is widespread agreement amongst nurses as to the most significant barriers preventing health practitioners from utilising the full extent of their scopes of practice. These barriers have particularly impacted on the registered nursing workforce and continue to prevent the optimal utilisation of registered nurses, who comprise almost half the health workforce, and nurse practitioners.

Of the 55 pieces of legislation identified by the expert reference group, we have prioritised eight, with the Medicines Act 1981 heading the list. Though we are aware that the Act is under review and that an action plan to progress changes to medicines legislation and regulations has been released, we are disappointed at further delay and not at all sanguine that the plan outlined in Actioning *Medicines New Zealand* 2010 will expedite appropriate change. In this context please note our comments to the Associate Minister of Health, the Hon Peter Dunne, in our letter of 15 April 2010, where we express our concern with:

> "… *the intention to simply 'explore' amending the Medicines Act 1981 to give Nurse Practitioners (NPs) the same prescribing rights within their scope of practice as medical practitioners, dentists and midwives (Page 8). We believe that this has been 'explored' for over a decade and that there is abundant evidence that NPs are safe and conservative prescribers, who refer appropriately. With a minimum of*

> *eight years training, post-graduate education and clinical experience, and a rigorous registration process, it is unnecessary and counterproductive to further delay removing the restrictions that prevent these expert practitioners from utilising the full extent of their scope of practice as authorised prescribers under the 2003 Health Practitioners Competence Assurance Act (HPCAA).*
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> *Similarly, the following action point for collaborative prescribing - to amend the Medicines Act 1981 to allow non-prescribing practitioners to prescribe "under the direct authorisation of a medical practitioner, dentist or midwife" – would effectively replace one barrier with another, by excluding NPs (or any other regulated practitioner outside these disciplines) as authorised prescribers.*

We draw your attention to the need for legislation to be consistent with the HPCAA, which provides for the regulation of health practitioners, including their competencies and scopes of practice, obviating the need for further definition in other legislation. It would be disastrous if the long delayed amendments to outdated legislation simply introduced a new set of barriers, or "built in" obsolescence by not allowing for the (unpredictable) development of new roles/models of care.

The HPCAA ensures an appropriate framework and processes for responding to workforce innovation in the health sector safely and quickly. NZNO believes that the best, perhaps only, way that New Zealand, with its small population and limited resources, will be able to maintain an affordable, advanced, continuously improving health workforce in today's global context, is to fully utilise a well-educated, flexible nursing workforce, able to respond professionally to a wide range of needs. Accordingly, amendments to the Medicines Act and other legislation should simply refer to "health practitioners authorised under the HPCAA" rather than specific roles or scopes of practice, which may be subject to change or introduced, as indeed is the case with NPs.

As well as the immediate costs and risks associated with duplication, the identified barriers affect funding and employment which have long-term implications for workforce development and quality improvement. Experienced, skilled and highly qualified practitioners have many choices about where and how they prefer to practice and few are disposed to have their expertise, gained at considerable personal as well as public cost, ignored. The obvious limitations to NP employment and practice have been a huge factor in discouraging nurses to step up to this leadership role. Further, most NPs work in primary public health, often with young people, where the most significant health gains are to be made, so limitations to their practice have a disproportionate effect on potential health outcomes and the

effective use of public funds. In this context we draw your attention to Dr R. Vaithianathan's comments[1] on research that indicates:

> *"the best benefits of healthcare spending is on the young because of the increased life over which the benefits are gained. Since the young rarely interact with the personal health system, changes to health in this age group have to be mediated through public health strategies".*

We have summarised our response to your questions as follows.

Which of the barriers are the most important to deal with first in order to address significant barriers to daily practice?

Apart from Those that impose "double handling" because the practitioner scope is either omitted or specifically excluded as authorised to prescribe, issue routine certificates etc., though regulated to do so.

1. Medicines Act 1981. *Nurse Practitioners should be authorised prescribers; does not encompass collaborative prescribing for Registered Nurses*.

2. Injury Prevention, Rehabilitation and Compensation Act 2001. *ACC does not recognise as NP autonomous practitioner for funding claims for prescription, assessments, treatments.*

3. Holidays Act 2003 – *NPs cannot provide sickness certificates.*

4. Health & Safety in Employment Act 1992 - *NPs cannot provide sickness and work certificates*

5. Social Security Act 1964 - *NPs cannot provide invalids' certificates*.

6. Children, Young Persons and Their Families Act 1989 – *GPs must authorise NP examinations, prescriptions and certificates.*

7. Land Transport Act 1998- *NPs cannot examine etc. for drivers' licences.*

8. Burial and Cremation Act 1964 - *NPs cannot sign death certificates*.

Why are these most significant?

- Expense and risks involved with duplicative processes.

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[1] Vaithianathan, R. 2010. NZMJ. Building on the myths: an economist's response to the Ministerial Review Group Report on the Health System. New Zealand Medical Journal 14 May 2010, 123 No 1314.

- Delayed treatment leads to poorer health outcomes, lower productivity.
- Increased bureaucracy means less time with patients.
- Most are barriers to the delivery of primary health care where the most benefits are to be gained.
- Constraint on retention, development (especially of nursing leadership) and sustainability of nursing workforce if NP and advanced nursing roles are not seen as viable career pathway in Aotearoa.

Additional barriers:
(apart from the other identified legislative barriers)

- Continuing contractual barriers in some DHBs related to radiological and laboratory diagnostics. For example, the ordering of CT scans and ultrasound.

- PHO structural barriers that prevent NPs from the direct enrolment of patients.

- Specific exclusion of NPs from being funded for the Purchase Unit for Nurse Led Clinics (NLCs), limits DHB workforce development and innovation. (*For example, NP work is currently funded under First Specialist Assessment and Follow Up purchase units, traditionally allocated to consultants. Where a NP has come into a service s/he has to share the allocated volumes. NPs work differently from doctors and tend to do more follow ups as they are focused on the functional health and well-being, of clients, as well as the medical components. If the volumes are capped then it poses a problem for NPs who have no other means of generating revenue for their services. Currently only Clinical Nurse Specialists are able to work under the NLC purchase unit. We recommend that the data dictionary definition should be extended to include the option for NPs to also claim Nurse Led Clinic volumes.*)

NZNO looks forward to expeditious resolution of these long outstanding legislative barriers to nursing innovation.

Nāku noa, nā

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ABOUT NZNO
NZNO is the leading professional body of nurses and nursing union in Aotearoa New Zealand, representing over 44 000 nurses, midwives, students, kaimahi hauroa and health workers on a range of employment-related and professional issues. Te

Runanga o Aotearoa is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.
The NZNO vision is "Freed to care, Proud to nurse". Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.