Parental Leave and Employment Protections (Six Months Paid Leave) Amendment Bill

Submission to Government Administration Committee

Principal Author

POLICY ANALYST: MARILYN HEAD, BA, DIP TCHG, MSC.

DDI: 04 4946372 | marilynh@nzno.org.nz
NZNO.ORG.NZ 499 9533 OR 0800 283 848

Executive Summary

The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Parental Leave and Employment Protection (Six Months Paid Leave) Amendment Bill. NZNO **supports** the Bill on the basis of evidence that it will:

- promote the physical, mental and emotional wellbeing of babies and families;
- is cost effective and will reduce future demand for health, social services, correctional and educational interventions; and
- is essential for maintaining the international competitiveness of a skilled local workforce by retaining and attract young skilled workers (including New Zealanders working overseas).

Introduction

1. NZNO has consulted its members and staff in the preparation of this submission, including members of our specialist Colleges and Sections, in particular the Nurses for Children & Young People Aotearoa Section, the Women's Health Section and the College of Primary Health Care Nurses (CPHCN); Te Runanga, Regional Council and Board members; and professional nursing, industrial, policy, research and legal advisory staff.
2. NZNO is an affiliate of the New Zealand Council of Trade Unions and a signatory to the "26 for Babies" campaign.
3. As NZNO has contributed to, and endorses, their respective submissions, it is not our intention to reiterate their content, but rather to emphasise the nursing viewpoint, from both a professional and industrial perspective.
4. In this context we note that not only is nursing a predominantly female occupation (93% of the nursing workforce is female), but also that nurses are aging, that our nursing workforce is reliant on internationally qualified health practitioners who make up 25% of nurses, and that the global demand for nurses is increasing (Nursing Council New Zealand, 2010).
5. Thus this Bill is particularly relevant to nurses as working women, who understand its implications for health and employment in the wider context of the sustainability of New Zealand's health workforce, in which respect we also note that Aotearoa New Zealand lags behind other OECD countries in the support given to families with young babies.
6. NZNO welcomes this Bill and **supports** it on the basis of evidence that it is will help to:
   - increase the physical, mental and emotional wellbeing of babies and families;
   - reduce expensive mitigation and correctional interventions later; and

- maintain a highly skilled local workforce and, in particular, retain and attract young, skilled people including New Zealanders, about to become parents.

7. This submission discusses the benefits of an extended period of paid parental leave to health, efficiency and workforce factors health, within an established context of estimated current costs.
8. NZNO recommends that the Committee accepts the Bill and notes our recommendation that financial assistance to support parents of babies is extended to all parents, not just those in paid employment, for at least the first year of a child's life.

Discussion

9. Nursing is an evidence-based profession so the following is based on the weight of scientific evidence and nursing observations which reinforce it.

Health: how the Bill will increase the physical, mental and emotional wellbeing of babies and families

10. Every person experiences some form of disability during their lives, whether it is temporary due to a broken limb, progressive such as with compromised eyesight, or the permanent loss of mobility or cognition.
11. But at no stage is anyone more vulnerable than as a baby who cannot see, move nor feed independently and is thus totally dependent on the good will and competence of the adults responsible for his/her care.
12. Yet it is precisely at this age of peak vulnerability, that the greatest societal changes - one might say the greatest *in vivo* experiments - have occurred to this most fundamental relationship: the replacement of breast milk with powdered milk made for cows (or goats, or even beans as is the case with soy), and the separation of babies from families.
13. Breast milk is not just "best" for baby in the way that one type of baby seat is better than another: it is the essential characteristic defining the class of vertebrates (*Mammalia)* to which humans belong. It is species-specific, 'living' in the same way that blood and semen are, adjusts to the age and condition of the child delivering protective antibodies when necessary, and plays a role in protecting DNA (Chapkin et al, 2010).
14. In addition to the well known protection that breastfeeding offers against immediate risks such as sudden unexpected death in infancy (SUDI), chest, ear and urinary tract infections (Ministry of Health), there can be no doubt that breastfeeding fundamentally affects health outcomes in later life (Koletzko et al., 2009).

15. There is epidemiological evidence that breast-feeding protects against more serious and long term disease such as tumour development in children (Mathur et al, 1993), immunological diseases (Ahmed & Fuchs, 1997), infantile diabetes mellitus (Gerstein, 1994), inflammatory gastrointestinal disease and obesity (Koletzko et al., 2009).
16. The prevention of disease and ill health is one of the reasons why the World Health Organisation advocates exclusive breastfeeding for the first six months and continued breastfeeding for two years and beyond.
17. Another is the way in which breastfeeding promotes normal physical and mental development, particularly the development of coordinated binocular vision and the development of the jaw, both connected (as original research of New Zealand speech therapist Frances Broad suggests) with children's later ability to read.
18. The biggest barrier to breastfeeding is the economic imperative to return to work. This is very evident in breastfeeding statistics not only for Aotearoa New Zealand but for other OECD countries as well: breastfeeding drops dramatically at the end of the period for paid parental leave (New Zealand Statistics).
19. Indeed nurses observe that the decision to breastfeed or not is critically influenced by the period a mother expects to be out of paid employment. The shorter the period, the more likely it is that the decision is made not to breastfeed, though the immediate individual financial benefit of working is miniscule in comparison to the significant, long term health and social costs of not breastfeeding.
20. Those who are financially vulnerable and for whom the economic imperative to return to work and not breastfeed are greatest, are also those for whom access to health services is the most difficult. Regardless of fees (though free GP and after hours care is rare, despite government subsidies), the costs and difficulties associated with lack of transport, inadequate housing, time off work, care for other children etc. are almost insurmountable for many as evidence presented by, amongst others, the Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty shows (2012).
21. Though there is legislation to make breastfeeding in employment situations more feasible, and to adhere to the WHO International Code of Marketing Breast milk Substitutes to halt the advertising and promotion of breast milk substitutes and to require accurate labelling, quite clearly an environment conducive to breastfeeding has not been achieved.
22. There are a myriad of reasons, but overworked nurses and midwives, particularly in hospital settings where staff shortages and a higher proportion of acute maternity care is required, report that they often do not have time to ensure that breastfeeding is established, and that specialist help with breastfeeding by lactation consultants is not always or readily available.

23. Further, other forms of assistance or follow up care/education for first time parents, or for those who are vulnerable, are *ad hoc* and highly variable between DHBs.
24. The importance of parental bonding, particularly in relation to emotional development and resilience can hardly be overstated.
25. Disturbances in parental bonding are linked with the development of mental disorders later in life (Canetti et al, 1997) and must be considered a factor in New Zealand's extraordinarily high rate of adolescent (and other) suicide (Shuttleworth & Theunisson,2012) and high incarceration of young people (Department of Corrections, 2011).
26. Clearly it is essential that there is as little interruption as possible to the bonding process, and that support for parents to be with their child for at least the first six months, though the weight of evidence suggests that a much longer time is optimal, is essential.
27. By extending the period of paid maternity leave, the Bill will enable and encourage many more mothers to choose and maintain breastfeeding, and will enhance parental bonding, thus promoting the physical, mental and emotional health of our most vulnerable future citizens.

Comparative Cost

28. Current provisions for paid parental leave are for payments that equal normal pay (before tax) for employees, or average weekly earnings for those who are self-employed, up to a current maximum of $475.16 a week before tax, for up to 14 weeks, and are transferable to a partner.
29. The difference between the current 14 weeks paid maternity leave and the proposed 26 weeks paid maternity leave is about $6,000. (Currently $475.16 weekly. $475.16 X 26 weeks = 12,354.16. 12 weeks [the difference between the current 14 and the proposed 26] x $475.16 = 5,701.92, though we acknowledge that there is some dispute as to whether parental leave attracts holiday pay which would be a further cost.)
30. That is less than the approximately NZ $6,200 that Australia, for example, gives to *all* new parents and is very much less than the cost of health, education, social and justice interventions that may be directly attributed to children lacking the necessities of life at the outset.
31. Cost estimates vary, but even the conservative $6 billion p.a. figure presented by the Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty, is a clear indication that funding consequential and remedial measures for damaged children unable to realise their potential is entirely unsustainable and inhumane.
32. It is not only more rational to invest $6,000 per baby/family rather than $90,000 p.a. per prisoner, for example, but also more just. Babies are not responsible for the circumstances they are born into, just as many people have little control over factors such as employment and housing which impact on their ability to better their circumstances.
33. NZNO draws your attention to the Final report of the World Health Organisation's Commission on Social Determinants of Health: *Closing the gap in a generation: Health equity through action on the social determinants of health* (Chapter 8, 2008) which specifically mentions

parental leave as important component of a suite of integrated measures to mitigate inequity and promote the healthy work/life balance essential for population health.

34. All New Zealand children deserve to be afforded the necessities of life and this Bill is a step in the right direction to help families do that.
35. Nationally we cannot afford to have young population that does not meet its potential in terms of health, ability or stability.
36. With fewer workers supporting an aging population there is a clear need to *enhance* the capability of future workforce to ensure they have the intellectual capacity, social skills, and emotional resilience to lead the innovation which drives high performance and productivity, and to reduce the demand for health care for the preventable diseases of diseases, obesity, infection etc. which are increasing (Baker et al, 2012).

Workforce: maintaining a competitive edge

37. In 2008 an OECD Health Working paper *Health workforce and International Migration: Can New Zealand compete?* pointed out an issue that NZNO had long been trying to raise awareness of, and that was the precarious position of New Zealand's health workforce in the face of increasing global demand for skilled health workers which makes it peculiarly susceptible to policy changes in other nations (Zurn and Dumont, 2008).
38. For some years IQN registration outstripped the registration of new New Zealand-trained nursing graduates, and of the latter, up to a third left Aotearoa, without practising here at all.
39. In the absence of nationally supported pathways for nursing development and leadership, overseas recruitment of experienced nurses by DHBs was the only uniform strategy for meeting nursing workforce needs, as evidenced by the Department of Labour's Essential Skills Shortages Listing of nursing which has not changed for over a decade.
40. With very limited funding for higher education or return to nursing programmes, no employment support or strategy for the utilisation of Nurse Practitioners, inferior wages and conditions, and the burden of student debt, it is not surprising that nurses are voting with their feet.
41. In addition, recruitment of IQN is becoming more difficult as New Zealand's employment conditions lag behind those that other countries offer, and there are additional challenges with the increase in recruitment of IQN from developing countries rather than from those with a similar culture, language and health system to Aotearoa.
42. Recently published NZNO research on new IQN and also young "Gen Y" nurses reveals the extent to which the nursing workforce is poised between sustainability or crisis as nurses balance commitment to careers in Aotearoa, or going overseas to nurse, or leaving the profession altogether (Walker & Clendon, 2012).
43. There are currently no strategies to entice IQN stay in Aotearoa, yet they make up such a large part of the nursing workforce, predominantly

in acute care, that their retention is critical to maintaining a stable, high quality workforce able to meet the health needs of New Zealanders..

44. The 'take home' message for both groups of mainly young women with, or about to have, families is that employment conditions matter; and while New Zealand may not be able to compete with other countries in terms of wages, being a good place to bring up children, being able to provide them with the necessities of life and knowing that they will have the opportunity to develop their full potential who will have opportunities, is critical to their decision about where they will work.
45. Anecdotally, that is a very similar message NZNO gets from members who have returned from nursing overseas.
46. During the last two decades fertility rates have decreased and have become positively correlated with female participation rates across the OECD. Many developed countries, including Aotearoa, are not maintaining replacement population levels, prompting several to initiate generous maternity benefits linked to employment (Adserà, 2004).
47. There is a clear policy choice here. Either New Zealand invests in affordable strategies that encourage young skilled people with families to stay or return to New Zealand, or we lose them, and accept the increasingly catastrophic effects on the health, and other skilled, workforces. The current situation of training young people to go overseas with no strategy for attracting them back, coupled with unsustainable recruitment of IQN for who there is also no retention strategy is a lose-lose one for New Zealand in every way. This is particularly so if people choose to have their families overseas as they are less likely to return in their productive years, though they may choose to retire here.
48. Currently there is an enormous mismatch between wages and conditions with even our nearest neighbours, Australia, and we are facing increased global demand for health professionals.
49. This Bill is an affordable and essential recruitment and retention strategy for skilled workers in New Zealand.

Conclusion

50. There is no question that breastfeeding and good parental bonding increase the physical, mental and emotional wellbeing of babies and families in both the long and the short term.
51. Supporting extended parental leave will reduce health disparities and future demand for health care.
52. It will also reduce the cost of remediation and intervention in other areas such as education, social development, justice and corrections.
53. Extended parental leave is an essential and affordable strategy for retaining a sustainable nursing workforce, and, we suggest, for the development of a healthy, skilled generation of workers capable of meeting the needs of an older population.
54. NZNO recommends that you:
    - **note** our support for this Bill; and
    - **agree** that extended paid support for all parents beyond 26 weeks should be an immediate priority.

REFERENCES

Adserà, A. Changing fertility rates in developed countries.The impact of labor market institutions. *J Popul Econ.* 2004. 17:17–43. Springer-Verlag.

Ahmed T, Fuchs GJ.: Gastrointestinal allergy to food: a review. *J Diarrhoeal Dis Res* 1997 Dec;15(4):211-23.

Baker, M. et al. (2012). Increasing incidence of serious infectious diseases and inequalities in New Zealand: a national epidemiological study, The Lancet, Early Online Publication. doi:10.1016/S0140-6736(11)61780-7.

Canetti, Laura; Bachar, Eytan; Galili-Weisstub, Esti; Kaplan De-Nour, Atara; Shalev, Arieh Y. Parental bonding and mental health in adolescence. *Adolescence*, Vol 32(126), 1997, 381-394.

Chapkin, K et al. Non-invasive stool-based detection of infant gastrointestinal development using gene expression profiles from exfoliated epithelial cells, *AJP - GI* May 1, 2010 vol. 298.

Department of Corrections. Prison Facts and Statistics as retrieved October 2012 http://www.corrections.govt.nz/about-us/facts_and_statistics/prisons/march_2014.html#ages

Gerstein HC (1994). Cows' milk exposure and type 1 diabetes mellitus. *Diabetes Care* 17: 13-19 .

Koletzko B, Decsi T, Molnár D, Hunty A. (Eds) 2009. *Early Nutrition Programming and Health Outcomes in Later Life: Obesity and Beyond*. Advances in Experimental Medicine and Biology Vol. 646. Springer.

Mathur G P. Breastfeeding and Childhood Cancer *Indian Pediatr.* 1993 May; 30(5):651-7.

Ministry of Health, Benefits of Breastfeeding web link accessed October 2012 http://www.health.govt.nz/yourhealth-topics/maternity/breastfeeding/benefits-breastfeeding

Nursing Council of New Zealand.(2010). *2010 Workforce Statistics.* Retrieved from http://www.nursingcouncil.org.nz/download/186/31march2010.pdf

Pascal Zurn and Jean-Christophe Dumont. 2008. *Health workforce and International Migration: Can New Zealand compete?* OECD Health Working paper N.33. OECD Publications. http://www.oecd.org/dataoecd/46/41/40673065.pdf

Shuttleworth, Kate Theunissen, M. *Horror over child suicide rate surge.* NZ Herald, 3 September 2012 As retrieved October 2012 http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10831455

Walker, L & Clendon, A multi-cultural nursing workforce: views of New Zealand and internationally qualified nurses and Generation Y registered nurses – career commitment and consequences for retention. 2012 Sept. *Kai tiaki nursing research journal* vol 3, No 1, NZNO.

World Health Organisation. Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organisation.

About New Zealand Nurses Organisation NZNO

The New Zealand Nurses Organisation is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 45 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership and 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.