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AOTEAROA NEW ZEALAND



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1. Environmental Scan

Nursing profile

Aotearoa New Zealand has 11 nurses per 1000 population, with a comparatively high number (10.5 per 1000) in Direct Care roles (Nursing Council of New Zealand, 2015). Just under half of the total number of 50,356 practising registered nurses work part-time or flexible hours ie less than 35 hours per week, the most commonly cited reasons being parental responsibilities, personal choice, and the effect of high workloads (Nursing Council of New Zealand (NCNZ), 2015, p14). The number of nurse practitioners (NPs) is growing steadily, while the number of enrolled nurses is decreasing. While overall the nursing population is ageing, there has been a significant increase in younger nurses as the number of nurses aged under 30 grew by 2,258 (41%) between those two dates, while the number aged over 50 fell by 350 (-2%). Internationally Qualified Nurses (IQNs) also contributed to this growth, with the number of IQNs increasing by 10% compared with growth of 4% in the New Zealand-Qualified Nurse population.

The number of male nurses increased more significantly (14%) than female nurses (5%) over the two years, but they still only constitute 8% of practising nurses (NCNZ, 2015, p13-15). 57% of nurses identify as Pākehā/New Zealand European) and 6% as Māori. 14% identify as European; 6% Filipino; 5% Indian; 3% Pacific, and 11% identify with multiple ethnicities. (The ethnic profile of the population is 74.6% Pakeha/European; 12.2% Asian; 15.6% Māori; Pacific 7.8%; 1.2% Other). The lack of progress and strategic action on growing the Māori nursing workforce proportionate to the population, prompted NZNO's Kaiwhakahaere Kerri Nuku to take the issue to the United Nations Permanent Forum on Indigenous Issues ("UN Indigenous Forum") in New York earlier this year.

Developments in nurses' working conditions

Nurses working conditions remain challenging in most areas as health services face higher patient acuity, increasing health demand from aging and chronic disease (notably diabetes, COPD, cancer and respiratory disease) and reduced resourcing. Eight hour shifts continue to be standard for most nurses. 10 and 12 hours shifts are included in the DHB MECA, but their use tends to be localised. NZNO does not recommend 12 hour shifts based on research undertaken by the organisation in this area (Clendon & Gibbons, 2015).

Funding constraints have impacted nurse staffing with staffing shortfalls, delayed recruitment, reductions/amalgamations of some senior nursing and nurse educator positions, and underemployment (eg substantive contracts of 0.8 FTE to manage demand variance without having additional permanent nursing capacity “on the books”). to provide integrated services for highly vulnerable children has had a serious impact on Public Health and Child and Youth nurses appointed as lead professionals in Children’s Teams. The “new approach” is expected to work within “existing resources”.

68% nurses have post graduate qualifications (Walker & Clendon, 2013). Funding for post registration nurse education and training is comparatively limited equating to just \$25.3m of the \$172.1m national funding pool (2014-2015), but nurses are encouraged and rewarded for participation in professional development recognition programmes (PDRP) and 26% participate in PDRP programmes.

Implementation of the care capacity demand management (CCDM) programme, matching patient demand with capacity, jointly developed by NZNO and the District Health Boards (DHBs), is progressing slowly and somewhat disparately. Where carefully implemented there has been a decrease in the use of casual staff, an increase in staff satisfaction and improved health and cost outcomes (O’Malley, Graham-Smith, Skeet, & Robinson, 2015), but it remains a challenge to secure commitment to the substantial investment in nurse and

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management training needed to embed changes to budgeting, planning practices, data collection and sharing, and ways of working within and across teams and disciplines.

Settlement of the DHB Multi-Employer Collective Agreement (MECA) 2015-2017 last year included a 2% wage increase for 2 years, above the rate of inflation which is currently 0.4%. Wages and wage increases in aged residential and community care (mostly privatised), remain, in general, significantly lower than those in DHBs; significant wage disparities remain between Māori and iwi providers, compared with DHBs and this was also brought to the attention of the UN Indigenous Forum. Te Rūnanga o Aotearoa, NZNO (Te Rūnanga) has been asked to set up an ICN indigenous forum.

Around 64% of new graduate nurses are supported into practice through the Nurse Entry to Practice (NEtP) programme, leaving around 36% to enter the profession without the support, mentorship and time for post graduate study that research evidence demonstrating the benefits for nurse retention and patient outcomes indicates. New graduates also have the opportunity to apply for limited positions on the Nurse Entry to Specialty Practice (NESP) programme for Mental Health and Addiction nursing. 220 positions are available for new graduate nurses under the Voluntary Bonding Scheme (VBS) for hard-to-staff locations, and hard-to-staff specialities of aged care and mental health. Unfortunately despite the success of VBS for low cost primary health care (PHC) services, funding was cut. Unemployment of new graduates remains an issue, particularly for graduates who are unable to relocate and where NEtP placements have been reduced. The lack of NEtP placements in aged care and mental health makes these areas high risk for nursing graduates.

A new direct entry to Nursing Masters has been introduced, as has limited placements for a national nurse practitioner (NP) programme which is funded and linked to employment. A more flexible regulatory environment in terms of scope, education, prescribing and statutory duties should see more

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opportunities for expanded and inter-professional practice, though barriers to dual scopes remain.

Some nurses have been affected by the “vaccinate or mask” policy on influenza adopted last year by one DHB, operating outside the structured collaboration between DHBs and health unions. The policy has not been reviewed and continues to be divisive and punitive.

Developments outside nursing

The National-led government is midway through its third elected term. Major social concerns remain, rising inequality, child poverty, and chronic housing shortages leading to homelessness, particularly in the largest and economically dominant city of Auckland. New regulations to improve the quality of rented housing stock, including State and council owned housing, fall well short of the ‘certificate of fitness’ advocated by health and civic organisations, while state-owned houses continue to be sold, without replacement. Record immigration has fuelled discussion about employment, cultural identity, equity and sustainability. The “New Zealand” flag was retained after a contentious \$26 million referendum.

Employment standards legislation, introduced mostly positive changes to employment rights, eg increased paid parental leave, preventing ‘zero-hour contracts’, strengthening health and safety capability and accountability, though no provision has been made for occupational health surveillance, and employee participation requirements have been weakened. The adult minimum wage rate (before tax) for employees aged 16 years or over has increased to \$15.25 per hour, but a lower starting rate can be paid to young workers and to employees in training. Average negotiated wage increases for collective agreements in 2016 are around 1.6% in the public sector compared with 2.3% in the private sector (Blumenfeld et al, 2016). Unemployment is relatively stable at around 5-6%, but there are significant disparities for vulnerable groups, and

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the rate does not reflect the increase in insecure work and underemployment (New Zealand Council of Trade Unions, 2013). Employment, taxation and the lack of affordable housing and inability of a growing proportion of New Zealanders to aspire to home ownership are likely to be key election issues next year.

The New Zealand Productivity Commission has conducted a number of inquiries into tertiary education, social services, boosting productivity, urban development etc. - which reflect the government's focus on commodity/tourism-driven economic growth, reducing public expenditure, targeting long-term welfare dependency, and increasing government/ private/ iwi/ NGO collaboration. Comprehensive reorganisation of Child Youth and Family services (CYFS), under a new standalone agency, the Ministry of Vulnerable Children Oranga Tamariki continues the government's programme for social service reform which includes the Children's Action Plan (CAP) implementing the Vulnerable Children's Act 2014.

In education, the government's contentious support for Charter Schools has been extended, while funding for disadvantaged children has been individualised, and legislation proposing online education has been introduced. Overseas students continue to be an important revenue source. An Action Plan to develop and implement a qualification, training, and career framework for the rapidly expanding care and support workforce (Kaiāwhina) is underway.

Health

Health funding has decreased in real terms by about \$1.2 billion over the past six years (Rosenberg & Keene, 2016) and there has been a continuation of trends towards increased outsourcing of services eg elective surgery, and service provision in communities, through devolution of secondary care to primary health organisation (PHOs) (mainly GP practices), pharmacies, and through *Whānau ora*, a Māori-led cross government integrated health, education and social services programme. There has been no change to the six priority health targets - shorter stays in emergency departments; improved

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access to elective surgery; faster cancer treatment; increased immunisation; better help for smokers to quit; more heart and diabetes checks – that DHBs are required to measure and report on annually.

The government is proceeding with a comprehensive programme of updating a number of national health strategies (disability, mental health, health of older persons, pharmacy etc.) through a framework which has been established by the recently updated New Zealand Health Strategy 2016 and its accompanying Roadmap of Actions. The Strategy articulates a shift from a wellness model of universal public health and primary health care, to commissioned private and community-based services that are tightly targeted and ‘outcomes-focused’. There is a significant emphasis on Health Information Technology platforms, including national health data and patient access systems, amalgamated telehealth, and new technologies. Primary health care is noticeably absent from the strategy and no review of the 2001 Primary Health Care Strategy has been proposed.

As with social services, ‘an investment approach’, based on largely untested predictive modelling, and collaborative private, public and NGO partnerships is favoured, though the government has not managed to contract any of the experimental social investment bond projects it selected. Strengthened capacity and positioning of the Office of the Chief Nurse (OCN) in a restructured Ministry of Health has accelerated response to some nursing workforce issues, including input into policy and health strategy development.

The national pharmaceutical purchasing agency, PHARMAC, has been expanded to include medical devices as well as community and hospital medicines. PHARMAC’s funding has been increased, possibly in response to public pressure over the lack of funding for the melanoma drug Keytruda (Aotearoa New Zealand has the highest rates of melanoma); and possibly in anticipation of increased costs because of intellectual property provisions in the Trans-Pacific Partnership Agreement and similar multilateral trade agreements.

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In particular special IP provisions for *biologics*, the fastest growing area of drug expenditure (PHARMAC, 2015) will delay entry of generic 'biosimilars' for at least five years, effectively extending protections for pharmaceutical monopolies.

Changes to increase the range of functions formerly restricted to medical practitioners to nursing and other health professionals are being implemented, including prescribing, statutory duties, and certification etc. as part of a comprehensive review of the pharmaceutical management regime.

A National Nursing Workforce programme has been established to provide oversight on a national workforce plan to advance the integrity of nursing workforce data; improve graduate nurse employment; and advance workforce planning and development. A strategy for the Māori nursing workforce has just been released, with the aim of matching the percentage of Māori in the population by 2018. The Ministry of Health is working on a predictive tool for modelling future nursing workforce shortages, using 60 years of NCNZ data to map trends in workforce changes. This complex-data-driven analysis produces mixed results for the security of the NZ nursing workforce between now and 2025, and offers a different perspective from the NCNZ commissioned report on nursing supply projections 2010-2035 (Nana et al, 2013).

The modelling assumptions behind the projections take account of established movements into and out of the workforce based mainly on age allowing comparison between figures for numbers of nurses on the register, and full time equivalent (FTE). Projections may be influenced by policy and management practices such as flexible hours and family-friendly rostering, and enable better matching of nursing supply and demand and sustainable IQN deployment.

Projections of deficits in the Māori and Pacific Island RN workforce numbers, and geographical differences in population distribution too should inform the provision of Māori nurse education and employment to allow Māori populations

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to be culturally served, and Māori students to study with/near their whānau and iwi links, and then to gain employment and career advancement while retaining their whānau and cultural links.

A Childhood Obesity Plan has been introduced focusing on the prevention and management of obesity in children up to 18 years, but falls short of the regulatory action recommended in the Report of the World Health Organization's Commission on Ending Childhood Obesity. However, at the instigation of the Director-General of Health, DHBs have developed a more stringent healthy food and beverage policy for all DHB settings.

Other health initiatives in this year's budget include the beginnings of a screening programme for bowel cancer; an increase in the excise tax on tobacco by 10% but the loss of funding to Smokefree advocacy services; and small increases in funding for health workforce training and school based health services. The Health Quality & Safety Commission concluded its Open for Better Care National Safety Campaign, and has overseen a number of mortality reviews. Findings from a two year trial (Suicide Mortality Review Committee, 2016) will inform a new Suicide Prevention Strategy and Action Plan to address Aotearoa New Zealand's high suicide rate, which is the leading cause of death for young people.

WorkSafe New Zealand, the regulatory agency responsible for workplace health and safety, is undertaking a systematic review of all workplace regulations and guidelines many of which are outdated, to ensure that they are relevant and reflect best practice. Healthcare has been added as a sector ACC/WorkSafe joint action plan, with body stressing, and slips trips and falls are added as cross-sector risks.

National Nursing Association (NNA)

As the NNA for Aotearoa New Zealand, NZNO has advocated for and supported:

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- a partnership approach between unions/professional association/employers and the Office of the Chief Nurse (OCN) significant in addressing safe staffing through the Care Capacity Demand Management (CCDM) programme;
- partnership between national nurse leaders through the National Nurses Organisation to have a collective voice and approach on nursing professional and workforce matters; and
- National and Regional collaboration through National Nurses Organisations (NNO), Nurse Executive of New Zealand (NENZ), and South Pacific Nurses Forum (SPNF). The NNO is Aotearoa New Zealand's key nursing stakeholder group comprising representatives from employers, educators, professional bodies, the regulator, and the OCN.

Leveraging synergy between professional and union aspirations through collective bargaining (eg safe staffing clauses in all collective agreements) Care Capacity Demand Management, tripartite (government, DHB, Union) Health Sector Relationship Agreement, Bipartite Agreement Groups is a key enabler of safe, healthy work environments and health services, as is active engagement and leadership in workforce and health issues eg Living wage movement, pay and employment equity, child poverty and homelessness, precarious work. NZNO became an accredited living wage employer in June 2016, and also undertook to disinvest in fossil fuels.

NZNO's 2015-2016 annual report, available September 2016, highlights the multiple ways in which nursing unions advocate for the nursing workforce and public health in professional and industrial and public fora. Professional nurse advisers (PNA) provide education, forums, and advice to members and nurse leaders and employers, and work closely with Colleges and Sections to advance professional and clinical goals. NZNO's lawyers provide nursing-specific representation and medico-legal forums, which this year focused on *Facing*

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Virtual Reality ie digital and social media, electronic records, tele-health etc. Submissions comprise a major part of NZNO's policy team's work which coordinates feedback from all member groups, the Board and te Rūnanga to inform government, health and public sector organisations. NZNO's Research in 2016 focused on workforce retention; nurses' health and safety including a study on fatigue; and professionalism, particularly issues around privacy and e-health. Research publications are listed in appendix 1. NZNO's fifth biennial employment survey is about to get underway. NZNO supports students through National Student unit (free membership is offered to first year students) and professional practise through Competency Advisory services.

NZNO publishes a number of documents relating to professional development practice, regulation and education. Recent publications include Position Statements on climate change, medical marijuana and obesity; an e-book on Quality in the Workplace; and Guidelines for nurses on the administration of medicines and has recently endorsed a Trade and Health Policy position statement (Public Health Associations of Australia and New Zealand, 2015). A full list of publications in professional practice areas is found in Appendix two (2015 and 2016). NZNO's election manifesto for 2017 is likely to reflect the same priorities identified in the 2014 manifesto *Nursing Matters*:

- A sustainable fully utilised nursing workforce.
- Investment in public health
- A primary health care approach to improving population health
- Social and health equity
- Best start of children

2. Issues related to Equality

The most significant labour development has been the upholding of the Employment Relations court decision in the claim made by health care assistant Kristine Bartlett against Terra Nova Homes (aged care), which economically
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empower those who work in low wage, female dominated occupations. Bartlett argued her \$14.46 hourly wage was less than would be paid to men with the same, or substantially similar, skills, and that it was a breach of the Equal Pay Act. The principal case is yet to be heard but a working group comprising representatives from unions, Business New Zealand and government officials has reached consensus on principles for addressing equal pay claims for work that is predominantly performed by women and historically undervalued. Once formally approved, it will become a key element in underpinning the future developments in both residential and home and community services.

Coverage of paid parental leave (PPL) that is more inclusive of casual, part-time workers and alternative carers has been extended to 18 weeks. In an unprecedented move, the government exercised its right to veto a private members bill proposing 26 weeks PPL which had majority support in the House.

While there have been some positive changes in employment standards legislation to remove indefensible injustices - zero hours contracts, travel times in low paid caring jobs, and the right for flexible hours to be *considered*, the following gender equality issues are of concern:

- increasing inequity between mana wahine (Māori women) and other New Zealanders – the gap between mana wahine and other women is greater than the gap between women and men (CEDAW Report, 2010)
- lack of progress on abortion law reform;
- erosion of employment conditions, including occupational health and safety, meal breaks, 90 day trial period;
- increasing issues with maternal mental health leading to suicide;
- violence against women including women workers eg nurses;
- unequal conditions for youth workers which legitimise inequality in employment for some groups.

Gender diversity has been included as a census category for the first time, a small step towards eliminating discrimination based on gender identity, which is only obliquely covered under sexual orientation in the New Zealand Bill of Rights Act 1990. NZNO is currently updating its position statement on gender identity.

The divide between New Zealand's poorest and wealthiest has widened alarmingly over recent decades, particularly from the late 1980s -1990's, with differences in income growing faster than in most other developed countries, and still reflecting historic socio-economic disparities (Rashbrooke, 2013). Aotearoa New Zealand has traditionally valued equity; however, the increasing limitations on social mobility and participation in society is polarising public opinion and leading to more distinct political choices between the neoliberalism of the incumbent National party and the social democracy and economic liberalism of the opposition parties - Labour and Greens, NZ First, and Māori.

3. Evolution of the Role of Nursing Unions in Today's Environment

While nursing unions continue to be primarily focussed on professional and industrial issues directly affecting members - employment, pay and conditions, health and safety, models of care, health policy and settings, etc. – new technologies, global challenges such as climate change, and new social and economic paradigms are driving a broader focus on collaboration within and between countries and organisations. In Aotearoa union membership has declined, and in general is strong only in the public and regulated sectors. However, NZNO's union membership grew by 1.3% from 46,778 in 2014/15 to 47,407 in 2015/16. The nursing union therefore has a prominent role as a leading union advocate on public health, social justice, employment and, as a predominantly female industry, gender issues.

It is increasingly evident that along with the benefits of globalisation, there are significant risks, which require a unified, international approach and broad government, private sector and civil society collaboration. Combatting climate
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change and reducing the concentration of power and wealth into fewer and fewer hands are overriding priorities because of their impact on everything else (including action on climate change). The UN Sustainable Development Goals (SDGs) which encompass both nursing workforce and health priorities are aspirational, and underpinned by a fair and practical agenda.

They are, however, almost entirely dependent on the willingness and ability of nations to pursue them, since there are few international legal instruments to enforce health and human rights agreements in the same way that, for example, trade agreements are enforced. Indeed, it is the structure of existing legal systems that paradoxically promote and protect public goods on the one hand that determines the distribution of wealth that have imbedded inequality and injustice, on the other (Allott, 2007, p100). As states are no longer the sole, or even dominant, actors controlling global activity, a new model is called for which transcends normative national and social interest boundaries.

In this environment, the role of nursing unions and the regional and international bodies they are affiliated to will be increasingly important in promoting awareness of and holding governments accountable for international commitments to the UN SDGs and Human Rights Conventions, and regulating WHO International Labour Organisation guidelines, codes and standards etc. Similarly, the close links nursing unions have with other professional and civil society groups is likely to be an important factor in strengthening international partnerships to address the embedded structural inequality that is a barrier to addressing the social determinants of health.

4. Campaigns and communication in the Age of Social Media

*Please describe **one** example of where your organization used social media*

All the way for Equal Pay. As part of the joint union campaign for equal pay for caregivers and health care assistants in the aged care sector, NZNO used its Facebook page to promote pay equity for women through a campaign targeting Members of Parliament (MPs), *"We're Relying on You!"*. Members were
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encouraged to write to their MPs inviting them to take the “Politicians Pledge” which stated: "I believe a person should be paid based on their skill, responsibility, effort and conditions of work. I support pay based on the job, not the gender, and will not ever support gender-based discrimination of pay." This was followed up with MPs who had signed being photographed and publicly acknowledged on Facebook and other media. Some MPs elected to work as caregivers for a day and videos were made and posted of them talking about that experience. The impact was measured by the number of MPs who signed, most did, and the enthusiasm and comments from members. The pledge served to maintain interest and action on a very long running campaign for pay equity, and, through the use various graphics, made a useful connection to the history of women’s suffrage in Aotearoa, where women gained the vote in 1893.



5. Global Strategy on Safe Staffing

Note that there will be a forum presentation by Hilary Graham-Smith, NZNO, on Aotearoa New Zealand’s approach to safe staffing, followed by other presentations on staffing ratios.

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The Report of the Safe Staffing/Healthy Workplaces (SSWH) Committee of Inquiry into workplace issues facing nurses, midwives and health care assistants in 2006, signalled a decisive move away from staffing ratios, and towards a dynamic system of identification and response to the key components that determine safety and quality ie The requirement for nursing and midwifery care; The cultural environment; creating and sustaining quality and safety; authority and leadership in nursing and midwifery; acquiring and using knowledge and skills; the wider team; and the physical environment, technology, equipment and work design.

Subsequent work by the SSHW Unit, jointly sponsored by the government and NZNO, focused on developing a robust mechanism for nurses, midwives and employers to respond immediately if workloads exceed the determined levels and enable sustainable solutions to safe staffing issues that have the confidence of nurses and midwives. Care Capacity Demand Management (CCDM) consists of Staffing Methodology (FTE Calculation and Work Analysis), Variance Response Management (Tools and processes to manage variance in capacity and demand) and Core Data Set (CDS), an agreed set of information that staff from the floor to the board understand. CDS measures CCDM impact. 14 of the 20 District Health Boards are engaged to varying degrees with the CCDM work. The programme is based upon workplace partnership between health Unions and DHBs. This type of partnership model is one of the first in the world.

Implementation of the CCDM Programme is supported by the Safe Staffing Healthy Workplace (SSHW) Unit Programme Consultants. Implementation is currently slow but continues to be supported with resourcing by the DHBs, NZNO and the SSHW Unit. The CCDM mandate has been strengthened with the wording in the Multiemployer Collective Agreement (MECA) in that the parties (DHBs and NZNO) have reaffirmed commitment to and funding of the Safe Staffing Unit.

There has been considerable international interest in CCDM from Canada, the UK, and Ireland. NZNO hosted 12 Canadian Federation of Nurses Union leaders over a week and coordinated presentations and information sharing from the Safe Staffing Healthy Workplaces Unit, NZNO, and District Health Boards. NZNO has been involved with the SSHW Unit's development of software for the Work Analysis and FTE Calculation. Processes are also being written to ensure the partnership between Health Unions and DHBs remain cohesive.

The programme is full and complete after years of development and refinement. To further refine the programme and offer additional clarity, a transformational change in that standards and processes are being written to simplify the implementation process. The reporting template has also been updated to ensure clarity of where each component of the programme is up to in each area of the hospital. NZNO strongly recommends a re-energised international agenda on development of a safe staffing strategy which profiles benefits in improved safe, quality patient care, quality work environment and best use of health resources.

6. Revisiting Migration – What does the Future Hold?

Global migration of health professionals is a fact and must be managed nationally and internationally to reduce, rather than exacerbate, inequitable access to health care within and between countries. The UN SDGs recognise the need for greater priority to be given to human resources for health (HRH) and set realistic *agreed* targets for low, middle and high income countries. The World Health Organization (WHO) has developed a suite of tools to support health workforce planning, retention and ethical recruitment, including the Global strategic directions for strengthening nursing and midwifery 2016–2020 (WHO, 2016). However, these are largely invisible, and neither referenced nor used in Aotearoa New Zealand's health, immigration, regional or workforce strategies.

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27 percent of Aotearoa New Zealand's nursing workforce are internationally trained nurses (IQN), a proportion which has doubled over the last few decades, and seems likely to persist. Around half new nursing registrations every year are IQN, and application numbers fluctuate in response to international events/instability and policy settings. BREXIT, for example, has prompted a significant rise in enquiries from the UK, though the longer trend has been towards increasing numbers of Asian, particularly Filipino, nurses. While the risk that overreliance on IQN poses to Aotearoa NZ has long been identified (Zurn & Dumonte, 2008), most recently in modelling for nursing supply projections (Nana et al, 2013, chpt.8), the Ministry of Health has only just recognised it as a nursing workforce priority (Ministry of Health, 2016, p11). Disappointingly, considering the roots of cultural competence in New Zealand nursing stem from Irahapeti Ramsden's seminal publication of *Kawa Whakaruruhau - cultural safety in nursing in Aotearoa* (1990), the staggering reliance on IQN does not seem to have been considered in the context of sustained Māori and Pacific nursing workforce shortages. NZNO continues to advocate for mandatory cultural competency training for all health professionals.

Retention, of both locally and internationally qualified nurses, is a significant issue for Aotearoa New Zealand (NNO, 2014, p18-20). Under the Trans-Tasman Mutual Recognition Act 1997 (TTMR) Australian and New Zealand registration standards are equal, and this is certainly a factor in the considerable influence this larger, more affluent neighbour has on nurse retention and migration.

In response to NZNO's submission, Immigration New Zealand (INZ) is now reviewing the registered nursing categories on the Essential Skills in Demand (ESID) lists, the aim of which is facilitate entry of appropriately skilled migrants to fill skill shortages (NZNO, 2016). The categories include Mental Health, Aged Care, (three years' experience required) Critical Care and Emergency, Medical, and Perioperative (five years' experience required). NZNO recommends that
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these are removed from the lists largely because of the evidence that recruitment of IQN has displaced sustainable workforce development ie growing dependence on IQN, new graduate unemployment, shortages in areas of higher staff turnover, heavier workloads, and inferior conditions (eg Ravenswood et al, 2014).

The move is a somewhat contentious one, since there are staffing shortages in some areas, but these are very largely attributable to resourcing and management issues, with fewer staff being deemed required to meet increasing health demand, posing a risk to staff and patients. Conditions which are unsafe and unfair for New Zealand-trained nurses are clearly unsafe and unjust for IQN. Efficient use of health workforce resources requires long term planning and alignment of immigration, education, regulation and employment policies. NZNO supports the policy objective in the draft WHO Human Resources in Health that middle and high income countries should provide appropriate health workforce 90% self-sufficiency. ie reliance on IQN should not be more than 10%.

The high Māori use of mental health services underlines the imperative to boost the very low numbers of Māori mental health nurses, and the Ministry of Health has prioritised mental health nursing alongside aged care. Ironically, however, Māori nurses who have applied for mental health nursing positions have not been employed. Recruitment of IQN to mental health services counteracts and undermines government initiatives to develop the New Zealand-specific mental health workforce needed.

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APPENDIX 1

NZNO Research 2015-2016

<http://www.nzno.org.nz/resources/research>

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Walker, L., Clendon, J., and Cheung, V. (2016) Family responsibilities of Asian nurses in New Zealand: implications for retention. *Kai Tiaki Nursing Research* (accepted for Publication)

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APPENDIX 2

Other NZNO Professional Publications (2015-2016)

http://www.nzno.org.nz/resources/nzno_publications

- > Guidelines on Transcribing Medicines
- > Employment policy framework
- > Legislation and regulation policy framework
- > Guideline on reflective writing
- > Retirement: policy context and political debates
- > Position statement on climate change
- > Position statement on obesity
- > Fact sheet on the Vulnerable Children Act and health worker safety checks
- > E-Book: Quality in the workplace
- > Guideline on standing orders
- > Fact sheet on supervision
- > Duty of care
- > Position statement on medical marijuana
- > Guidelines for nurses on the administration of medicines