NEW ZEALAND NURSES ORGANISATION

Country Report

AOTEAROA NEW ZEALAND

ICN WORKFORCE FORUM 2013

Dublin

23 to 25 September

1. Environmental Scan

Note ICHRN Environmental scan March2013 http://natoff-sql/Lists/Announcements/Attachments/122/ICHRN_Environmental_scan_March_2013.pdf

- **Developments in nurses' working conditions**

The period from 2011-2013 has been one of continuing national and international recession and continued substantial structural and organisational change in the New Zealand health system. The nursing workforce, in common with the workforce as a whole, appears to have responded to uncertainty in general employment, and to unemployment, by working extra shifts and changing employment less frequently. There have also been ongoing changes to the regulatory structures, roles and scopes of practice, and to the education of nurses.

The effect of funding shortfalls continues to be seen in the form of widespread restructuring of services to cut costs and the attempted development of new, more productive models of care. The immediate impact on nursing includes work intensification and a general deterioration in the practice environment, though in general hours of work have not been affected. These in turn impact negatively on patients and communities through rationed care and an increasingly stressed workforce. Christchurch has had particular and ongoing workforce and resource challenges to face in the aftermath of the devastation caused by earthquakes.

Changes to immigration with the removal of most nursing categories from the Essential skills in Demand List have affected the work and residency prospects of some internationally qualified nurses (IQN). Only four of the 12 RN categories in the Australian and New Zealand Standard Classification of Occupations (ANZSCO) remain and midwifery may follow.

While most new graduates find employment quickly, there have been delays in some locations. However, with a significant number of nurses due to retire within the next ten years, and with IQN registrations necessary to maintain and slightly grow the nursing workforce, New Zealand is still far from achieving self sustainability. The lack of a long term health workforce strategy to reduce dependence on overseas health workers continues to be the major barrier to the further development of Aotearoa New Zealand's nursing workforce.

Aged residential care continues to be a significant area of challenge for nursing both professionally and industrially. Without mandatory standards ensuring appropriate staffing levels and skill-mix, public and practitioner safety is at risk. Poorer wages and conditions, heavy workloads, and a disproportionately high number of IQN and migrant workers are characteristic in this largely privatised sector which nevertheless receives $800m public funding.

More positive developments are: the successful negotiation of collective agreements in two services for the first time - Te Rau Kōkiri, for Māori and iwi providers, and for Prison Nurses; the implementation of a joint Department of Corrections (Prison Health Services) and NZNO prison-based Healthy Workplaces Project (a world first); and the inclusion of safe staffing/healthy workplace clauses are included in most collective agreements.

- **Government/governance**

The re-elected National government has continued its programme to reduce government spending; rationalise procurement and other health infrastructure such as information technology, where considerable progress has been made; promote private/contracted service provision; and devolve secondary health and other services into community-based primary care.

Disruptive change to health workforce regulation has been foreshadowed with the potential of enforced amalgamation of authorities into a single secretariat. Adverse consequences for the nursing profession could include increased annual practicing certificate fees, though the real risk is a potential loss of nursing autonomy.

The introduction of the Medicines Amendment Bill this year giving Nurse practitioners (NPs) the same 'authorised prescriber' status as medical practitioners, dentists and midwives is an important, though overdue, step forward in affirming the value of this role, and will inform an imminent review of the NP scope of practice by the NCNZ which may consider making prescribing a compulsory part of the scope. The Bill is not due to be enacted before June 2014.

The Trans Pacific Partnership Agreement (TPPA), a 'free trade agreement' negotiated in secret between twelve countries including the United States, Australia and New Zealand has excited health sector concern. The TPPA has significant implications for health particularly for developing countries in our Pacific region as it has the potential to raise the cost of medicines and to limit the ability of governments to make choices to protect the health and wellbeing of their people and resources.

2. Nursing Data

- **Nursing Workforce profile**

In keeping with recent trends, the number of practising nurses in Aotearoa New Zealand increased in 2012 to 49, 356 nurses, comprising 95 Nurse Practitioners (NPs); 46,284 Registered Nurses (RNs); and 2,977 Enrolled Nurses (ENs). 2684 nurses were added to the New Zealand register. However the rate of growth has slowed somewhat with the nursing workforce increasing by just 829, down from around 1400 the year before. Similarly, the number of new Nurse Practitioners dropped from 19 to 14, and the number of ENs continued to trend down.

IQN continue to be an important part of Aotearoa's nursing workforce. They accounted for nearly half (47 percent) of nurses registered in New Zealand in 2011-2012, and, overall, make up a quarter of the nursing workforce. There has been a change in the country of origin of IQNs over recent years. In 2006 the dominant country of origin was the United Kingdom; in 2010-11 most of the 1,304 IQNs registered in New Zealand came from Asia, mostly from the Philippines (434) and India (331).

There has been no increase to the number of male nurses who make up 7 percent of the workforce. Traditional gender disparities in the nursing workforce are echoed in ethnic disparities with 68 percent of nurses identifying as Pākeha/NZ European,

7 percent Māori and 4 percent Pacific, though the population which comprises ~ 15 percent Māori, 7 percent Pacific and 12 percent Asian.

The median age of New Zealand's nursing workforce now 46.7 years. 41 percent are aged 50 years or over, with 3.5 percent aged over 65 years old. There is an ethnic component to the aging profile with Pākeha/NZ European RNs having the oldest age profile of any ethnic group: 45 percent are aged 50 or over, and 27 percent are aged under 40. Most other age groups have significantly younger age profiles.

Aotearoa now has over 100 NPs, which remains a very low number for an established scope of practice. While the past two years has seen an appreciable growth in employment from 69 to 95 NPs, it remains a significant challenge to find job opportunities which fully utilise the NP scope of practice.

The largest single practice setting in which nurses are employed is in DHBs and surgical practice. 41 percent of all RNs reported working in acute District Health Board (DHB) settings and these tend to be younger nurses aged under 40. By contrast, less than 1 percent of RNs reported working in Pacific Health Service Provider and rural settings and over half of these nurses are aged over 50. 32 percent of RNs aged under 40 are employed by Nursing Agencies. Overall, 46 percent of RNs had at least one post-registration (level 700) qualification.

25 percent of the New Zealand RN workforce received their registration qualification outside New Zealand, most commonly in the UK (40 percent), South East Asia (17percent), or India (11percent). The practice area with the highest proportion of IQN is Intensive Care/Cardiac Care (38 percent). IQN who fail to get registration in Aotearoa are often employed in private aged care facilities as health care assistants (HCAs), though their nursing skills are a considerable asset to these providers.

75 percent of RNs graduating in 2012 gained employment within three months; 61.5 percent of graduates were employed in Nurse Entry to Practice (NEtP) programmes. Increasing the number and range of practice areas for NEtP placements has been prioritised by the Chief Nurse. Some NEtP placements have a post graduate education requirement, which may prioritise education funding to nurses in their first two years of practice at the expense of those having been in the workforce much longer. New graduates also have the opportunity to join the Voluntary Bonding Scheme (VBS) which offers student loan repayments in return for three years continuous employment in identified hard to staff fields.

3. Labour Conditions

The third biennial employment survey of the New Zealand Nurses Organisation (NZNO) nurse membership, a web-based survey of regulated nurse members (Registered & Enrolled Nurses, and Nurse Practitioners) provides insight into core employment issues (contracts, hours, pay, job change) along with demographic details, and items related to plans for, and perceptions of, working life for nurses. Themes identified in previous NZNO research related to the retention of nurses in the workforce (especially that of older nurses) emerged strongly in this survey too. In particular, for many, the loss of clinical nurse leadership, increases in workload and patient acuity, the challenges of night shift work, and the pain and discomfort

associated with the more physically demanding aspects of nursing were considerable.

Nearly a quarter of the respondents had experienced significant restructuring in their main employment with 27 per cent reporting reductions of senior nursing leadership positions, and changes to skill mix. Regionalisation and privatisation of specialist services, and mergers of general practices were also recorded. The processes involved had severely impacted on morale, damaging feelings about their employer, and leading to 43 per cent of those affected questioning their nursing future.

Eleven per cent had required time off work in the previous two years with workplace-acquired infections and injury. The commonest causes were flu or norovirus infections, and back, knee, wrist and shoulder injuries relating mostly to slips and lifting. Only 41.5 per cent of all respondents felt their employer was fully compliant with Occupational Health and Safety standards.

The EQ5D health tool was used to survey nurse's perception of their own health. Thirteen percent reported having some problems with performing their usual work, study, housework, family or leisure activities, 14.4 per cent felt moderately anxious or depressed, and 28 per cent reported moderate pain or discomfort. These are nearly all lower than for New Zealand women at all age groups. This may be a real effect, perhaps reflecting nurses looking after their own health. It might also be that nurses self-select out of the workforce if less healthy, or that their perceptions of their own health are more positive than the general population. The exception was that women aged 30-39 in a New Zealand general population reported less moderate levels of pain and discomfort than nurses of the same age (Nelson Bays Health status survey 2010).

There is no doubt the morale of nurses has continued to decline slightly. While it is not possible to directly assess the causes, heavier workloads, higher patient acuity, restructuring and the financial climate are cited frequently in the recent survey, both in the answers given to questions about workload and restructuring, and in the free text general comments. Though overall the profession is in good heart, it is clearly vulnerable to badly handled and on-going change, long-term staffing issues, and growing disenchantment with workload and pay.

The standard age of retirement in Aotearoa is 65 years and most nurses have 'Kiwisaver', an earnings related saving scheme, with some having an additional superannuation savings plan. Little research has been done on nurses' retirement intentions but careful workforce planning could alleviate some predictable shortages from the large cohort retiring within the next decade. A survey of late career nurses over 50 indicated that while 57 percent intend to retire within the next ten years, a wide range of factors that could affect that decision were identified, including shift work, flexible hours of work, financial resources, health status, relationship status and the location of family.

4. Allocation of Resources

There has been no change to funding constraints as the Health budget continues failing in keeping up with rising costs and inflation. Analysis of the Health Vote in the 2013 Budget indicated a $238 million shortfall to cover announced new

services, increasing costs, population growth and the effects of an ageing population.

While Aotearoa faces similar health challenges to other OECD countries, serious infectious disease, largely the preventable diseases of poverty associated with poor housing and overcrowding, is also increasing. In general the response has been to implement targeted, rather than holistic strategies. Programmes with specific goals for reducing rheumatic fever, increasing immunisation, improving waiting times in emergency departments and for first specialist appointments, have established an environment in which the success of health policy is assessed on the basis of measureable health outputs rather than less measureable, long-term health outcomes.

Gaining access to care is a problem for the increasing number of those living beneath the poverty line as they struggle to meet costs, transport issues and/or motivation to improve their health status. a feature of which is to fund more nurse-led sore throat clinics to address rheumatic fever. The Green Party has recently released a policy designed to employ a nurse in every low decile school, but this will be dependent on the outcomes of the next election.

5. Scope of Practice

NCNZ consulted on two proposals to extend registered nurse prescribing in March and April of this year: Community nurse prescribing to enable nurses in community and outpatient settings to prescribe medicines for minor ailments and illnesses and Specialist nurse prescribing, to enable nurses working in a collaborative multi-disciplinary team in specialty services or in general practice, to be able to prescribe for common conditions such as diabetes, asthma, hypertension. RNs are eligible to become designated prescribers through a Nursing Council authorisation process. Two successful demonstrations of Diabetes Nurse Specialist prescribing and Gerontology Nurse Specialist in Primary Care, a nurse-led initiative with a preventative and early intervention, should see wider implementation. Similar advanced nursing practice pilots have been mooted for respiratory nurses and nurses undertaking endoscopy, and colposcopy.

A new post graduate training programme for Registered Nurse First Surgical Assistants (RNFSAs) at Auckland University has been established.

6. Positive Practice Environments

- **Care Capacity Demand Management (CCDM)**

NZNO has worked with public sector employers and the Ministry of Health to develop a dynamic, systems-based process of planning and achieving a reliable match between care demand and care capacity so that the quality of patient care and the quality of the work/practice environment can be assured while also achieving optimal use of health resources. Currently twelve of the twenty DHBs have either begun implementing the CCDM programme or are preparing for implementation. NZNO works in partnership with the Safe Staffing Healthy Workplace Unit to support the implementation of CCDM and has developed a suite of integrated support strategies under the name CarePoint. Currently this work is

located within the DHB sector, but NZNO is also engaged in work adapting CCDM for implementation right across the health sector.

- **Occupational health and safety**

The Peri-Operative Nurses College of NZNO, has completed a project investigating a maximum surgical instrument crate weight for the Education Committee of Peri-Operative College of NZNO to be included in a guidance statement on Health and Safety. The key objective to endorsing such a weight is to set a figure which minimises the risk of manual handling injuries for those involved in the transport and management of surgical instruments / equipment.

BIBLIOGRAPHY

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.

Expert Advisory Group on Primary Health Care Nursing. (2003). *Investing in health: A framework for activating primary health care nursing in New Zealand*. Wellington: Ministry of Health.

Gleeson, D. (2012). *Analysis of the June 2011 leaked TPP Transparency Chapter Annex (Annex on Transparency and Procedural Fairness for HealthCare Technologies): A comparison with the text of Annex 2-C of the Australia-US Free Trade Agreement and Chapter 5 of the Korea-US Free Trade Agreement*. Retrieved from http://www.dfat.gov.au/fta/tpp/subs/tpp_sub_gleeson_120911.pdf

Greenwood, D. (2012, June 15). *Alcohol 'threat' to trade deals*. The National Business Review.

Kelsey, J., Adamson, D., & New Zealand Law Foundation. (2010). *No ordinary deal: Unmasking the Trans-Pacific Partnership Free Trade Agreement*. Wellington, N.Z: Bridget Williams Books with the New Zealand Law Foundation.

Ministerial Taskforce on Nursing. (1998).*Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Retrieved from http://www.moh.govt.nz/notebook/nbbooks.nsf/0/380f282d7caedadc4c25669b007c00ca/$FILE/nursing4.pdf

Newton et al. (2006). Counterfeit anti-infective drugs. *The Lancet Infectious Diseases, 6*(9), 602-613. doi: 10.1016/S1473-3099(06)70581-3

New Zealand Nurses Organisation. (2011). *NZNO Manifesto Election 2011*. Retrieved http://www.nzno.org.nz/LinkClick.aspx?fileticket=zZ0X53vC7O4percent3d

New Zealand Nurses Organisation. (2013). *NZNO Employment Survey 2013: Our nursing workforce: For 'Close observation".* Wellington : Author

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

Nursing Council of New Zealand.(2011). *The New Zealand Nursing Workforce*. Retrieved from http://www.nursingcouncil.org.nz/download/186/31march2011.pdf

Nursing Council of New Zealand.(2012a). *Annual Report*. Retrieved from http://www.nursingcouncil.org.nz/download/91/annual-report-2012.pdf

Nursing Council of New Zealand.(2012b). *Consultation on the qualifications prescribed by the NCNZ for Internationally Qualified Registered Nurses under the Health Practitioners Competence Assurance Act 2003 consultation document*. Retrieved from http://www.nursingcouncil.org.nz/index.cfm/1,225,html/Consultation-on-qualifications-prescribed-for-Internationally-Qualified-Registered-Nurses

Rosenberg, B. (2013). *New Zealand Council of Trade Unions Working Paper on Health, Number 10: Did the Budget provide enough for health?* Retrieved from http://union.org.nz/sites/union.org.nz/files/Did-the-Budget-provide-enough-for-Health-2013.pdf

Walker, L., & Clendon, J. (2012). *Late Career Nurses: Research advisory paper*. Retrieved from http://www.nzno.org.nz/Portals/0/publications/Late%20career%20nurses%20in%20New%20Zealand%20Research%20Advisory%20Paper%20(RAP)%202012.pdf