2020 and Beyond:

A Vision for Nursing

‘To mua I te tau

Rua mano rua tekau’

He tirohanga mo nga Tapuhitanga

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Executive Summary

Introduction

The New Zealand Nurses Organisation (NZNO) is Aotearoa New Zealand's largest professional and industrial organisation for nurses. With a membership of over 46,000, NZNO has a key leadership role in the New Zealand health sector. In 2007, NZNO began preliminary work on developing a vision for the future. In 2010, a background document and draft vision were written and an extensive consultation process based on the principles of partnership and collegiality was initiated. The vision is designed to provide all members of the profession of nursing in New Zealand a future to which they can aspire, and that strategically guides nursing practice. It also provides a platform for the development of effective policy frameworks in education, employment, social and health policy, legislative and regulatory areas, and practice.

Method

A comprehensive background document underpins the vision, identifying a range of challenges and opportunities for nursing development over the next twenty to thirty years. Marsha Rhea's (2005) future thinking anticipatory learning framework was applied to the field of nursing in New Zealand and provided the basis for analysis. The key tenets of Rhea's method are foresight, identity, direction setting and innovation. Based on Rhea's framework, five critical areas of nursing practice were firstly oriented in time (the current situation) and then examined in light of potential official futures (the futures that current national and international policy documents advocate for). An analysis of trends and developments utilising a strengths, weaknesses, opportunities and threats (SWOT) approach enabled identification of key areas nursing can focus on into the future.

Section 1: Background

Analysis: This section provided the context for the study exploring underlying assumptions, demographic trends, technology, genetics, treatment modalities, global issues and issues facing nurses in a range of practice areas. Each area explored the current situation and the implications for nursing.

Findings: Key issues identified included the ageing population and ageing nursing workforce, the impact of new technology and advances in the field of genetics, the development of new treatment modalities and associated costs, and the impact of globalisation on health including nurse migration and global pandemics. The implications of funding cuts in the health sector and the impact of this on nurses in practice, the importance of leadership, increasing patient acuity, low staffing levels, and poor pay for nurses working in Māori and Iwi health services were also identified as critical issues.

Section 2: Health and Social Policy Frameworks

Analysis: This section analysed current health and social policy issues that impact on nursing in New Zealand including te Tiriti o Waitangi, the New Zealand health system, the social determinants of health, and a primary health care approach to the provision of health care.

Findings: Key findings indicated the importance of future health and social policy to articulate how the persisting ethnic and social inequalities in health are to be addressed, to emphasise the need for collaborative policy across sectors to address the social determinants of health, and to refocus the provision of health care clearly onto primary health care as the most effective means of addressing health care need, improving health outcomes and addressing health inequities.

Section 3: Legislative and Regulatory Frameworks

Analysis: In this section the key legislative and regulatory frameworks that impact on nursing in New Zealand were discussed including: the Health Practitioners Competency Assurance (HPCA) Act 2003; the role of the Nursing Council; current scopes of practice; the range of existing legislative and other barriers to workforce innovation; and issues surrounding safety including the health care assistant workforce.

Findings: Continuing to develop appropriate legislative and regulatory frameworks for practice is an important opportunity both to ensure patient safety and to enable nurses to provide enhanced levels of care. Removing existing legislative and other barriers to practice including improving funding mechanisms for nurses in primary health care and addressing prescribing and other limitations to nurse practitioner and registered nurse practice are required. Addressing health workforce planning, recruitment and retention issues, and the impact of deregulation on nursing in the older adult sector – in particular nurse to patient ratios – are imperative.

Section 4: Models of Care

Analysis: Existing models of care are unlikely to meet changing population health needs and new approaches are needed. This section examined some of the more common models of care currently in existence in nursing and health and some of the proposed models of care.

Findings: Nurse-led clinics, nurse-led intermediary care, and collaborative, interdisciplinary approaches to health care will provide a strong basis for meeting population health needs in the future. Robust evaluation of existing and emerging models of care is required to ensure health inequities are addressed and heath needs are met.

Section 5: Education

Analysis: Changing demands on the profession of nursing has seen registered nurse education move from an apprenticeship style of education, to a diploma programme, to a degree programme. Enrolled nurses complete an 18 month diploma programme. New challenges exist to ensure that nursing education programmes meet the changing demands of the health system, and the people it serves.

Findings: While existing structures of undergraduate education meet current demand, it is important to remain open to future opportunities. Insufficient funding for nurses to develop post graduate clinical and research skills, an ageing faculty experiencing poor succession planning and remuneration, a lack of clinical learning placements, and the need to ensure adequate support is available to all new graduate nurses will hinder nursing's efforts to develop the flexible and skilled

nursing workforce required to meet future need. Improved collaboration across health and education sectors is required.

Section 6: Employment

Analysis: Quality nursing care improves health outcomes, but quality nursing care cannot be provided without the systems and structures to support it. This section outlined current employment issues facing New Zealand nurses and some of the initiatives intended to ensure nurses have equal access to good health including employment relations and healthy workplaces.

Findings: The significant research that supports the value of nursing to people can be used as a basis for developing effective employment frameworks and as an argument in the bargaining process. Continuing research into safe staffing and healthy workplaces and extending this to look at primary health care and other settings will continue to strengthen our understanding of those factors that impact on nurses in their workplaces. Efforts to retain older nurses in the workplace and attract younger nurses to nursing will need to be strengthened.

The Vision

The vision is found on page 12 of this document and as a separate document available for free download from the NZNO website: www.nzno.org.nz

Recommendations

This document has examined a number of the trends, issues and developments both within and external to nursing that will shape the provision of nursing care in New Zealand over the next twenty to thirty years. It has also identified the strengths, weaknesses, opportunities and threats that will continue to challenge nursing but also provide us with a direction for the future. Strong leadership, a focus on primary health care and addressing the social determinants of health in all areas of practice, undertaking and utilising nursing research to demonstrate nursing's contribution to improving health outcomes, staying true to nursing's core values, strengthening nursing education, and working together as a profession will guide us as a group into the future.

Further work is required to develop a strategy for addressing many of the issues identified in the background document prior to realization of the vision. It is recommended that the next stage of the vision project is to establish a working group to develop a comprehensive strategy for NZNO to advance the vision and incorporate it into their annual planning process.

2020 and Beyond: A Vision for Nursing
Vision Statement

Introduction

Nurses are the largest health professional workforce group in the world, providing effective nursing care to individuals, families, whānau, groups, and communities in a diverse range of settings and locations. Nurses also undertake research, provide policy advice, hold leadership roles, and manage teams. Ultimately, the goal of all professional nursing care and activity in Aotearoa New Zealand is to achieve improved health outcomes and improved health and social equity for all New Zealanders regardless of their age, ethnicity, religion, gender, sexual orientation, or ability to pay.

The New Zealand Nurses Organisation (NZNO) Vision for Nursing is designed to provide all members of the profession of nursing in New Zealand with a common vision for the future. The vision offers nurses something they can aspire to, that strategically guides nursing practice, and that provides a platform for the development of effective policy frameworks in education, employment, social and health policy, legislative and regulatory areas, and practice. NZNO is the leading professional and industrial organisation for nurses in Aotearoa New Zealand. For NZNO to lead nursing into the future, we must not wait to respond to what others see as the best pathway for nursing and nurses but set our vision and lead from the front.

The attached background document proactively identifies those things that will impact on nursing into the future and identifies a range of strengths, weaknesses, opportunities and threats for nurses and nursing as we face the future.

Vision Statement: 2020 and Beyond

Nursing is an exciting and dynamic profession with multiple opportunities for every member of the profession to contribute toward achieving optimal health outcomes for individuals, families, whānau, communities and populations. Nurses in Aotearoa New Zealand face a set of challenges that are unprecedented in the history of the profession in this country. New technology, a growing population, an ageing nursing workforce, new treatment modalities, genetics, and the local and global context of health care are emerging within a context of constant restructuring, a tightening economic climate, and nursing workforce variability. The ability of nursing as a profession to achieve improved health outcomes for people through effective nursing interventions is well known within nursing but poorly understood by the public, by other health professionals, and by government. We must continue to meet these challenges head on if we are to enable the profession of nursing to achieve its full potential.

Nursing's common goal is good health and well being for all. Specifically nurses and nursing seek to achieve significantly improved health outcomes for our most vulnerable citizens through addressing inequalities in health. All people should have the opportunity to live and work in a safe environment, have access to affordable, quality healthcare whenever and wherever they need it,

know how to make appropriate choices about what they eat and how much they exercise, know that in times of hardship there will be financial and social support available to them, and have equal opportunities to achieve good health regardless of their age, ethnicity, gender, sexual orientation, level of disability or health status. Nurses know and understand how achieving these things will improve people's health. Nurses must advocate for all health and social policies to include evidence of how the social determinants of health will be addressed and how inequalities in health will be improved. Nurses will be actively involved in health policy and service design decision-making.

Health is a human right. Nurses in the future will focus on utilising primary health care and health promotion across the health-illness continuum to keep people well, prevent hospital admissions, manage acute episodes of illness when they arise, and lead improvement in health care. Public and population health approaches including addressing the impact of climate change and environmental degradation will become an increasingly important part of nursing practice. Te Tiriti o Waitangi provides the foundation for health development for all people in New Zealand and nurses will be at the forefront of integrating the principles of te Tiriti in the provision and future development of all health care. Cultural safety, the NZNO Code of Ethics, and the NZNO Definition of Nursing encompass the fundamental values of the nursing profession, providing a foundation for safe and effective practice. Nurses are valued for their input and leadership in developing an effective and efficient publicly funded health system that meets the needs of all New Zealanders. New Zealand nurses will continue to demonstrate their commitment to global health development by supporting their nursing colleagues in developing countries – in particular in Asia and the Pacific.

Nursing will continue to be a regulated profession which meets the highest standards of quality and safety in practice. Nursing's professional associations will continue to lead the development of specialist frameworks for nursing practice, provide standards for credentialing, and develop standards of practice for all regulated nurses. Nursing will be at the forefront of research into interdisciplinary and nursing practice, and the mechanisms required to ensure safe utilisation of all health care workers to effectively meet the health needs of the New Zealand population. There will be no legislative, contractual or funding barriers to practice because people will recognise the value of nursing in improving health outcomes and addressing health inequalities and will work with nursing to remove these barriers. Nurse practitioners, registered nurses and enrolled nurses will work collaboratively to ensure the best possible health outcomes for all New Zealanders. Nurse practitioners will be widely recognised as an integral part of the health system and nurse practitioners and registered nurses will provide first point of contact care for many New Zealanders in a range of health settings. Nursing will work closely with those bodies charged with workforce planning to ensure nursing shortages do not occur and that appropriate and ethical recruitment and retention strategies are implemented.

Innovative and flexible models of care that are person-centred will be developed and evaluated by nurses. Technology, enhanced communication, and new treatment modalities will be utilised to ensure that models of care are appropriate, cost effective and meet the needs of all people. People will be consulted about the models that best meet their needs and nurses will work collaboratively with other health professionals to meet these needs. The principles of whakawhanaungatanga, manaakitanga, rangatiratanga, and wairuatanga will continue to guide professional nursing practice. While acute hospital care will always be required, the development of models of care that focus on people's, family whānau and community strengths will mean that those needing support will have

this available when and where they need it from the most appropriate person. Those experiencing the effects of chronic or life-long conditions will manage their conditions at home with support from family whānau and nurses where needed. If acute care is required, this will be a seamless experience with overall management of the person's care being undertaken by a specialist nurse across the primary-secondary-tertiary continuum in liaison with other health professionals. Nurses will be the case managers of care using their expertise in building effective relationships with people to guide them through their health experiences. Fully-funded nurse-led clinics will be a first point of call for people seeking support to manage their health needs. Nurse practitioners and nurse specialists will be the key health practitioners in a range of settings but particularly in the older adult care sector where they will provide specialist nursing care to clusters of residential facilities while supporting registered and enrolled nurses and health care assistants to provide expert care on a daily basis. Nurses will demonstrate that they are achieving intended population health outcomes through evidence-based research. Nurses will continue to be respected clinical leaders whose advice is sought consistently, and subsequently actioned.

Demands on nurses to be actively involved in research, to develop and integrate new technology and treatment modalities to meet health needs, and to develop, implement and evaluate new models of care are increasing. Nursing education will proactively prepare nurses to meet these challenges and the changing health needs of New Zealanders, implementing a greater curriculum focus on primary health care approaches to health care across the continuum. Recruitment in to the profession will aim to reflect the diversity of New Zealand's population. Interprofessional bachelor's level education will be based on a partnership model that integrates clinical practice with academic learning. Formal collaboration and partnership among and between nursing education providers and clinical environments based around a fundamental framework of nursing education will see all nursing programmes including Māori and Pasifika programmes consistently create graduates with the clinical and academic skills required to meet people's diverse health and cultural needs. Following the final year of their degree, all new graduate nurses will complete a fully funded transition period designed to support their transition to practice. By 2020 New Zealand will educate sufficient nurses to meet workforce requirements. New Zealand nursing qualifications will set the benchmark internationally and the qualification will become fully portable worldwide. Lifelong learning will be recognised as fundamental to nursing practice and all registered nurses and nurse practitioners will have access to a range of flexible, appropriate, affordable, acceptable, relevant, and employer supported professional development opportunities. Similarly supported post graduate education opportunities will prepare nurses to take up advanced and specialist positions clinically, in research, in education, in leadership, in management and in education. Advice on career and academic planning will be available to all nurses. Nurses who take up academic positions will be remunerated appropriately and will be fully supported to focus on research and/or clinical practice as part of their teaching roles. All registered nurses and nurse practitioners will have access to up-to-date information technology in their workplaces to support evidence based practice. Enrolled nurses will have access to professional development and post enrolment education that ensures they are able to meet the needs of the people they nurse. Enrolled nurses will also be formally recognised for the post enrolment education they undertake. Structured pathways from health care assistant to enrolled nurse to registered nurse to nurse practitioner will exist that recognise prior learning.

By 2020, all health care settings will have incorporated the principles of healthy workplaces and safe

staffing and New Zealand will have the best and most equitable health outcomes for people in the world. All people will recognise the value of nursing, and the common platform of improving health outcomes and addressing health inequalities will be the basis for development of the profession, uniting the professional and industrial endeavours of nurses. While political change will continue to impact on the provision of quality healthcare, nursing as a profession will stay committed to its defining values. The combination of safe staffing, healthy workplaces, competitive salaries, quality practice, job satisfaction, professional career pathways, and culturally appropriate support for Māori and Pasifika nurses makes nursing one of the most attractive professions in New Zealand and nursing becomes the career of choice for young people by the end of 2020.

2020 and Beyond: A Vision for Nursing Background Document

Background

In 2007, NZNO Professional Services Manager Susanne Trim saw the need for NZNO to consider thoughtfully the role of nurses and nursing in Aotearoa New Zealand over the next decade. The Vision 2020 project (as it was then called) was born out of the desire to set a vision for nursing that members of NZNO could aspire to, that would guide nursing practice, and would provide a platform for the development of effective policy frameworks in education, social and health policy, employment, legislative and regulatory areas, and practice. In August of 2007, the Vision 2020 project was discussed in Kai Tiaki Nursing New Zealand with a presentation made at the NZNO annual general conference in September of that year. Since then, three consultation rounds including three focus groups with nurses from across New Zealand has culminated in this document *"2020 and Beyond: A Vision for Nursing:"*

Aotearoa New Zealand is in desperate need of a greater understanding of what nurses achieve in their every day practice and how that makes a tangible impact on health outcomes. The NZNO Vision articulates the position of nurses and nursing in the Aotearoa New Zealand health care system now and into the future. It is designed to describe the nature and characteristics of the profession of nursing that Aotearoa New Zealand has now and is likely to need in 2020. It is also designed for the public and other health care providers to be able to fully understand the contribution of nursing to health outcomes in Aotearoa New Zealand and therefore how they can seek our input into designing and implementing an effective health care system.

Underlying assumptions and values

Underpinning the development of the NZNO 2020 and Beyond: A Vision for Nursing project are a number of key values and assumptions. The NZNO Social Policy Statement (NZNO, 2009a) and the NZNO Code of Ethics (NZNO, 2010a) outline those values that members have identified as underpinning their nursing practice and provide the basis for development of the Vision. These include:

- Health and self-determination are basic human rights;
- Health care should be universally available to all who need it regardless of their ability to pay;
- Achievement of health potential will be impacted upon by the social determinants of health including environmental, social and cultural factors, housing, employment, education and transport;

- The profession of nursing implements the principles of Te Tiriti o Waitangi, partnership, participation and protection in the delivery of professional nursing care;
- Relationships and interactions take place in a climate of respect for the other. This encompasses a respect for culture, religion, life choices, sexual orientation, ethnicity and other life-directing values held by individuals and groups. An example of enacting this assumption is shown in providing and working within the concept of cultural safety;
- Respect for the person/group/community encompasses the notion of partnership and collaboration, where the person/group/community participates actively in the process of nursing. This stand acknowledges the contribution of person/group/community effort, knowledge and expertise to the partnership;
- Relationships and interactions seek to achieve an equitable outcome for the person/group/community. The purpose of nursing is to uphold and improve the health of the person/group/community;
- Nurses are committed to providing ethical nursing practice based on an identified code of ethics.

Key questions for nurses to consider into the future

Below are a number of key questions and challenges for nursing to consider into the future. These questions are designed to be provocative and encourage readers to think about the future of nursing. Suggestions for how some of these questions may be addressed can be found in the document, some are not addressed at all and will challenge the way we think about nursing as a profession. I outline these here as a means of encouraging you to think broadly about both the potential of nursing, and the limitations of nursing and what it can achieve for the people of Aotearoa New Zealand. These are not consultation questions, they are simply questions designed to provoke thought.

1. Will nursing as a profession continue to exist or will health care be achieved by different models of health care worker/provider – what are the realities of continuing with current models?

2. Does the nursing profession need to be regulated – would the removal of regulation also result in the removal of many of the existing barriers to practice? Do current legislative and regulatory frameworks provide a sufficiently robust safety net to ensure competent practice?

3. How and where will nursing leadership, education and professional practice be developed and recognised in future health care planning?

4. Will mental health nurses continue to be a part of the regulated profession of nursing or will generic mental health workers take over much of the current role of mental health nurses?

5. Is there a place for nursing in the disability sector in the future?

6. Should bachelor level nursing education be removed from the polytechnic sector and be offered only in universities? What would be the benefits or risks of this?

7. Where can nursing be best utilised to improve the health outcomes of New Zealanders and what education needs to be funded to achieve this?

8. How will the development of new cadres of health worker impact on population health outcomes and health equity? How will these new health workers impact on the profession of nursing and how will nursing respond?

9. How will the health sector cope with increased demand for health professionals with an understanding of Te Reo Māori and Tikanga?

Key areas that will impact on nursing into the future

There are a number of factors that we know will impact significantly on the provision of health care over the next 20 years. Examining these areas provides us with background information to help identify the key drivers that will influence the provision of nursing care over this period. We need to use this information to ensure nursing care will meet the needs of New Zealanders in the future. This section outlines a number of key drivers and issues that set the scene for the vision.

1. Demographic Trends

There are a range of predicted demographic trends that will influence the provision of nursing care into the future. These are outlined here along with an analysis of the potential impact they will have on nursing.

<u>The ageing population</u>

Increased longevity and decreased birth rates worldwide will see the number of people aged over 60 rise to over 2 billion by 2050 (World Health Organisation 2008). The Aotearoa New Zealand population is ageing – the number of people aged 65 years and older is anticipated to increase by up to 76% in some parts of the country by the year 2026 (Health & Disability Intelligence Unit 2008). On average, by 2026, Aotearoa New Zealand's population is forecasted to grow by 0.8% per year from its current 4.2 million to 4.9 million and the over-65 age group will grow from 13% to 19% of the population (National Health Board, 2010). There will also be considerable growth in the numbers of the 'oldest old' that is, people over the age of 80. The other demographic trend of significance is that a large proportion of the current workforce is due to retire within the next 20 years, potentially reducing their contribution to the economy through taxes – although this is likely to be balanced by other financial and social contributions. People over the age of 65 years are currently estimated to receive per capita health expenditure three to five times greater than that of those aged 15 to 64 and this is anticipated to increase substantially as the population grows, while the anticipated tax income to fund health care may proportionately drop (Nursing and Midwifery Workforce Strategy Group 2006).

Aotearoa New Zealand's nursing workforce is also ageing: over 40% of Aotearoa New Zealand nurses are aged over 50 years (Nursing Council of New Zealand, 2010a) and will join their peers in retirement over the next 10 to 20 years, although many nurses are not looking to retire at 60 or 65 years but closer to 70 years. This has significant ramifications for the provision of nursing care, the education of nurses, and the recruitment and retention of nurses. These issues will be discussed throughout this document.

Ethnic diversity

Demographic changes in the ethnic diversity of Aotearoa New Zealand will also influence the type of health care that will need to be provided. Māori, Pacific and Asian populations will all increase over the next 20 years. By 2026, Māori will make up 16.6% of the Aotearoa New Zealand population (14.9% in 2006), Pacific people will make up 9.8% (up from 7.2% in 2006) and Asian people will make up 16% (up from 9.8% in 2006) (National Health Board, 2010).

Rural – urban mix

By 2026, the bulk of the Aotearoa New Zealand population will be resident in urban centres (particularly Auckland) while there will be much smaller growth in smaller centres and rural areas. Some smaller centres and rural areas will see the resident population decline (National Health Board, 2010).

Brief overview of the implications for nursing

The implications of an ageing population are not entirely clear, as people are likely to be healthier into older age. This and the next generation of older people have been exposed to the messages surrounding the benefits of a healthy lifestyle and the benefits of new technologies, and it is not yet known how this will impact on the overall health of the population into the future. It is also unknown what impact declining tax intake may have or what impact immigration may have. However, it is anticipated that there will be a growing emphasis on long-term conditions management and that conditions will become increasingly complex to manage with greater co-morbidities – particularly among the oldest old (National Health Board, 2010). Burgeoning levels of obesity and obesity related illness may also impact significantly on the health care sector. By 2036, some estimates indicate that nearly half a million people in Aotearoa New Zealand will have Type II Diabetes (Tobias as cited in National Health Board, 2010). Increasing financial demands are likely to be placed on the health sector to meet the needs of the ageing population in an increasingly tight environment.

Of growing importance will be the need to consider more fully the individual health needs of people based on their cultural and social expectations. There will be increased demand for more culturally responsive services and the development and utilisation of models of care that are culturally specific. This will see an increased demand for health services and workers who have the ability to speak other languages, with recruitment and retention of these workers becoming a priority.

Workforce shortages particularly in rural areas already require the development of new roles for health professionals, and will require the development of new models of care and more effective use of existing health professional capacity (National Health Board, 2010). The Acute Care in

Provincial Hospitals project is currently reviewing workforce capacity and future roles in provincial regions in order to identify new and future models of care in that area. Health Workforce New Zealand (HWNZ) is also undertaking a range of service reviews looking at the future configuration of the New Zealand health workforce.

2. Demographic trends specific to nursing

As noted above, the nursing workforce is also ageing but there are other demographic features of the nursing profession that have important implications for the future. The following table is adapted from the Nursing Council of New Zealand *New Zealand Nursing Workforce* document (Nursing Council of New Zealand, 2010a) and the District Health Boards New Zealand (DHBNZ) *Future Workforce* document (DHBNZ Future Workforce, 2009a) and provides a snapshot of the current nursing workforce in Aotearoa New Zealand. Unfortunately figures pertaining to the areas where nurses work are inconsistent with poorly defined parameters, limiting their usefulness. Cook (2009) for example, claims that up to 50% of nurses are working in primary health care roles but this is not supported by Nursing Council of New Zealand and DHBNZ data.

Total regulated nursing workforce who meet the criteria to practice: 47,129 (Nursing Council of New Zealand, 2010a)	**Registered nurses:** 42,334 (practising) **Nurse Practitioners:** 69 (active) **Enrolled nurses:** 3,130 (practising)
Gender: 7.2% male 92.8% female	**Ethnicity:** European – 62% Asian – 10.1% Māori – 6.3% Pasifika – 3.2% Other – 7%
Average age: 46.7 years	**Post Graduate Qualifications Completed (2006):** Post graduate certificates and diplomas – 470 Masters degrees – 80 Doctoral degrees – 3
Where registered nurses work (approximate): Long term care – 7-12% Mental health – 10-11% Acute care – 42-44% Primary Health Care –20-22%	**Where Enrolled nurses work (approximate):** Rest home/residential care – 31% DHB acute settings – 27% Mental health – 5% Primary Health Care – 9.3%
Hours of work: Approximately 51% work >0.9 FTE and above Approximately 50% work <0.8 FTE and below	**Overseas trained nurses working in Aotearoa New Zealand:** 7893 (50% from UK, 13.5% from the Philippines)

Table 1. Snapshot of the current nursing workforce in Aotearoa New Zealand (Nursing Council of New Zealand, 2010a; DHBNZ Future Workforce, 2009)

Brief overview of the implications for nursing

Despite concerns expressed in recent government documents regarding a future shortage of nurses (National Health Board, 2010), work is still continuing to determine the actual presence or significance of this shortage (DHBNZ Future Workforce, 2009a). There has been a notable absence of any assessment of the nursing workforce needed either now or into the future and reported shortages are almost always determined by the number of vacant positions at a given moment of time. Measuring vacancies is simply a measure of the number of nurses needed to deliver a particular model of care at the level currently funded. This may or may not relate to actual need and is not indicative of future need.

As noted in the previous section, the ageing population and increasingly complex long term conditions will impact on the provision of health care in Aotearoa New Zealand and when these issues are compared with the current nursing workforce, a number of conclusions can be drawn. The average age of the nursing workforce and the implications of a retiring nursing workforce mean we do need to consider how we can retain the experience and expertise of these nurses. Succession planning will be vital including mentoring programmes and more flexible work arrangements and roles for older nurses. The retirement of a large pool of Aotearoa New Zealand nurses may also have implications internationally with a flow on effect on developing countries from where increasing numbers of nurses may be recruited. There will be an increasing reliance on the younger Māori and Pacific workforce (Cook, 2009).

There is a growing need for the nursing workforce to become more representative of the ethnic diversity of the population as a whole. Recruitment and retention strategies for Māori, Pasifika and Asian nurses are a growing priority. The gender mix is also an area nursing has not addressed effectively. Nursing needs to consider more effective ways to attract men to the nursing profession.

There is growing impetus for the provision of health care in the primary health care sector yet 50% of nurses still work in acute care settings. We need to consider ways in which we can further support the transition of nurses from acute care to primary health care roles in order to meet the changing needs of the population. The ageing primary health care workforce is of significant concern. Issues surrounding the use of overseas trained nurses are also significant and will be addressed later in the document.

The poorly and inconsistently defined areas of work in current workforce data limits effective workforce planning. It is not clearly known how many nurses work in each sector as there is no standard definition around what is included in each area of work. For example does primary health care include Māori and Pasifika nurses?

3. Technology

Technology is probably one of the fastest developing areas of health care in the world. We are now dependent on technology in ways that were unimaginable even 15 years ago. Fax has given way to email, receiving information in hard copy has given way to internet access, the phone line has given way to cellular phones, and electronic banking and e-learning are part of everyday life. Technology

has resulted in significant changes in health care and nurses utilize technology in nearly every work setting. IV infusion pumps, electronic monitoring systems, telemetry, digital blood pressure cuffs, digital blood sugar monitoring, databases to support evidence-based practice, and insulin pumps are just some of the technology nurses use. Nurses are expected to check lab results using computers, monitor population health status using databases, and record patient notes electronically. Nursing informatics is an entire specialty area of its own. The ability to understand and utilize technology in nursing practice is an essential element of nursing care. A lack of interoperable IT systems, inconsistency in the availability of technology, and a lack of recognition of the costs of IT in contractual arrangements are significant problems that are still to be addressed and have substantial ramifications for quality of care.

The National Health IT Plan (Osborne & Cooke, 2010) provides a framework for the development of IT infrastructure in the Aotearoa New Zealand health sector over the next 5 years. Key issues identified with the use of information technology in the Aotearoa New Zealand health care sector in the past include the fragmented relationship between health care service delivery, workforce planning, management and health IT solutions, along with the fragmented implementation of IT solutions nationwide that fail to account for the 'whole' system (Osborne & Cooke, 2010). Information technology platforms support clinicians to do their job effectively, ensure patient care is cohesive and safe, and are fundamental to the development of integrated care models. The new plan proposes that by 2014 a shared care record will be developed in which all clinicians submit basic patient data to a central repository that is able to be accessed nationally (Osborne & Cooke, 2010). Basic clinical data will include patient vitals, E-events, care plans and decision support. Full patient records will continue to be maintained with the patient's primary health care provider. Other IT initiatives in the plan that will have a significant impact on the provision of health care include e-prescribing, e-referrals, e-discharges and community e-prescribing.

The NZNO supports the National Health IT Plan in principle but is concerned that there is a lack of recognition in the Plan of the importance of ensuring equity for all people accessing health services and on the specific needs of nurses. Nurses are significant users of Health IT and have very different needs to medical professionals upon whom the IT Plan focuses. For example, district nurses that have paper notes that then have to be duplicated online; one computer station shared between numerous nurses; and the need for nurse friendly software.

Brief overview of the implications for nurses

Nurses need to embrace new technology for the benefits it can bring to the people they nurse. While many nurses readily adapt to the use of new technology in nursing, new and emerging technologies arising in the health sector place increasing demands on nurses to upskill in areas they may not be familiar with. Employers must recognise the diverse levels of knowledge surrounding IT that currently exist and provide appropriate training and education as well as ongoing support for nurses at a level appropriate to the user's existing skills. More formal education programmes including undergraduate and postgraduate programmes must also recognise the diversity of understanding that exists in relation to information technology. Undergraduate programmes need to make the use of IT a priority in curricula and ensure that nurses graduating into the workforce have the skills and knowledge to utilise IT to improve patient outcomes and be familiar with trends

in IT. For example, the increasing use of text messaging to support clients endeavouring to quit smoking (e.g. txt2quit) or the online self-help course on depression fronted by John Kirwan (www.depression.org.nz). These types of initiatives will become increasingly utilised to facilitate self-management and nurses need to be aware of these, utilise them in practice and be developing them. At the recent Primary Health Care Nurses conference, American nursing professor Carol Huston outlined a range of technological developments that will impact on nursing over the next 20 years. These include body scans which identify underlying pathology while a person showers, 'nano bots' that circulate in the blood stream and identify and repair disease processes, and the ability to grow new teeth (O'Connor, 2010a). Of significant importance is the need to ensure all nurses have access to electronic databases to support evidence-based practice. Nurses must be supported to embrace these new technologies for what they can bring to improving health care and health outcomes (including safe staffing levels). Implementation of new technology should not be at the cost of the relational, person-centred care that nurses provide.

4. Genetics

The human genome project was designed (among other things) to identify all existing genes and determine the sequences of the 3 million chemical base pairs in human DNA. These findings were intended to lead to new and revolutionary ways to diagnose, treat and possibly prevent many of the thousands of disorders that affect people. Improvements in genetic testing, genetic therapy procedures and genetic engineering are also intended to benefit the many people with gene related disorders (Nicol, 2010). Despite the promise of the human genome project, the intended benefits of the project to health care have yet to be fully realised (Wade, 2010). Some areas that have shown particular promise have been disappointing. For example a study of 19,000 women in the USA that attempted to use genetic risk scores to predict cardiovascular disease found that taking a family history was more effective (Paynter et al., 2010). Other areas have had more success. For example a number of researchers are working successfully on identifying the genes that influence susceptibility to chronic obstructive pulmonary disease (Silverman, Spira & Pare, 2009). Regardless of the mixed results thus far, genetics and genomics are increasingly being integrated into the screening, prevention, diagnosis and treatment of diseases and are likely to significantly impact on the way health care is provided into the future (International Council of Nurses (ICN), 2009).

The rapid development of the science of genetics and genomics in health care does however raise ethical questions. The ICN have identified a number of significant concerns associated with the increasing availability of genomic technology. These include:

- Stigma, discrimination, stereotyping, and misuse of genetic data.
- Lack of access to discoveries for research purposes – through patenting of genes.
- Simplistic view of humans as assemblage of genes.
- Attribution of behavioural and social ills to genes.
- Lack of respect for individuals, families and populations.
- Zoonotic diseases.
- Marginalisation of those with disabilities.

(ICN, 2009, p.1)

Other legitimate concerns include questions surrounding privacy, access to care and discrimination based on genetic information (ICN, 2009).

Brief overview of the implications for nurses

The role of nurses in genetics and genomics will be of increasing importance as new genetic knowledge comes to light. Already nurses have a significant role in providing counselling to families with inherited genetic risk, developing education programs on genetics and the science of genomics, and undertaking research using genetics as a basis (Trossman, 2009). Nurses provide the link between genetics and genomics and the people who will benefit from these areas of knowledge (Trossman, 2009; Nicol, 2010). People who seek health care expect nurses to understand the implications of genetics and genomics and provide care accordingly (Pestka, 2009). The Nursing Council of New Zealand clearly indicates that genetics is a core component of any nursing education programme leading to registration as a nurse (Nursing Council of New Zealand, 2010b).

The ICN also advocate for National Nurses Associations (of which NZNO is one) to become involved in developing appropriate legislation surrounding genetics, collaborate in developing national guidelines and standards relating to genetic services, and support genetic research in nursing (ICN, 2009). Of importance in Aotearoa New Zealand is consideration of the impact of genetics and genomics on Māori. For Māori, human dignity is linked to the core values of mana tipuna, tapu o te tangata, whakapapa and mauri (Dickenson, 2005). Whakapapa and the genetic material associated with its transfer across generations is considered sacred, therefore any manipulation or mixing of whakapapa lines is unacceptable to many (Hudson, Ahuriri-Driscoll, Lea & Lea, 2007). These cultural implications must be considered carefully as genetics and genomics develop in Aotearoa New Zealand.

5. Treatment Modalities

New and emerging methods of treating disease and injury will continue to alter the way in which we provide health care. The impact of genetics and genomics on health care is only starting to be realised but other treatment modalities will also have a significant impact on the provision of nursing care in the future. The combination of biomedical science with public health measures has contributed significantly to the treatment of disease and injury in the past including for example the development of antibiotics and vaccines, the development of new surgical techniques, recognition of the importance of safe drinking water, fluoridation, and mass vaccination programmes. New and emerging methods of treatment may have a similar impact on the future health of people. Examples include stem cell therapy (International Society for Stem Cell Research, 2008), synthetic antibodies (Hoshino et al., 2010), and the development of new drugs (for example a gel that can replace fillings and act to encourage tooth regeneration (Fioretti et al., 2010). However new and emerging treatment modalities are not limited to medicine and science. As new emphasis is placed on the prevention and management of long term conditions and associated risks such as depression and

anxiety, non-medical treatment modalities will have an increasingly important role to play in health care.

Research in a number of areas already demonstrates the successful impact of lifestyle programmes on the health of people experiencing a range of conditions including psychiatric disability (Forsberg, Bjorkman, Sandman, & Sandlund, 2010), obesity (Seo & Sa, 2010), and diet, physical activity and smoking (Sarrafzadegan et al., 2009). Marmot and Friel (2008) demonstrated that collective action at the grass roots level can lead to improved housing and employment conditions, which, in turn, can lead to health equity. Community-based intervention programmes designed to address the social, cultural and economic determinants of health will become increasingly common as well as programmes designed to address the environmental factors that impact on health. Examples include increased cross-sectoral collaboration with environmental planners to address issues associated with the obesogenic environment, and increasing integration of complementary and alternative approaches to health care along with culturally specific programmes within mainstream models of practice. One example includes Ngāti Porou Hauora (NPH) on the East Coast who have implemented a programme called Ngāti and Healthy, aimed at reducing the risk of type 2 diabetes mellitus by promoting a lifestyle characterised by healthy eating and regular exercise (Tipene-Leach, et al., 2004). The programme also aims to increase awareness of diabetes and pre-diabetic conditions both amongst those at high risk of developing diabetes and the community at large. In particular, the programme aims to reduce the prevalence of insulin resistance before it progresses to impaired glucose tolerance or impaired fasting glycaemia. A prevalence survey of carbohydrate metabolism was conducted in 2003, preceding the intervention, and it will be repeated again after the intervention has been in place for two, five, and ten years to provide an evaluation of the programme (Coppell, et al., 2009).

One of the key concerns associated with the advent of new and emerging treatment modalities – particularly those associated with medical technology – is cost. Morgan and Simmons (2009) are particularly scathing regarding the cost of health care in Aotearoa New Zealand and argue that not all treatments should be provided or funded given the limited funds available in the health care sector. Others agree and indicate that new medical technologies continue to be implicated in rising health care costs and the sustainability of health care systems globally depends on our ability to control usage (Rosen & Mays, 1998). However, the risk of limiting access to high technology interventions results in the passing down of cost to other areas of the health system as people who may benefit from high technology interventions may face lifelong disability requiring long term care. Limiting high technology interventions also restricts the ability of health care providers to select the health care that is best suited to the patient.

Brief overview of the implications for nurses

Nurses will continue to integrate new and emerging treatment modalities in practice as well as work collaboratively to ensure integration of such modalities is person-centred, appropriate and safe. One of the biggest opportunities for nurses lies in the development and implementation of lifestyle intervention programmes. Nurses are the health professionals who work most closely with those people experiencing the impact of long term conditions and are the ones who are best able to identify those approaches that work. Nurses will use research based approaches to identify,

implement and evaluate new treatment modalities in communities and develop best practice guidelines around lifestyle intervention programmes and other nursing initiatives. Already this is underway internationally (see for example Hauck, Kelly, & Fenwick, 2007) and to a small degree in Aotearoa New Zealand (see for example Yarwood, 2008) however nurses need to increase their leadership role in developing these programmes in Aotearoa New Zealand and publishing their findings.

Integration of Māori models of care and Whānau Ora principles including increased use of Rongoa Māori incorporating karakia and tikanga into mainstream practices is likely to become increasingly common. Nurses must be suitably prepared to integrate and observe these practices in the nursing care they provide.

Nurses are also in a prime position to develop policies around effective use of existing resources in order to gain maximum health benefits. Nurses already identify health needs in the people, family whānau and populations they work with and lead change in health service delivery in order to meet these needs and we need to continue to advocate for cost effective treatment modalities for these people.

6. Global Issues

Of key importance to the future of nursing in Aotearoa New Zealand is the impact of the global economy on the provision of health care. Globalisation and global climate change have already begun to impact on the way nursing care is provided and will profoundly shape the way in which we provide nursing care in the future. Globalisation is putting the social cohesion of many countries under stress and health systems are struggling to cope with the demands of a globalised world (World Health Organisation, 2008). Globalisation refers to the integration of the world economy over the past quarter century through the movement of goods and services, capital, technology and labour (Labonte & Schrecker 2007). This integration has led to a situation where economic decisions affecting people in all corners of the world are influenced by global conditions. The 'global village' metaphor captures the essence of the connectivity that occurs between people as a result of globalization.

Global climate change and increasing demands on limited natural resources to fuel our economies mean that every decision we make both individually and as a collective has the potential to impact on the sustainability of the environment that supports us. Global climate change is already impacting on health in varying ways. For example, global climate change has resulted in an increase in extreme weather events (Weber, 2010). Extreme weather events themselves can create disaster conditions where large numbers of people may become displaced, becoming forced to live in crowded, unhygienic conditions, and where water supplies may be contaminated (Weber, 2010). The prevalence of infectious diseases transmitted through water, food, mosquitoes and other insects is also being affected by global climate change. Although there have been no outbreaks of mosquito borne disease in Aotearoa New Zealand, the Southern Saltmarsh mosquito which is known to carry the Ross River Virus was found in Aotearoa New Zealand in 1998 and an eradication programme has been running since this time (Biosecurity New Zealand, 2007). The prevention of

global health issues has become of increasing importance and prevention is now a key element of health care in most countries.

The rapid proliferation of new infectious disease due to air travel has already had a significant impact on global health and the risk of global pandemics is not likely to diminish.

Brief overview of implications for nurses

The impacts of globalization specific to nursing are both simple and complex. Global migration, for example, results in large numbers of overseas trained nurses (OTNs) coming to practice in Aotearoa New Zealand. In 2008 there was a 13% increase in OTNs registering to practice here (Nursing Council of New Zealand, 2009a). These nurses meet many of the demands of the health care system where shortages of qualified nurses are endemic. However, simply meeting the demands of the Aotearoa New Zealand health care sector through the utilization of OTNs can place a significant burden on the country of origin of many of these nurses (Little & Buchan, 2007). The International Council of Nurses (ICN) has called for developed countries to attain a level of self-sufficiency and sustainability in meeting their needs for a qualified health workforce in order to prevent the impact on already struggling countries of nurses migrating to developed countries (Little & Buchan, 2007) and Aotearoa New Zealand must work toward achieving this.

It is important to note here that the language requirements for OTNs are neither occupationally nor culturally appropriate, being largely predicated on the patented Cambridge International English Language Testing System (IELTS). IELTS has a number of failings that mean the qualification does not do justice to the needs of the health sector in Aotearoa New Zealand. These include: the level of pass does not give a robust indication of the level of understanding or communication competence in a Aotearoa New Zealand health setting; it unfairly penalises many for whom English is a second language but who may have been educated in or mainly speak English; it is inconsistent, culturally inappropriate and, at times, unethically administered; and it imposes additional costs on the migrant and regulatory authority with no regard for public safety (Head, 2010).

Aotearoa New Zealand educated nurses are also entering the global labour pool and we lose substantial numbers of these nurses overseas each year. While it appears that many of these nurses eventually return to Aotearoa New Zealand, this may not necessarily be a labour pool that Aotearoa New Zealand can rely on into the future – particularly with the disparities in wages and salaries that exist between Aotearoa New Zealand and countries like Australia and the United Kingdom. Nurses educated in Aotearoa New Zealand who wish to work overseas must also meet the standards required of those countries where they want to work. This can include EU standards and US standards where IELTS may also be required. Ensuring Aotearoa New Zealand educated nurses meet international standards will facilitate the process of registration internationally.

Nurses will need to be ready to respond effectively to emerging disease and potential pandemics. Although nurses have a duty of care, this does not occur without limits and any risk to personal safety must be considered when providing care during pandemic or disaster situations (NZNO, 2008). However, serious consideration needs to be given to the readiness of Aotearoa New Zealand nurses to respond to the potential implications of emerging global health issues given that current pandemic, disease and disaster plans remain largely untested. Planning with the employer is vital, nursing cannot manage pandemics in isolation from rest of the team. In addition, nursing standards of practice may need to reflect the needs of an emergency situation.

Issues for nurses across the health care sector

There are a range of issues facing nurses across many of the health sectors in Aotearoa New Zealand. Some of these are common to all of them (for example creating healthy workplaces), but some are unique to the particular area of practice – for example primary health care or rural health. The following section provides a brief overview of some of these issues, however no attempt is made to consider how any of these can be or are being addressed at this stage. How some of the issues identified here can be addressed will be found later in the document.

Acute care

The majority of nurses working in Aotearoa New Zealand work for District Health Boards (62%) with the majority of these nurses working in acute care and emergency, surgical, and medical and palliative care settings (DHBNZ Future Workforce, 2009a). Many of the issues facing nurses in acute care settings are similar across the DHB sector and across nursing as a whole. Issues such as quality and safety in health care, and the impact of working conditions on patient outcomes have become increasingly challenging aspects of nursing care in an increasingly challenging fiscal environment (Clarke & Aiken, 2008). Other issues include: nursing shortages and recruitment and retention issues; patient management systems that frequently do not recognise the challenges of increasing patient acuities; a largely part-time workforce; increasing numbers of internationally-trained nurses; increasing violence; increasing patient complexity; anticipating the appropriate skill mix to meet patient need; an increasing burden of administrative responsibilities; provision of acute care in rural areas; and the challenges of creating a healthy workplace. Nurses often feel unsupported by management when decisions are made in response to a rapidly changing environment without consideration of the long term implications. The restructuring of nurse leadership positions that occurred in the 1990s for example, had significant negative consequences for patient care quality in New Zealand (McCloskey & Diers, 2005) and recent restructuring of nurse leadership positions in various district health boards may result in similar outcomes if lessons from the past are not acknowledged.

Mental health

Approximately 10% of the nursing workforce in Aotearoa New Zealand work in mental health (DHBNZ Future Workforce, 2009a). Many of the issues in mental health are similar to those outlined above but there are a number of additional issues specific to the sector. These include funding cutbacks to the NGO sector who provide the bulk of community support services for people experiencing the effects of mental illness, increasing use of an unregulated workforce, increasingly unstable clients being maintained in community settings for longer periods of time as availability of psychiatric beds decreases due to work force shortages and deinstitutionalisation, legal considerations in all cases, and changing models of service provision (Henderson, Willis, Walter, & Toffoli, 2008). There has been increasing emphasis on primary mental health care since release of a comprehensive review of primary mental health care in 2002 (Ministry of Health, 2002a). Evaluation of primary mental health care as an approach in 2009 shows 80% of clients utilising primary mental health care services demonstrated some improvement in mental health and that care and access to care has been improved (Dowell et al., 2009; Ministry of Health, 2009a). Nurses have been

instrumental in the provision of primary mental health care and the results of the evaluation suggests further opportunities for nurses will develop in this area. Consideration should be given to an additional review of the current workforce and identification of what qualifications are required to work in mental health areas including in leadership positions. This is especially critical for those nurses working in dementia level care who now also provide residential care for people with known mental health diagnoses. The impact of alcohol and drug misuse is also likely to impact on mental health services in the coming decades.

Te Ao Māramatanga (New Zealand College of Mental Health Nurses) is developing a certification programme for mental health nurses who have completed a post graduate entry qualification that will see New Zealand in a position to meet the demand for specialist mental health nurses – particularly in primary health care as mentioned above.

Primary health care

Primary health care is both a philosophy of care and an organizing framework for nurses, midwives and other health professionals encompassing a broad spectrum of activities to encourage health and wellbeing. These can include primary (initial) care and include follow-up activities for promoting the health of the community, protecting community members from harm, and/or preventing illness or injury (McMurray & Clendon, 2010). Actual figures for the Aotearoa New Zealand nursing workforce working in primary health care settings are unclear. Cook (2009) claims 50% of nurses are working in primary health care while the Nursing Council of New Zealand (2010a) claims 20-22% are working in this area. Significant work on defining where nurses work so that effective health workforce planning can occur is required – consistency in defining workplace is essential.

Issues for nurses working in the primary healthcare sector have been identified as a lack of nursing leadership, mentoring and governance, and ineffective recruitment and retention strategies (Finlayson, Sheridan, & Cumming, 2009). Poor pay equity with their DHB counterparts have contributed to poor recruitment and retention although this is being addressed. Other issues that impact on the ability of primary health care nurses to work effectively include the existence of employee-employer models of practice in general practice settings, a largely part-time workforce and the need to increase education in primary health care approaches at undergraduate and postgraduate levels (Finlayson et al., 2009). Flexible funding, purchasing, and contracting models must be developed to enable a continuum of care model, and enrolments in PHOs should be linked directly to the PHO or practice rather than a general practitioner as is currently the case. While primary health care frequently includes the aged care sector within its frame of reference, a number of the issues facing the aged care sector are unique to that sector and therefore warrant a brief analysis of their own.

The aged care sector

The aged care sector is one of the largest employers of nurses in Aotearoa New Zealand with between 7 and 22.4% of nurses claiming to work in long term and continuing care settings (Nursing Council of New Zealand, 2009a; DHBNZ Future Workforce, 2009a). Of concern is the loss of 655 nurses from continuing care between 2001 and 2008 (DHBNZ Future Workforce, 2009a). This underscores concerns regarding: the poor RN to patient ratios in the sector; the increasing number

of complaints about unsafe practice and reports of competence concerns (see later in the document); the removal of the requirement for managers of continuing care facilities to be a registered nurse or medical practitioner and hold a current practicing certificate; and the proliferation of profit driven, privately run companies (many with overseas owners/shareholders) now providing the bulk of continuing care in Aotearoa New Zealand. As the Aotearoa New Zealand population ages, the demand for highly skilled, quality care will increase. A recent study exploring nurse leaders' perceptions of the skills nurses working in continuing care need included the following areas:

- Advanced assessment skills including: auscultation, palpation, percussion, basic urine analysis, glucose testing, rapid emergency assessment skills.
- Direction and delegation skills.
- Chronic condition management e.g. Flinders model.
- Management of delirium and dementia.
- Communication skills.
- Medication competency in particular with regard to polypharmacy.
- Wound care and assessment of skin integrity.
- De-escalation of challenging behaviour skills.
- Palliative care skills e.g. Liverpool pathway.
- Auditing skills.
- The ability to manage complex care.
- A focus on primary health care and keeping people well.

(Clendon, 2011)

These advanced skills underline the need to ensure nurses taking up positions in continuing care are prepared for the complexity of need that exists among clients, and that employers and funders are also aware of the importance of ensuring an appropriately skilled workforce is available. Recent activity has seen the skilled and regulated enrolled nurse workforce replaced in favour of unregulated and cheaper health care assistants, potentially placing many older adults at risk of poor health outcomes.

Rural health care

Rural health care is not just about the delivery of health services in a rural area, but health care provided in the context of a complex matrix of socio-cultural, ecological and environmental understandings (Howie, 2008). Rural nurses work within this complex matrix and face a range of issues unique to this environment. Professional and geographical isolation, difficulties in accessing professional development and educational opportunities, limited access to specialties, and the need for a generalist/specialist focus are some of the demands placed on rural nurses (O'Connor, 2009a). Approximately 1.3% of the total nursing workforce works in rural health care (Health Workforce Information Programme, 2010). Demand for rural nurses is anticipated to increase by 37% between now and 2026 and while supplies of nurses will meet this growth in demand until approximately 2020, by 2026 demand will have outstripped supply (Health Workforce Information Programme, 2010). The increasing demand for rural nurses may be linked to the documented decreases in the numbers of other health professionals working in rural areas. It is known that the rural workforce in general practice decreased by 170 (32%) between 2001 and 2005 and that rural pharmacists and rural midwives have also decreased in number (New Zealand Institute of Rural Health, 2008).

Iwi and Māori health providers

Māori and iwi health and disability providers (Māori providers) are a distinctive feature of the New Zealand health sector, with approximately 275 services nationwide. Māori providers offer a diverse range of culturally appropriate services that empower Māori and their whānau to take control of their health and wellbeing (Ministry of Health, 2009b). The services have a distinctly Māori kaupapa and delivery framework, and are available to Māori and non-Māori alike.

Māori providers play a critical role in developing appropriate, accessible and affordable health services for Māori (Crengle, 2007). The services provided vary according to the size, capacity and contract type and range from specialist services, to comprehensive provision of public health services to integrated health and social services.

There are numerous issues faced by those working in Māori health settings, including inconsistencies in funding, the challenge of using whānau ora approaches to providing service delivery, recruitment and retention of Māori health professionals, ongoing workforce development, and encouraging Māori students into health science careers (Ministry of Health, 2009b).

Nurses and other health workers employed by Māori and iwi health providers face significant disparity in pay and conditions when compared with those employed by District Health Boards. The failure of the government to fund Te Rau Kōkiri (the multi-employer collective employment agreement for Māori and iwi providers) perpetuates inequalities in Māori health in New Zealand.

Leadership

Nurse leaders work across all settings where nursing care is provided. Nurse leaders may be charge nurse managers in acute care hospitals, nurse educators, clinical nurse specialists, nurse practitioners, director's of nursing, nurse academics, nurse researchers, and others. Nurse leaders may manage budgets in excess of several million dollars per year or may provide day to day mentorship and preceptorship to new graduates and students of nursing. Strong leadership in nursing and particularly clinical leadership is an important factor in the provision of good patient care, the advancement of nursing practice and the creation of healthy and productive work environments (Aiken, Havens, & Sloane, 2009; Murphy, Quillinan, & Carolan; 2009; McCloskey & Diers, 2005). A lack of nurse leadership has been noted as a major issue in primary health care (Finlayson, et al., 2009), and it is likely that poorly supported nurse leadership in aged care may be implicated in the increasing number of complaints in the aged care sector. It is vitally important that the nursing profession mentors and supports nurse leaders in their development and continues to lobby for nurse leadership positions in all health care forums. Nurses must also be encouraged and supported to put themselves forward for elected and appointed Board positions on DHBs, PHOs and for other governance roles. Nurse leadership is a key element of ensuring the future of nursing and is referred to throughout this document.

Method

Nursing may develop in a number of different ways. This background document uses a framework for future thinking that enables us to consider a number of different futures and to identify which one has the greatest potential for nurses to improve health outcomes. Although Rhea's (2005) anticipatory learning framework was designed for educators to orient learning toward the future, a modified version of it has proved a useful tool for this project providing the knowledge and skills to understand future possibilities.

The key tenets of Rhea's (2005) method are foresight, identity, direction setting and innovation.

Foresight analyses what we need to know about alternative futures (Rhea, 2005). A range of tools assist us to become aware of what the future will require of us. These include:

- Orienting in time (considering the past and present and how these will shape the future)
- Exploring images of the future (for example examining the 'official future' – that is the future that the government or other organisations may have articulated)
- Scanning the environment for trends, issues and developments (searching for the emerging issues that can become key drivers of the future)
- Analyzing trends and issues for implications – SWOT analysis

Identity examines what we believe about the world and ourselves and is one of the most important determinants of the future we can create (Rhea, 2005). The values, beliefs, ethics, emotions and intelligence of the profession of nursing and how we teach these to new comers to nursing will shape the identity of nursing and the subsequent strength of the profession to achieve a future that contributes to improving health outcomes for all New Zealanders.

Direction setting takes the learning from foresight and identity and makes decisions about what we want to create in the future and how we will do it (Rhea, 2005). Here we define our vision through reflection and strategic conversations from which we choose the goals and actions that will enable us to achieve an effective future. This is where we set the strategic direction for how nursing is going to achieve improved health outcomes.

Innovation explores the solutions we can create together (Rhea, 2005). That is, what innovations are required to achieve the future we envision?

As mentioned above, aspects of Rhea's method have been modified for the purposes of this document and a range of focus group and consultative processes have been used to inform development of the vision. In this document, each of the following areas has been examined to provide background context to the vision:

- Health and social policy frameworks
- Legislative and regulatory frameworks for practice
- Models of practice
- Education
- Employment issues

2020 and Beyond: A Vision for Nursing

Nursing is an evidence-based practice discipline with a distinct body of knowledge and skills underpinned by nursing theory and research. Nursing's core focus is people (with or without disease), and the way in which people respond to health, wellbeing, illness, disability, the environment, health care systems, and other people. The discipline of nursing in Aotearoa New Zealand draws on the uniqueness of the Aotearoa New Zealand cultural experience in developing the effective relationships hallmarked as essential for improving health outcomes. Individuals, family whānau, hapu, iwi, and the wider society are the recipients and benefactors of professional nursing care. This section of the vision is split into five parts: health and social policy frameworks, legislative and regulatory frameworks for practice, models of care, nursing education, and employment. Each section provides an overview of the current situation (orienting in time), followed by a review of the proposed official futures (images of the future), a summary of trends, issues and developments, and finally a strengths, weaknesses, opportunities and threats analysis.

Part 1: Health and Social Policy Frameworks

In this section I outline the current health and social policy issues that impact on nursing. This includes te Tiriti o Waitangi, the Aotearoa New Zealand health system, the social determinants of health, and a primary health care approach to the provision of health care. The Aotearoa New Zealand health and social policy context is informed by both what happens locally and what happens globally. Te Tiriti o Waitangi underpins the social and cultural context of Aotearoa New Zealand society and the partnership, participation and protection tenets ensure te Tiriti is recognised in all health and social policy. However, Aotearoa New Zealand health and social policy and structures are also informed by international perspectives. In particular the World Health Organisation provides guiding policy on global health issues that Aotearoa New Zealand draws on to develop its own policy. This section provides a brief outline of the current situation both in Aotearoa New Zealand and internationally in regards to health. The areas examined provide a broad overview of some of the key issues facing nurses and are not meant to cover all aspects of existing health and social policy in Aotearoa New Zealand. Each area is firstly oriented in time (the current situation) and then examined in light of potential official futures. These official futures are the futures that current national and international policy documents advocate for. These official futures are the images of the future portrayed by governmental organisations and it is important these are examined in terms of where nurses and nursing are intended to play a role.

Te Tiriti o Waitangi – orienting in time

Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand and underpins its economic and social development. Key tenets of the Treaty are partnership (between the Crown and Māori), participation (by Māori in all aspects of society), and active protection (recognition that the Crown must actively work toward protecting the rights of Māori) (Waa, Holibar, & Spinola, 1998). Te Tiriti recognizes the social and economic aspirations of Māori and non-Māori and can be used as a

framework by both to exercise control over their health and well-being (Waa et al., 1998). NZNO's Social Policy Statement (2009a) acknowledges the principles of protection, participation and partnership between nursing and the indigenous people, Māori.

Nurses acknowledge the unique relationship between Māori and the Crown as part of their practice and have a proud history of being among the first to recognise the impact of culture on health. In the late 1980s Irahapeti Ramsden, a Māori nurse of Ngai Tahupotiki and Rangitane descent, spearheaded the cultural safety movement as a means of recognising the power imbalances and inequitable social relationships that exist between Māori and non-Māori (Eckermann et al., 2006; Anderson et al., 2003; Ramsden, 2002). Cultural safety is a concept that refers to exploring, reflecting on, and understanding one's own culture and how it relates to other cultures with a view toward promoting partnership, participation and cultural protection. This notion of cultural safety has now evolved beyond working with Māori to include other ethnic and cultural groups, is an integral part of all nursing education curricula in Aotearoa New Zealand, and is a competency for practice for registered and enrolled nurses and nurse practitioners (Wilson & Neville, 2009; Nursing Council of New Zealand, 2010b; 2010c; 2009b; Eckermann et al., 2006).

Te Tiriti o Waitangi – Images of the future

Te Tiriti o Waitangi recognizes Māori as tangata whenua in Aotearoa New Zealand and provides the platform for partnership and biculturalism in Aotearoa New Zealand. Aotearoa New Zealand is also a multicultural society and people are beginning to consider the role of te Tiriti in a future Aotearoa New Zealand and how it may help shape relationships between all people who live here. Te Tiriti was signed with the intention that it would provide a platform for future development and it has been used as a guide for the development of health policy and service delivery since it's signing in 1840 (Kingi, 2007). Solomon (2009) advocates for people to use te Tiriti as a vehicle for ongoing nation building and resolution of conflict, visualizing te Tiriti as underpinning the development of a common future for all Aotearoa New Zealand. In the Te Papa and Radio New Zealand 2010 Treaty of Waitangi debate series, Mason Durie (Durie, 2010) outlined three possible scenarios for the future of te Tiriti o Waitangi by 2035. In the first scenario, Aotearoa New Zealand had become a Republic and the highly successful Māori enterprises that resulted from earlier Treaty settlements had led to Aotearoa New Zealand's distinctiveness as a vibrant Māori economy incorporating an indigenous approach to climate change. Te Tiriti had contributed to an Aotearoa New Zealand society that achieved negotiated solutions rather than undertook dogmatic decisions and as a result te Tiriti was integrated into an Aotearoa New Zealand constitution. In scenario two, Durie describes the formation of a Confederation of Australasian States in which Aotearoa New Zealand becomes the 10th member having to relegate te Tiriti to history after Australia fails to recognize is importance. In the third scenario Māori have become world leaders in indigenous business and lead a global indigenous network as a result of the development of a Māori integrated economy that came about through successful Treaty settlement processes. The Aotearoa New Zealand government relied heavily on te Tiriti to gain access to world markets and now placed more emphasis on te Tiriti than the tribes. Of the three scenarios, Durie claims any may be possible but that '…the position of Māori in Aotearoa and the standing of the treaty in the future cannot be contemplated without considering the global context and the inevitability of significant economic and political change in the future' (Durie, 2010, 34.15mins).

Nurses were one of the first professions to incorporate the tenets of te Tiriti o Waitangi into their practice, recognizing the importance of te Tiriti to improving health outcomes for Māori. The nursing profession will continue to recognize te Tiriti as the founding document of Aotearoa New Zealand into the future and seek new ways of expanding their practice using te Tiriti and other culturally appropriate approaches to better meet the needs of Māori and other New Zealanders.

Health policy and the health system – orienting in time

Health policy and the structure of the health system have a significant impact on the ability of nurses to provide effective, professional nursing care to people and it is important that nurses have a good understanding of the processes of government. Briefly, overall responsibility for the delivery of health services in Aotearoa New Zealand lies with the Minister of Health who is elected through the democratic process to government and appointed to the role of Minister. The Minister of Health, in conjunction with the Ministry of Health, provides overall leadership and direction for the numerous providers of health care, and develops health policy that guides the provision of health care in Aotearoa New Zealand. Presently, the New Zealand Health Strategy (Ministry of Health, 2000) provides direction for the current system of healthcare in Aotearoa New Zealand along with He Korowai Oranga Māori Health Strategy (Ministry of Health, 2002b) and the Primary Health Care Strategy (King, 2001). In terms of mental health, Te Tahuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (Minister of Health, 2005) and Te Kokiri: The Mental Health and Addiction Action Plan (Minister of Health, 2006) provide strategic direction. Developed by the Labour government, these strategic documents recognized health inequalities, the social determinants of health and active participation by communities as key contributors to the health of the Aotearoa New Zealand population. In a clear shift from disease oriented models of care to a primary health care approach, the focus was clearly on achieving health and social equity for all New Zealanders. However the implementation strategies for primary health care were not clearly articulated and the necessary enabling regulatory and legislative frameworks were slow in coming.

The election of a National government in 2008 saw a dramatic shift in thinking around health expenditure, as well as a reconsideration of the priorities around primary health care and social equity. Many of the current government goals for primary health care for example sit around devolution of secondary services to primary health care as a means to achieve cost savings (National Health Board, 2010). Although the strategic documents outlined above have not been superseded, there has been a clear refocusing on efficiencies in provision of care and more emphasis on acute care. In 2009, a Ministerial Review Group led by Murray Horn was established to consider the challenges faced by the Aotearoa New Zealand healthcare sector, in particular those associated with fiscal issues, and to develop recommendations to help meet these challenges (Ministerial Review Group, 2009). In 2011, there is a clear focus on fiscal restraint in the health sector.

While some argue that the Aotearoa New Zealand health care system compares well with other, similar health care systems (Morgan & Simmons, 2009; Matheson, 2009), others are more critical, arguing our current health system is ineffective and that substantial change is required (National Health Board, 2010; Ministerial Review Group, 2009; Cook & Hughes, 2009). There is ongoing debate within Aotearoa New Zealand on whether improved health outcomes are more effectively

achieved by investing in health and society or by investing in the economy as a whole. Current government policy favours the second approach. However, while cost containment, fiscal restraint in the health sector and investment in the economy are intended to enable the Aotearoa New Zealand health system to meet the growing health demands of the population, there is a growing body of evidence that suggests that investment in health now will reduce health costs tomorrow (Keene, 2010). In fact, approximately 1/3 of the total health gains made by people in Aotearoa New Zealand over the past quarter century are directly contributable to the investment in and provision of health care (Tobias & Yeh, 2009). It is important to note that these gains are not shared equitably across ethnic and income groups. Deaths that can be prevented by the provision of health care were more likely to occur in low income groups and/or Māori, Pacific and Asian people than European and/or high income groups (Tobias & Yeh 2009), making it clear that ethnic and social inequalities persist and must be addressed. Estimates suggest, however, that even small improvements in health (for example a decline in disability rates of 0.5% per year across all age groups) could offset approximately one-third of the projected extra health care costs resulting from population ageing, further supporting the argument for investment in health as a strategy for improving long term health outcomes (Keene, 2010). Clearly though, a significant focus must be on addressing the ethnic and social inequalities that exist in Aotearoa New Zealand for Māori, Pacific and low income population groups.

Health policy and the health system – images of the future

The National party's key health policy document prior to the 2008 general election 'Better, Sooner, More Convenient' (Ryall, 2007) was intended to set a policy platform for health focused on:

- reducing waiting times;
- establishing integrated family health centres (co-locating either physically or virtually a range of primary and secondary health services);
- improving clinical leadership;
- extending thinking to consider public-private partnerships in health; and
- strengthening the health workforce.

Of prime importance in the document was the clear intention that much of the development of better, sooner, more convenient health care will occur largely as a result of shifting secondary services to primary care. In 2009, the Ministry of Health called for expressions of interest (EOI) from Primary Health Organisations to develop the envisioned better, sooner, more convenient health services. This was a key opportunity for nurses to articulate their role in future health service delivery. However, analysis of the 9 EOIs accepted for funding by the government, found that the proposed future health services did little to consult with nurses and that while some of the EOIs effectively incorporate nursing and collaborative models of care, others were less enabling (NZNO, 2010b). Many of the EOIs are characterised by broad aspirational ideas rather than concrete proposals and the workforce implications and funding streams are not clear. There has been little consultation by those putting together the EOIs due to extremely tight timeframes placed on Primary Health Organisations by the Ministry of Health. The changes proposed by the EOIs will significantly change the face of health care in New Zealand yet are poorly understood and lack the involvement of those people most likely to be affected by them including nurses and consumers.

The proposal to shift secondary services to the community does not take into account the differing set of skills required by practitioners to practice in the community. Bringing a primary health care approach to practice (discussed below) is not as simple as shifting people and services to the community and requires a fundamental shift in a practitioner's philosophical approach to practice. Nursing in the community relies on acceptability to clients and the relational aspects of nursing care take on a different aspect that many used to working in a secondary/tertiary setting may be unfamiliar with (MacGeorge, 2011).

The 'Horn Report' (Ministerial Review Group, 2009) mentioned above, visualises a future in which patients are at the centre of care; health professionals play a key role in leadership; patient safety and quality of care are paramount; patient needs are identified and met appropriately with appropriate services and technology; the health workforce is sustainable; and the services provided are cost effective. Steps toward achieving this ideal future include the establishment of a National Health Board to oversee spending, and the reorganisation of the Clinical Training Agency into Health Workforce New Zealand (HWNZ). HWNZ are charged with planning, developing and implementing a national health workforce plan while the National Health Board is charged with supervising expenditure of the $10 billion of public health funding that occurs each year.

NZNO supports the general thrust of the 'Horn Report' – in particular the call for increased clinical leadership, and a strengthening of national and regional decision-making around funding, safety and quality, and capacity utilisation (NZNO, 2009b). However, NZNO is concerned that there is no mention of a future that addresses health and social inequities, nor an explicit recognition of the role and scope of nursing practice in the future envisioned by the Horn Report. While paying lip service to the importance of nurses in clinical leadership, there is no recognition of the specific barriers faced by nurses in achieving effective clinical leadership in the health care sector. A simple example of the rhetoric around nurses in clinical leadership positions was the original positioning of the Chief Nurse in the Ministry of Health without a voice at the Executive Leadership table (Ministry of Health, 2010a). While vocal opposition from nursing groups and others saw the advancement of the position to a more appropriate level, the small numbers of nurses in the Ministry as well as the initial positioning of the Chief Nurse demonstrates the efforts nurses must go to simply to have a voice at the leadership table. In addition, while the Horn report recognises the importance of improving patient safety and quality of care, the report does not link this to the importance of healthy workplaces and safe staffing – well known determinants of improved patient outcomes (Aiken, et al., 2009; Murphy, et al.; 2009; McCloskey & Diers, 2005).

In 2010, the National Health Board acknowledged the persisting inequalities in health in Aotearoa New Zealand and noted that long term commitment reflecting the need to look across all sectors including health, education, and social services would be required. Combined with a range of demographic trends (many of which are outlined above), the National Health Board suggests the development of four models of care that will address many of the current health system pressures:

- prevention, self management and home-based services (doctors appear to take a lead role in this despite nurses specific expertise in this area);
- integrated family health centres, partnerships and teams (the 'health care home', once again little mention of nurses in this proposed model of care);

- hospital clusters and regional services (people may have to travel to receive care and an indication that the number of Nurse Practitioners in acute care will increase);
- managed specialisation and consolidation into a smaller number of centres/hubs (people will have to travel to receive care and some clinicians will travel to provide care).

While it is commendable that persistent health inequalities have been recognised in the new document, there is little to indicate how the necessary cross-sectoral collaboration required to address these inequalities will occur. Health and economic policy needs to be about people and be based on the principles of fairness, participation, security, improved living standards and sustainability (Council of Trade Unions, 2009). Future health and social policy needs to clearly articulate how the persisting ethnic and social inequalities in health are to be addressed, emphasise the need for collaborative policy across sectors to address the social determinants of health, and refocus the provision of health care clearly onto primary health care as the most effective means of addressing health care need and improving health outcomes. The barriers to achieving these things created by the health system itself must also be addressed.

The social determinants of health – orienting in time

The primary factors that shape the health of New Zealanders are not individual lifestyle choices or medical treatments. It is the conditions in which New Zealanders live. The social determinants of health broadly refer to the conditions in which people are born, live, work and age including the health system (World Health Organisation, 2010). These conditions are shaped by the policy decisions that are made surrounding income, resource and money distribution. Mikkonen and Raphael (2010) outline 14 determinants of health that have been shown to have larger effects on health than the effects associated with behaviors such as physical exercise, diet, or alcohol and tobacco consumption. They are:

- Aboriginal status
- Gender
- disability
- housing
- early life
- income and income distribution
- education
- race
- employment and working conditions
- social exclusion
- food insecurity
- social safety net
- health services
- unemployment
- job security

The World Health Organisation uses the following diagram to visually represent the social determinants of health.

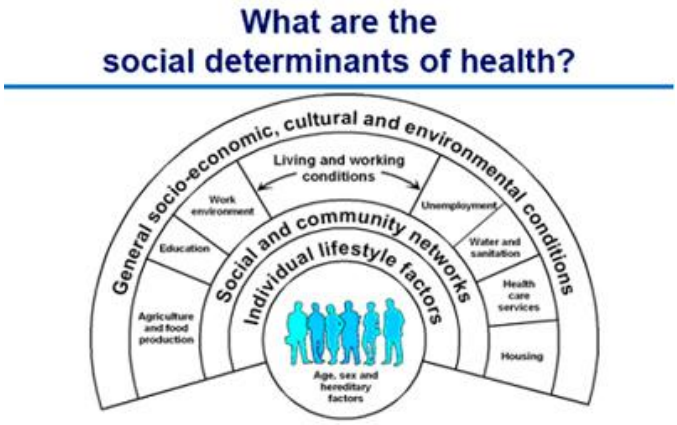

Figure 1. What are the social determinants of health?

Aotearoa New Zealand is not immune to the impact of the social determinants of health. In Aotearoa New Zealand lower income groups experience greater risks of dying at every age group than higher income groups (Blakely et al., 2007). Māori and Pacific people in Aotearoa New Zealand have the highest mortality rates of any group and although the gap between Māori and Pacific and other New Zealander's has decreased in recent years (Blakely et al., 2007), Māori still live 7 ½ years less than non-Māori and a person of Pacific descent lives 5 years less (National Health Board, 2010). The largest contributor to these disparities is the social determinants of health. While the New Zealand Health Strategy (Ministry of Health, 2000) recognized the social determinants of health as a significant influence on the health of New Zealanders, recent health policy has failed to overtly include the determinants and how these can be addressed. The ongoing inequalities in health between New Zealanders are unfair and must be a focus for health and social policy.

The social determinants of health – images of the future

The World Health Organisation (WHO) sees a future in which all countries lead global action on the social determinants of health to achieve health equity (Commission on Social Determinants of Health, 2008). The three key interventions proposed by the Commission on Social Determinants of Health (2008) are:

1) Improving the conditions of daily life – the circumstances in which people are born, grow, live, work and age.
2) Tackling the inequitable distribution of power, money and resources.
3) Measuring the problem, evaluating action, expanding the knowledge base, developing a workforce that is trained in the social determinants of health, and raising public awareness of the social determinants of health.

These three interventions should provide the basis for Aotearoa New Zealand health and social policy now and into the future.

As mentioned earlier, while some in Aotearoa New Zealand advocate for economic growth as a means of improving the social determinants of health and as a result the overall health of the

population (Morgan & Simmons, 2009), others have found that the health inequalities that exist within countries are not due to society not being rich enough, but because the scale of material differences between people are too big – that is, as the rich get richer as a result of economic growth, the poor get poorer as the material goods associated with economic growth do not filter down to the poor (Wilkinson & Pikett, 2010).

The Commission on Social Determinants of Health (2008) argue that economic growth is important, but growth without appropriate social policies to achieve fairness does little to address health inequity and that the agendas of health equity and global climate change must be brought together to achieve health for all people in all countries.

The Commission indicates that nurses have a significant role to play in addressing health and social inequities in the future. For example, nurses have a strong history of undertaking qualitative research and the Commission argues strongly for increasing funding for qualitative research into the lived experiences of people experiencing health inequities (Commission on Social Determinants of Health, 2008). The Commission also sees education in the social determinants of health as a core component of nursing curricula. This will ensure that nurses have a good understanding of the key causes of poor health and how they might be addressed as well as be in a position to facilitate improvements in health literacy among the people they work with. Health literacy is an important element in addressing health inequities, as those with lower levels of health literacy are often the ones who live in socioeconomically disadvantaged communities. Health literacy is the ability to make sound health decisions every day and is a core component of primary health care (McMurray & Clendon, 2010). Improving health literacy must also become a core focus of Aotearoa New Zealand health and social policy now and into the future.

Primary health care – orienting in time

Primary health care is a philosophy of care intended to redress inequities in health by recognising that well-being is dependent on a broad range of social, political, economic and environmental factors (McMurray & Clendon, 2010). Primary health care also provides us with a framework within which we can enact nursing interventions to improve people's health. Primary health care was first defined and described in the Declaration of Alma Ata (WHO, 1979) as '...essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals, and families in the community through their full participation and at a cost that the community and country can afford...' (WHO, 1979, p. 1). Primary health care goes well beyond the provision of the type of care traditionally provided by general practices in Aotearoa New Zealand (known as primary care) to include services that contribute to health, such as those centred on employment, community development, environmental protection and voluntary work. Primary health care promotes co-ordinated approaches to health from all public sectors including housing, agriculture, education, and public infrastructure. In particular, primary health care requires maximum community participation and involvement in the planning, organisation, operation and control of primary health care initiatives. The Declaration of Alma Ata proposed that all governments should formulate national policies, strategies and plans of action to include primary health care as a part of any national health system. Aotearoa New Zealand's eventual response to

the 1979 Declaration of Alma Ata was development and adoption of the Primary Health Care Strategy in 2001 (King, 2001) – 22 years after primary health care was suggested as the way forward for health systems. Despite the clear definition of primary health care in the Primary Health Care Strategy, confusion continues over the provision of primary care and primary health care in this country.

When people are ill or injured, they seek primary care for the condition they are experiencing. Primary care can be provided by many different types of health professionals – including doctors and nurses – with the focus on addressing the condition or illness the person is presenting with. Care may be provided over a long period of time or may occur at just one visit with a health professional. Primary care tends to be offered by general practices. Primary health care extends the focus of primary care beyond the presenting condition to consider what factors contributed to the person presenting for care and how these can be addressed to prevent others from experiencing the same health condition – in other words, primary health care seeks to address the determinants of health as a means of preventing and addressing poor health. Primary care may best be considered a subset or part of primary health care.

In 2008 the World Health Organisation re-visited the concept of primary health care and repeated its commitment to utilising a primary health care approach to addressing the world's health issues (World Health Organisation, 2008). Of significance is the World Health Organisation's commitment to putting people first in the health care system. While recognising that biomedical science is at the heart of modern medicine the World Health Organisation go on to indicate that: *'Insufficient recognition of the human dimension in health and of the need to tailor the health service's response to the specificity of each community and individual situation represent major shortcomings in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing the health outcome returns on the investment in health services.'* (World Health Organisation, 2008, p. 42).

Aotearoa New Zealand nurses are involved in the provision of both primary care and primary health care and have been vocal advocates for the potential of primary health care for improving the health of the people they work with. Nurses are specifically educated to address the human dimension of health that the World Health Organisation indicates is absent in current systems. Although the Primary Health Care Strategy (King, 2001. p. 23) clearly stated that 'Primary health care nursing will be crucial to implementation of the Strategy...' the opportunities for nurses to enact their potential in primary health care have been limited. Since introduction of the Strategy there has been growth in the development of nurses' roles and capability in the primary health care sector but this has been limited by a need for improved nursing leadership, mentoring, governance, and effective recruitment and retention strategies for nurses (Finlayson, et al., 2009). Funding, purchasing and contracting models have also constrained nursing innovation in primary health care and continue to do so (Carryer, 2008). In 2010, the NZNO College of Practice Nurses combined with the Public Health Nurses Section and the District Health Nurses Section to create the NZNO College of Primary Health Care Nurses, contributing to the unity of primary health care nurses in Aotearoa New Zealand and underlining their commitment to primary health care. There is still significant work for nurses to undertake to ensure their place in primary health care is fully realised. Progress is occurring but this has not been rolled out nationally and a lack of overall direction persists.

Primary health care – exploring images of the future

Primary health care was mooted as the way of meeting the future health needs of the world's population including Aotearoa New Zealand at the Declaration of Alma Ata in 1978. In 2008, the World Health Organisation (2008) outlined four avenues for governments to utilize as they address the health needs of their populations into the future. These were:

1. Universal coverage – health systems must contribute to health equity and social justice as a means of addressing health need.
2. Service delivery reform – health services must be reorganized around people's needs.
3. Public policy reforms that ensure public health care is integrated with primary care and that healthy public policy is present in all sectors.
4. Leadership reforms – inclusive, participatory, and negotiation-based leadership throughout the health sector.

One of the most important avenues is the reorganization of health services around people. That is, people will come first and the relationship they form with their health care provider will be one of the most important contributors to improved health outcomes (World Health Organisation, 2008). The importance of a stable relationship with a health care provider is one that holds true anecdotally and in research. My own research into the relationship between nurses and mothers in the context of well child care demonstrated that it was frequently not the information provided by a nurse that was important to a mother but the strong relationship that existed between the two (Clendon, 2009). The World Health Organisation cites an Alaskan example where services were reoriented to ensure each person or family seeking care had an ongoing and exclusive relationship with a specific health professional. As a result, emergency department attendance decreased 50%, specialty care visits decreased 65%, primary care visits decreased 20%, and hospital admissions decreased 20-30% (Eby, 2007). These examples underline the reasoning behind the World Health Organisation's vision for future health care to be reoriented around the needs of people rather than the needs of the health sector as has traditionally been the case.

The International Council of Nurses (ICN) (2008a) outlines the future of nurses in primary health care in research, education and practice. In practice, the ICN indicates that nurses must move away from a medically dominated approach to health care toward practice that is participatory and empowering. Nurses must use tools such as community health needs assessments to work with their communities to involve them in identifying their own health needs and how they see their needs are best met (ICN, 2008a). In education, the ICN advocates for nursing curricula to be clearly and explicitly based around the principles of primary health care and that multidisciplinary learning become a mandatory component (ICN, 2008a). In research, the ICN support the World Health Organisation's position on qualitative research, arguing that future research agendas must include the synthesis of qualitative research into determining health outcomes (ICN, 2008a). The ICN (2008a) also articulate the importance of ensuring that nursing is valued by governments. Quality research, evaluation, political awareness and leadership will ensure this occurs (ICN, 2008a).

While general practice is considered to play a key role in the provision of primary care in Aotearoa New Zealand, the extent to which general practice extends its focus to primary health care is limited. Primary Health Organisations have a role in extending this focus but as long as nurses continue to be

employed by general practices rather than PHOs, nurses' attempts to extend their own practice beyond primary care will be limited.

Trends, issues and developments

In this section, the findings from examining te Tiriti o Waitangi, Aotearoa New Zealand health and social policy, the social determinants of health, and primary health care have been analysed to determine the key trends, issues and developments that will impact on nursing in relation to developing an effective health and social policy framework:

- A range of demographic changes will impact on the provision of health care into the future including ageing, ethnic groupings and urban growth.
- An increase in long term conditions will require finding new ways of providing care to people.
- There is a significant need to build a workforce that is culturally safe and competent both in Māori, and other cultures.
- Te Tiriti o Waitangi will provide a strong and strengthening basis for the development of relationships between Māori and all other New Zealanders.
- The Aotearoa New Zealand government is focused on improving patient care, improving clinical leadership, and containing costs into the future.
- The Aotearoa New Zealand government acknowledges the existence of health inequalities but does not articulate a clear pathway for addressing these.
- There is disagreement over whether improving the state of the economy will improve health equity and health outcomes or if investment in health and social conditions will improve health outcomes.
- The Aotearoa New Zealand government recognizes the significant contribution that nurses can make to health care provision and health outcomes in the future but little is done to enable nurses to enact this contribution.
- Proposals for Better, Sooner, More Convenient health care will significantly change the face of health care in Aotearoa New Zealand yet are poorly understood and lack the involvement of those people most likely to be affected by them including nurses and the people who are recipients of health care.
- The World Health Organisation recognizes that addressing the social determinants of health will achieve health equity and improve health outcomes.
- The World Health Organisation recognizes that primary health care is still the most important approach to achieving health equity and improving health outcomes.
- The World Health Organisation and the International Council of Nurses both see nurses as having a significant role in developing, leading and providing effective health care into the future.
- Funding and employment models in general practice limit the ability of nurses to integrate a primary health care approach to their practice.

Analyzing trends and issues for implications – SWOT analysis

Addressing the social determinants of health through the provision of effective primary health care is mooted as the most effective way of addressing health inequities and improving health outcomes. Nurses have been identified as having a key role in developing, leading and providing effective primary health care internationally but Aotearoa New Zealand has yet to move beyond the policy rhetoric to fully articulating and enacting the potential of nurses and the development of new interdisciplinary models of care in this area. The development of an effective future health and social policy framework for the NZNO must take into account the current situation and the proposed futures outlined above.

To reiterate, future health and social policy needs to articulate how the persisting ethnic and social inequalities in health are to be addressed, emphasise the need for collaborative policy across sectors to address the social determinants of health, and refocus the provision of health care clearly onto primary health care as the most effective means of addressing health care need and improving health outcomes.

Strengths

- Clearly identified pathways to health – addressing the social determinants of health through effective primary health care.
- NZ government acknowledgement of persisting inequalities in health.
- International support for the role of nurses in improving health outcomes.

Weaknesses

- Poor recognition by NZ government of nursing capability and/or poor enactment of nursing models of care.
- Rhetoric regarding nursing capability in the NZ health sector.
- Disagreement over need for investment in health versus investment in the economy to improve health outcomes.
- Restrictive purchasing, funding and contracting models.
- Barriers within the health system that create inequalities by decreasing access to affordable health services.

Opportunities

- Can use the international frameworks to continue to argue for nursing capability in improving health outcomes.
- Can use the international frameworks to reiterate tenets of current NZNO social policy and widen this to become embedded in the vision.
- Can use a social determinants and primary health care philosophy to explain the link between the industrial and professional concerns of the NZNO – if nurses promote primary health care as the key approach to addressing health inequities and improving health outcomes, then the social determinants of health must also be addressed for nurses.

Threats

- Continued lack of recognition of nursing capabilities by government and the wider health sector.

- Weakening economic structures that will constrain Vote: Health.

Part 2: Legislative and Regulatory Frameworks for Practice

In this section I outline the current and proposed legislative and regulatory frameworks that guide nursing practice. The primary goal of professional nursing care is improved health outcomes for individuals, families, communities and society. Part of improving health outcomes is to ensure the safety of the public who are the recipients of nursing care. There are a range of legislative and regulatory requirements surrounding nursing practice, largely designed to protect the safety of recipients of nursing care. Some of these enable nursing practice and some serve as barriers to developing nursing practice. In this section the key legislative and regulatory frameworks that impact on nursing are discussed including: the Health Practitioners Competency Assurance (HPCA) Act; the role of the Nursing Council and current scopes of practice; the range of existing legislative barriers to workforce innovation; and issues surrounding safety including the health care assistant workforce.

Orienting in Time

The Health Practitioners Competence Assurance (HPCA) Act 2003

The HPCA Act is designed to protect the health and safety of the public by providing mechanisms to ensure the life-long competency of health practitioners. A number of titles are protected under the Act, and only health practitioners who are registered under the Act are entitled to use such titles. Professions regulated include nursing, midwifery, medicine, pharmacy, physiotherapy, and a range of other allied health professions. Under the HPCA Act nurses must demonstrate their fitness and competence to practice. The Act provides a safety net for the public by ensuring health professionals are competent to practice. The Act separates health practitioner registration activities from disciplinary processes. Registration, competence assessments and some disciplinary proceedings are undertaken by the respective health profession's Council or Board. For nurses, the Nursing Council of New Zealand is the statutory body that governs the practice of nurses, monitors and sets standards for practice, and maintains the register of nurses (see below for further details). The Health Practitioner Disciplinary Tribunal however is responsible for hearing and determining disciplinary proceedings brought against nurses under the HPCA Act. Health care workers such as Health Care Assistants, Mental Health Support Workers, phlebotomists, anaesthetic technicians, physician's assistants, ambulance officers and paramedics are not covered by the Act and as such there are no legal requirements surrounding the competency of these individuals.

Increasingly, members of health professions are being held accountable for their practice. Any recipient of health care or their family has the right to complain about the care they receive under the Code of Health and Disability Services Consumer Rights (1996) and any health professional whether regulated or not may find themselves the subject of such complaints. For nurses, there are a number of agencies that can scrutinize a nurse's practice including:

- The Nursing Council of New Zealand
- The Health Practitioners Disciplinary Tribunal (HPDT)

- The police
- A coroner
- The Health and Disability Commissioner (HDC)
- The Privacy Commissioner
- The Director of Proceedings
- ACC
- Private/civil legal challenges

NZNO is increasingly involved in cases where members are subject to complaints regarding their practice. Although not all of them lead to a hearing with the Health Practitioners Disciplinary Tribunal, there is evidence of an increasing trend in complaints being laid with or referred to the Nursing Council associated with the practice or competency of nurses (Nursing Council of New Zealand, 2009a). This is also reflected in increasing numbers of NZNO members seeking assistance from the professional services team following complaints being laid against them (K. Rose, personal communication, May 18th 2010). The area of practice where this is most visible is in the aged care sector (Nursing Council of New Zealand, 2009a; K. Rose, personal communication, May 18th 2010). The increasing number of members of NZNO seeking advice and support may be reflective of increasing membership of NZNO. It is important to note that any increase in complaints may also be associated with the increasing agency of nurses in the health care sector. That is, nurses are becoming increasingly visible members of the health workforce. With the Health and Disabilities Commission focus on educating members of the public about the right to question the quality of the care they or their family member have received and the development of a culture of learning from the complaints process, this may explain an increase in numbers of complaints.

The Nursing Council of New Zealand

The Nursing Council of New Zealand is the regulatory authority responsible for the registration of nurses and its role and responsibilities are outlined in the Health Practitioners Competence Assurance Act 2003. Its primary function is to protect the health and safety of members of the public by ensuring that nurses are competent and fit to practice.

It fulfills this function by:

- Registering nurses
- Setting ongoing competence requirements and issuing practicing certificates
- Setting scopes of practice and the qualifications required for registration
- Accrediting and monitoring education providers and setting the state examination
- Providing guidelines and standards for practice
- Receiving and acting on notifications of health and competence concerns
- Receiving and acting on complaints about the conduct of nurses
- Promoting public awareness of the Council's responsibilities.

(www.nursingcouncil.org.nz)

Nurses whose practice is governed by the Nursing Council of New Zealand are registered nurses, nurse practitioners and enrolled nurses. Only nurses who meet the competency requirements of any of these three scopes of practice outlined by the Nursing Council may legally call themselves by the applicable title under the HPCA Act.

The Nursing Council frequently consults the broader nursing workforce on issues associated with the regulation of nursing. In 2009 and 2010, consultation processes took place for example on education programme standards for the registered nurse scope of practice, the enrolled nurse scope of practice and transition arrangements, and the scope of practice for registered nurses. Aotearoa New Zealand is fortunate in that the Nursing Council oversees the practice of all nurses in Aotearoa New Zealand and that we are not subject to the fragmentation of regulation that exists across states in Australia, the United States and Canada.

Scopes of Practice

It is the respective scopes of practice for registered and enrolled nurses and nurse practitioners that describe the extent and the limits of practice of each practitioner. As nurses seek to enhance their capacity to improve health outcomes for people, scopes of practice must be sufficiently broad and enabling to ensure practice is not limited unnecessarily, yet still ensure patient safety. A scope of practice describes the profession of nursing for the public so that they have a clear understanding of the skills and qualifications of nurses and of the types of health services provided by nurses (Nursing Council of New Zealand, 2009b). Scopes of practice for registered nurses, enrolled nurses and nurse practitioners in Aotearoa New Zealand are defined by the Nursing Council. Although an individual nurse and/or a service provider may also define an area of practice, the scopes of practice discussed here are specific to the regulatory definition provided by the Nursing Council of New Zealand. In the following sections, each scope of practice as it currently exists is examined and some of the barriers and facilitators to improving health outcomes that exist for nurses practicing under each scope are outlined.

The Nurse Practitioner

Nurse practitioners (NPs) are Aotearoa New Zealand's highest level of clinical nurse. Nurse Practitioners have completed advanced education and training in a specific area (a minimum of four years experience in an area of practice and successful completion of a clinically focused master's degree) and have met the requirements of the Nursing Council of New Zealand to assess, diagnose and manage health conditions. Nurse Practitioners may also apply for prescribing rights as designated prescribers under the Medicines Amendment Act 2002. As nurses have developed their clinical skills and expertise in the provision of health care, the NP role was seen as a natural extension of nursing practice. Formal recognition of the NP scope of practice by the Nursing Council occurred in 2001 and there are currently 69 NPs in Aotearoa New Zealand (Nursing Council of New Zealand, 2010a) practising in a range of clinical areas such as neonatology, primary health care, child and youth, mental health, chronic care, palliative care and acute care.

NPs contribute significantly to improving health outcomes in the populations they work with and new models of care based around NP practice have the potential to add further to this. However, many parts of Aotearoa New Zealand have been slow to embrace the nature of NP practice and

despite efforts to educate funders and providers of the benefits of nurse practitioner care, a range of barriers to enabling NP practice continue to exist. Resistance by health professionals, including nurses themselves, has also existed. Analysis of the legislative barriers to NP practice identified 55 pieces of legislation that must be amended to enable NPs to practice effectively. Of the 55, 8 have been identified as key. These include:

1. Medicines Act 1981 – *NPs are currently designated prescribers limiting the full range of medicines which can be prescribed.*

2. Injury Prevention, Rehabilitation and Compensation Act 2001 – *ACC does not recognise a NP as an autonomous practitioner for funding claims for prescription, assessments, or 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* (addressed in 2010, NPs can now approve patients for sickness benefits).

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

7. Land Transport Act 1998 – *NPs cannot provide examinations for drivers' licences.*

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

Additional barriers to enhancing NP practice include:

- 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.

- Funding, contracting and purchasing models are not conducive to developing new models of care. For example, ACC payment levels differ between doctors and nurses for same care provision.

With a minimum of eight years training, post-graduate education and clinical experience, and a rigorous registration process, nurse practitioners are highly skilled and experienced practitioners. It is unnecessarily counterproductive to further delay removing the restrictions that prevent NPs from utilising the full extent of their scope of practice as authorised under the 2003 HPCA Act (Trim, 2010a).

The Registered Nurse

Registered nurses are the largest group of health professionals in Aotearoa New Zealand to be regulated under the HPCA Act 2003. In 2010, there were 43,826 registered nurses holding practicing certificates in Aotearoa New Zealand (Nursing Council of New Zealand, 2010a). To become registered as a nurse in Aotearoa New Zealand in 2010, applicants must have completed a 3 year Bachelor level course of study or demonstrated equivalency if qualified overseas – demonstration of cultural safety is required of all nurses registering in Aotearoa New Zealand. The previous scope of practice for registered nurses was developed by the Nursing Council of New Zealand in 2004 following enactment of the HPCA Act and described the skills of a beginning registered nurse. In 2010, the Nursing Council of New Zealand released a new and enabling scope of nursing practice that allows for nursing practice above the beginning level, enhancing opportunities for advanced and specialist practice (more below).

Nurse Entry to Practice programmes (NEt-P) and professional development and recognition programmes (PDRPs) are both initiatives that have been implemented to support registered nurses develop and maintain competence under the HPCA Act (2003). NEt-P programmes provide a structured support programme for new nursing graduates in the health sector. The programme is intended to assist in the recruitment and retention of registered nurses in the long term however the programme is not compulsory and funding does not extend to cover all new graduates. New graduates entering mental health practice areas complete a post-graduate entry to mental health and addiction nursing programme rather than a NEt-P programme.

PDRP programmes are competency programmes designed to assess nursing practice against a set of pre-determined competencies, recognise levels of practice from novice to expert, and support ongoing professional development (http://www.dhbnz.org.nz/Site/Future_Workforce/Nursing-Midwifery/Nursing-Projects/PDRP/Overview.aspx 29 June 2010). Nurses completing PDRP programmes approved by the Nursing Council of New Zealand are able to use these to demonstrate competency to practice under the HPCA Act (2003).

The Registered Nurse (advanced practice)

Changes in the health service environment, the changing nature of the health workforce (including the development of unregulated health workforce roles), and increasing specialisation by medical practitioners and nurses have led to nurses taking on a range of new practices and decision-making responsibilities (Nursing Council of New Zealand, 2009b). Tasks that may have once been considered nursing are frequently being taken on by health care assistants and tasks that were once considered the domain of medical practitioners are now part of everyday nursing practice. New skills, technologies, medicines, and education that focuses on sciences and evidence based outcomes requires nurse education and nursing practice to keep up with this constantly changing environment and new demands to meet service delivery needs. The flexibility of the nursing workforce in being able to quickly assimilate new practices and be deployed where most needed, has been critical to improving healthcare in Aotearoa New Zealand.

In 2009 Mark Jones, then Chief Nurse at the Ministry of Health, hosted a meeting of representatives from the key nursing organisations to discuss a range of issues facing the profession including the

unfettered growth in subspecialty standards and how developments challenging the scope of RN practice could be managed to ensure patient safety. A number of work streams emerged from the meeting, with NZNO and the College of Nurses Aotearoa [CNA] (NZ) facilitating two. The first was to establish in 2010 a group of representatives (NZNO, CNA (NZ), New Zealand College of Mental Health Nurses (NZCMHN) and Te Kaunihera o Ngā Neehi Māori o Aotearoa) to provide a professional validation and endorsement process for specialty standards. A framework for specialty standards is in development. The second was the development of a decision making flow chart to address RN scope challenges through a robust credentialing process congruent with the process outlined in the *Credentialing Framework for New Zealand Health Professionals* (Ministry of Health, 2010b). This flow chart has been shared with the Nursing Council and informed the development of their policy on the expanded RN scope of practice. These processes ensure the development of advanced nursing specialty practice is robust and appropriate.

Registered nurses in advancing practice roles also face legislative, contractual and other barriers similar to nurse practitioners that need to be addressed to ensure future health needs are met.

The Enrolled Nurse

Enrolled nurses make up a significant component of the regulated health workforce in Aotearoa New Zealand. In 2010 there were 3,130 enrolled nurses (Nursing Council of New Zealand, 2010a). Enrolled nurses practice under the direction and delegation of a registered health practitioner providing nursing care and health education to people. In some settings enrolled nurses may co-ordinate a team of health care assistants (Nursing Council of New Zealand, 2010c). Enrolled nurses have faced a number of challenges over recent years including closure of the Roll in 2004, replacement of the enrolled nurse title with nurse assistant, and finally the 2010 reinstatement of the enrolled nurse title, development of a new scope of practice and reopening of the Roll. All enrolled nurses and nurse assistants previously and currently practising under the old scope will transition to the new scope and be called enrolled nurses. Education standards have been set for the new scope and graduates of the new enrolled nurse programmes will have completed an 18 month course of study at Level 5 on the New Zealand Qualifications Framework (Nursing Council of New Zealand, 2010c). The new scope for enrolled nurses will not be realised until 2011 and over time will change nursing team skill mix. Post enrolment education of ENs is an area yet to be examined and it is important that ENs have access to appropriate post-enrolment education and are formally recognised for this within the context of their work settings.

Significant debate occurred among nursing groups regarding the position of enrolled nurses in the Aotearoa New Zealand health care sector prior to establishment of the new scope. Some argued that a combination of registered nurses and unregulated health care assistants (HCAs) would be appropriate as care shifts into the community and increasing acuity in hospitals will see the need for an all RN workforce whereas others argued that an expanded scope of practice for enrolled nurses would result in improved quality of care and patient safety (O'Connor, 2009b). The issue polarised and divided the nursing community as debates continued over the reinstatement of the enrolled nurse scope of practice. Fundamental arguments surrounding the use of an unregulated health workforce versus a regulated workforce underpinned much of the debate and the issues surrounding increased use of unregulated health care workers remain unresolved despite the new scope of enrolled nursing practice. NZNO strongly supported the reinstatement of the enrolled nurse

scope of practice (NZNO, 2007a). The HCA workforce has expanded exponentially with no safety parameters as a result of poor planning whereas enrolled nurses provide safe and effective care to people within their scope of practice. Recent moves by a number of DHBs to disestablish EN positions in favour of HCAs has occurred without robust discussion of the impact of this on the multidisciplinary team or on patients.

Health Care Assistants

Health Care Assistants (HCAs) make up a large (as yet uncounted) and growing sector of the health workforce in Aotearoa New Zealand and can be differentiated from other unregulated health care workers such as paramedics and physician's assistants by their level of education and role. HCAs '...must...have the appropriate skills and knowledge to undertake activities, and be working within policy and the direction and delegation of a registered nurse' (Nursing Council of New Zealand, 2011, p. 2). HCAs are employed under a range of titles (including caregivers, health care workers, health assistants, kaimahi hauora, hospital aides, and health care assistants) and in a range of settings. For the purposes of this document the term HCA is used. There has been growing recognition both within Aotearoa New Zealand and internationally of the role HCAs play in the provision of health care as well as growing concern regarding the level of education and knowledge HCAs bring to direct care roles. A joint health professions statement issued by the World Health Professionals Alliance comprising ICN, the International Hospital Federation, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association indicates that task shifting and adding new cadres of worker results in fragmented and inefficient health services and that '...whatever the strategy selected, task-shifting should not replace the development of sustainable, fully functioning health care systems. It is not the answer to ensuring comprehensive care, including secondary care, is accessible to all' (ICN, 2010a, p. 14). In New Zealand, HCAs are unregulated under the HPCA Act 2003 although they are expected to work within other legislative requirements such as the Code of Health & Disability Services Consumers Rights (1996) and the Health and Disability Services Standards (2008) (Weston, 2010).

Many HCAs working in the older adult care sector have undertaken some training but this varies across health care providers (Walker, 2009a). Work is underway in some acute care settings to provide in house training for HCAs (for example the Waikato DHB), but again, this varies across providers and many HCAs provide direct care to patients with little or no training (Walker, 2009a). While registered nurses direct and delegate the work of HCAs, and enrolled nurses may co-ordinate the work of HCAs, considerable risks exist where there are unclear standards of practice of individual HCAs. The Nursing Council of New Zealand, the International Council of Nurses, and the Royal College of Nurses (UK) acknowledge the existence of such risks and have produced guidelines to assist registered and enrolled nurses in determining when, how and what delegation of tasks should occur (Nursing Council of New Zealand, 2011; International Council of Nurses, 2008b; Hopkins, Hughes & Vaughan, 2008). The NZNO have published a position statement that supports standardised, appropriately funded and nationally accessible education for unregulated health care workers (NZNO, 2010c). While HCAs make a valuable contribution to patient care and must be appropriately supported to achieve this safely and within appropriate parameters, registered and enrolled nurses and nurse practitioners should not be held accountable for the practice of HCAs in organisations that do not meet the standards outlined in the Indicators for Safe Aged-care and Dementia-care for Consumers document (Standards New Zealand, 2005). Enrolled nurses who are

regulated under the HPCA Act 2003 to ensure public safety should be the health professionals of choice over HCAs.

Exploring images of the future

The legislative and regulatory frameworks for nursing practice have a significant impact on nurse's ability to provide effective nursing care and achieve improved health outcomes for people. The key issues outlined above include:

- Small but increasing numbers of nurses being investigated following complaints and concerns about practice.
- Legislative, contractual and other barriers to nurse practitioner practice.
- The changing scope of registered and enrolled nursing practice.
- The interface between regulated and unregulated workforces, how it is negotiated and issues of safety.

This next section explores how some organisations propose addressing these issues with a view to improving standards of practice and patient safety.

The HPCA Act and increasing investigations of nurses

As the Health and Disability Commission has worked toward increasing people's understanding surrounding their right to question the quality of the care they or their family member have received and are developing a culture of learning from the complaints process amongst health service providers, a 5% increase in complaints to the Commission was noted in 2009 (Health and Disability Commissioner, 2009a). A brief review of complaints made to the Health and Disability Commission in 2009 found that the majority of complaints against nurses appear to be associated with standards of care in rest homes (http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2009 28 June 2010). In response to this, the Commission intends to work closely with registration authorities to develop competencies that are consistent with the Health & Disability Services Code of Consumers Rights (1996) and advise workforce advisory committees to help overcome the workforce shortages and inappropriate skill mixes that impact on safety and standards of care (Health and Disability Commission, 2009b). This last point is of significance and it is important to consider the steps that are being taken nationally to address standards of care, skill mix and patient safety issues – particularly in the aged care sector. As noted above, registered and enrolled nurses and nurse practitioners for example, should not be held accountable for the practice of HCAs where organisations do not meet the standards outlined in the Indicators for Safe Aged-care and Dementia-care for Consumers document (Standards New Zealand, 2005). Registered and enrolled nurses and nurse practitioners must ensure they report all instances of unsafe staffing or poor skill mix to their employer.

Health Workforce New Zealand (HWNZ) is one entity charged with addressing health workforce issues. HWNZ was established in late 2009 to provide national leadership around developing Aotearoa New Zealand's health and disability workforce with a particular focus on training, recruitment, retention and addressing workforce shortages (HWNZ, 2009). The terms of reference for HWNZ indicate that a priority will be developing a '…simpler, more unified and responsive approach to workforce issues that is driven by the future needs of the sector and which enables changing roles and practices to deliver improved models of care and service delivery' (http://www.healthworkforce.govt.nz/about-health-workforce-nz/terms-of-reference Accessed 28 June 2010). Although workforce shortages are implicated in patient safety and standards of care issues, this is only one part of a very complex equation. Along with ensuring sufficient numbers of health care workers comes the need to ensure these people are appropriately trained and regulated, that their work places are safe and supportive, that they have access to appropriate on-the-job training as well as wider study and research opportunities, and that they have a leadership voice in developing new models of care and in setting the future direction of the health care system. These are sector wide issues and it is not immediately clear how HWNZ will address these issues. Among the immediate goals of HWNZ however are the following areas of focus:

- identifying and funding innovative models of care and service delivery;
- establishing an intelligence unit to ensure future needs are based on sound evidence;
- supporting workforce initiatives targeted at reducing surgical waiting lists;
- developing initiatives to support the government's better, sooner, more convenient primary care priorities and;
- developing recruitment and retention strategies focused on the medical workforce

(HWNZ, 2009).

Although HWNZ has a number of projects that focus on nursing, it has been noted that HWNZ priorities are not immediately focused on nursing (Ministry of Health, 2010a). Nurses are essential to the health care sector and must be consulted consistently and broadly in the same manner that the various providers of medical care and allied health care are. Consistent and positive relationships between HWNZ and nursing groups will be key to ensuring nursing is consulted appropriately on workforce issues and that future population health needs can be met.

One of the concerns HWNZ has noted as a barrier to addressing nursing workforce needs, is an *apparent* fragmentation of opinion within nursing circles. While it is difficult for any governmental agency to be clear on who to consult with in regard to developing new and innovative models of care and service delivery, nursing in Aotearoa New Zealand has clear consultation pathways to a wide variety of nurses throughout the country through the National Nursing Consortium[1]. Aotearoa New Zealand nurses number over 45,000 and it is unrealistic to expect that 45,000 people will have the same opinion. The nursing profession is actively questioning, seeking, and exploring issues associated with health and health care systems and is receptive to new ideas. All ideas should be

[1] The nine groups comprising the National Nursing Consortium are NZNO, the College of Nurses Aotearoa Inc., the New Zealand College of Mental Health Nurses, Te Kaunihera o Ngā Neehi Māori o Aotearoa, the Nursing Council of New Zealand, Nurse Educators in the Tertiary Sector (NETS), the Council of Deans, Nurse Executives of New Zealand (NENZ), and the Directors of Nursing (DONS).

thoroughly tested, subjected to scrutiny and open for consultation – on any given matter. If HWNZ seeks an opinion on workforce skill mix in general practice for example, then they consult with the Royal College of General Practitioners, not the Royal College of Surgeons. In a similar way, HWNZ may choose to consult with the NZNO College of Primary Health Care Nurses but not with the Perioperative Nurses College (both accessed through NZNO). HWNZ and other agencies need to understand and work with existing consultation pathways in order to be able gauge nursing opinion. What is important for agencies to know and understand is that the fundamental goal of all nursing care is to improve health outcomes and that nurses are specifically educated to use nursing skills to achieve this. There is significant opportunity for NZNO Colleges and Sections to be more strategically aligned in the manner that the College of Primary Health Care nurses has been in order to provide consistent viewpoints representative of a larger group.

Legislative, contractual and other barriers to Nurse Practitioner practice

Nurse practitioners (NPs) provide effective and appropriate care to a wide range of people in Aotearoa New Zealand. Some initiatives have been put in place to address the existing barriers to developing Nurse Practitioner practice. The NP Facilitation programme established by DHBNZ has seen the provision of funding for innovative models of NP practice, promotion of the NP role in DHBs, and the establishment of a NP mentor programme. The Nurse Practitioner Advisory Committee (NPAC-NZ) is currently developing a NP Registrar training project that will see nurses seeking to become NPs being employed by DHBs specifically to train and be mentored into NP positions. A number of nursing groups including NZNO and the College of Nurses Aotearoa have made repeated submissions to the Ministry of Health as they seek to address the 55 pieces of legislation that have been identified as barriers to NP practice. Of most significance however, is the potential role for NPs in the Aotearoa New Zealand health workforce and where organisations see NPs can provide the most benefit to improving health outcomes.

While HWNZ does not specifically articulate how they see NPs contributing to future health outcomes, the Ministry of Health, Nursing Council of New Zealand, District Health Boards NZ, and the Nurse Practitioner Advisory Committee of New Zealand jointly published a document in 2009 that does (Ministry of Health, Nursing Council of New Zealand, DHBNZ, NPAC-NZ, 2009). The document clearly outlines the role and potential contribution of NPs to the health of the Aotearoa New Zealand population. For example, with the increasing focus on the management of lifelong conditions, NPs are in a key position to take up leadership roles both across the primary and secondary interface and in the primary health care sector managing the care of people with long-term conditions. NPs can lead groups of primary health care nurses to meet the changing needs of the Aotearoa New Zealand population while working collaboratively with GPs to deal with people who present with acute exacerbations and complex needs (Ministry of Health, Nursing Council of New Zealand, DHBNZ, NPAC-NZ, 2009). NPs and primary health care nurses are also specifically educated to recognise the human dimension in health and respond to this – an area the World Health Organisation has identified as key to improving health outcomes (WHO, 2008). Future investment in NP practice should be to increase significantly the numbers of NPs working in primary, secondary and tertiary health care settings as a means to improve health outcomes (Ministry of Health, Nursing Council of New Zealand, DHBNZ, NPAC-NZ, 2009).

The changing scope of registered nursing practice

The changing health care arena and the demand for new models of service delivery open up significant opportunities for registered nurses to enhance their contribution to improving health outcomes. The new scope of registered nursing practice recognises the increasing need for nurses to be adaptable to new and arising demands from people and agencies to meet health needs. The need to reassure the public that expanded nursing practice roles such as colposcopy or diabetes nurse specialist roles are safe is important. The expansion of nurse prescribing to include diabetes nurse specialists is a great start to increasing the flexibility of the nursing workforce to respond to health need but a disease based approach to nurse prescribing is fragmented and unlikely to deliver full potential. An enabling RN scope of practice sitting alongside a clear credentialing process and professionally recognised specialty standards will assure the public of safety. The development of competencies for advanced practice and clinical specialist nurses is important to support and complement the ultimate role of the NP (MacGeorge, 2011).

District Health Boards New Zealand (DHBNZ) has been doing significant work over the past 5 years to examine the current nursing workforce and consider future models for the nursing profession. DHBNZ believes nursing will continue to be a key workforce in future health and disability services in Aotearoa New Zealand and it will be the generalist nature of nursing practice and the ability to deploy nurses across many settings that will be nursing's key strengths (Nursing and Midwifery Workforce Strategy Group, 2006). DHBNZ also sees a future where there will be a need for changing skills sets and structures of employment for nurses to meet the changing needs of the Aotearoa New Zealand population. Nurses will work in increasingly autonomous roles and have the ability to assess and respond to community needs with growing numbers of nurses working in specialist roles (Nursing and Midwifery Workforce Strategy Group, 2006). Specific competencies proposed by DHBNZ include:

- Expanded assessment skills
- Working with new technologies
- Competencies in population health and community development
- Cultural competency
- Relationship management and leadership
- Interdisciplinary teamwork and practice

(Nursing and Midwifery Workforce Strategy Group, 2006).

NEt-P, entry to mental health and addictions nursing, and PDRP programmes have provided an excellent basis from which to build registered nurse workforce capacity. DHBNZ has expressed concern regarding a lack of co-ordination of post-graduate education and suggest the development of centres of excellence for specific post-graduate education to build on the NEt-P and PDRP structures (Nursing and Midwifery Workforce Strategy Group, 2006). Provisional registration has also been proposed as a possible approach to ensuring initial competence of registered nurses (Carryer, 2009). Carryer proposes that provisional registration would be awarded on completion of the degree then followed by full registration conferred after satisfactory completion of the NEt-P programme (first year of practice) and achievement of level 2 on the PDRP program. All nurses would be required to complete the provisional year. There is also a need to link post-graduate and

undergraduate education with the new and enabling scope of registered nursing practice. A clear framework for transition through undergraduate education, NEt-P, PDRP, post-graduate education and any move toward credentialing will be imperative. Such a framework will assist registered nurses seeking to expand their scope of practice and meet required competencies – particularly those seeking clinical nurse specialist status. The Nursing Council of New Zealand has provided clear guidance on decision-making frameworks. Clarity around the structure of the nursing profession would also be helpful, providing coherence around the varying titles and career pathways possible for registered nurses.

Preparing registered nurses for future leadership roles is also an area that has been given some thought in the literature. Huston (2008, p.905) for example, argues that nurse leaders of the future need to be prepared to meet the following competencies:

- A global perspective or mindset regarding health care and professional nursing issues.
- Technology skills which facilitate mobility and portability.
- Expert decision-making skills.
- The ability to create organisational cultures that permeate quality health care and patient/worker safety.
- Understanding and intervening appropriately in political processes.
- Highly developed collaborative and team building skills.
- Being able to envision and proactively adapt to a healthcare system characterised by rapid change and chaos.

Preparing registered nurses to meet these competencies requires us to consider carefully the educational frameworks that currently exist for undergraduate nursing degrees and this will be discussed later in the document.

Funding barriers to innovation in practice continue to limit registered nurse practice – particularly in primary health care where restrictive contracting arrangements limit nurses' ability to address heath need. Funding structures that are designed around specific disease states (for example smoking cessation or cardiovascular risk assessment) or on how many people are seen, limit nurses' ability to address family whānau issues and the social determinants of health in the broader context. Nurses must continue to undertake robust research that demonstrates the impact they have on people's health in order to support their arguments for more acceptable funding structures.

<u>The regulated versus unregulated health workforce and issues of safety</u>

Global health workforce shortages along with increasing workforce pressures within Aotearoa New Zealand (including demand for cost savings) have seen significant growth in the employment of an unregulated health workforce. The unregulated health workforce is anticipated to grow significantly in the coming years and according to DHBNZ will play a critical role in the sustainability of the Aotearoa New Zealand health care environment (DHBNZ Future Workforce, 2009b). Despite the significance of this workforce, no strategy exists to inform ongoing development of the unregulated workforce across Aotearoa New Zealand and there has been no discussion around how HCAs or other unregulated health care workers such as physician's assistants will contribute to the

collaborative team to improve health outcomes. In order to address this shortfall and work toward ensuring the safety of the public who are recipients of the care provided by this workforce, DHBNZ propose the development of a unified and flexible training framework and the development of a competencies model (DHBNZ Future Workforce, 2009b). While admirable goals there is little to describe how these things will be achieved in terms of implementation strategies backed by adequate funding and proper workforce planning. DHBNZ do link their proposals to the New Zealand health workforce career framework (Ministry of Health & District Health Boards New Zealand Health Workforce Group, 2007) which clearly outlines eight bands with level descriptors for the health workforce including descriptors for the unregulated workforce. The New Zealand health workforce career framework links appropriately with work completed by the International Council of Nurses on a continuum of nursing (ICN, 2008b) and NZNO (2010c) who support a health care assistant qualification at level 4 on the New Zealand Qualifications Authority Framework.

It will be vital that RNs, ENs and NPs who are accountable for the safety of people seeking nursing care and also play a key role in the direction, delegation and co-ordination of HCAs ensure that both the Ministry of Health and ICN documents play a pivotal role in providing a structure around the unregulated health care workforce. Achieving an appropriate skill mix with the right balance of registered and enrolled nurses, nurse practitioners and health care assistants is one of the largest challenges facing the health care sector (ICN, 2008b). There are a range of possible models and different settings may require different models. For example, in high acuity settings RNs and ENs could provide the bulk of nursing care while in low acuity settings, a RN or EN and HCA mix may be more appropriate. With the reinstatement of the expanded enrolled nurse scope of practice, the health care sector will have access to a high quality, regulated workforce that can provide safe and effective care to people in a range of settings, and employment of ENs by providers should be a priority. As noted above, RNs, ENs and NPs should not be held accountable for the practice of HCAs where organisations do not meet the standards outlined in the Indicators for Safe Aged-care and Dementia-care for Consumers document (Standards New Zealand, 2005).

Registered nurses and nurse practitioners may be unaware of the expanded scope of enrolled nurse practice and education must be provided to RNs and NPs to ensure ENs are appropriately utilised in the future nursing workforce.

An additional point for consideration is the international call to consider collaboration across jurisdictions in regards to regulation. While it is imperative that nursing retains the self-regulatory mandate currently in operation, by sharing best practice and information a global regulatory framework may be established to allow safer and more effective global flexibility of the nursing workforce (Morrison, 2009).

Summary of future findings

The future findings in this section have been analysed below to identify the key trends, issues and developments that will impact on nursing in relation to legislative and regulatory frameworks for practice.

Trends, issues and developments

- There is a small but growing number of complaints from people regarding the health care they have received. Nurses working in aged care are the most likely to receive complaints about their practice.
- The Health and Disability Commission intends to address the growing number of complaints by working closely with registration bodies and DHBs to develop appropriate competencies and advise workforce committees regarding the need to overcome workforce shortages.
- Workforce shortages are implicated in patient safety and standards of care issues but are only one part of a complex equation.
- The profit imperative in aged care is a significant driver to employ cheaper HCAs to provide patient care but this will not assure patient safety and such task-shifting is considered inappropriate. ENs should be the health professional of choice in aged care with support and direction from RNs.
- Health Workforce New Zealand (HWNZ) has been established to address future workforce issues but nursing is not an immediate focus.
- Consistent and positive relationships between HWNZ and nursing groups will be key to ensuring nurses are consulted appropriately on workforce issues.
- Development of NP practice is hindered by a number of legislative and practice barriers.
- Nursing groups need to continue to work toward alleviating the barriers to NP practice and encourage the development of strategies to encourage uptake of NPs by health care providers.
- Health care providers do not always see how NPs can contribute to health care, however DHBNZ, the Nursing Council, the Ministry of Health and NPAC-NZ have a clear vision for future NP practice.
- DHBNZ clearly articulates a future registered nurse workforce that sees nurses working in increasingly autonomous roles with a range of highly developed skills and competencies
- Increasing use of an unregulated health care workforce is occurring as a result of workforce pressures including shortages and cost savings.
- The unregulated health care workforce is anticipated to grow significantly.
- No strategy currently exists to inform ongoing development or management of the unregulated workforce although some work is beginning.
- Health care providers should be encouraged to utilise a regulated health care workforce where possible to alleviate risks to patient safety – in particular enrolled nurses provide a cost effective and appropriately skilled workforce without the need for organisations to provide in house training.
- Limited understanding of the scope of EN practice limits effective deployment – ENs can enrich the skill mix in aged care and other sectors in order to improve quality issues.

Analyzing trends and issues for implications – SWOT analysis

Of significant concern are the growing number of complaints against nurses in aged care. Deregulation of the aged care sector and increasingly profit-driven private ownership have seen the rise of the unregulated health care workforce in aged care and the increasing acuity/frailty of those needing residential and continuing care has impacted significantly on the ability of the limited numbers of registered and enrolled nurses to provide safe and effective care. While health workforce planning, and recruitment and retention strategies are important factors in the provision of safe and effective care, these are only a small part of a complex equation. Continuing to develop appropriate legislative and regulatory frameworks for practice is an important opportunity both to ensure patient safety and to enable nurses to provide enhanced levels of care. The following SWOT analysis identifies those areas that NZNO can utilise to continue to build an effective nursing workforce.

Strengths

- Registered and enrolled nurses and nurse practitioners are a regulated health care workforce with accountability under the HPCA Act (2003) that provides safe and effective nursing care.
- Nurse practitioners are seen by DHBNZ, the Nursing Council, the Ministry of Health and NPAC-NZ to be in a position to provide significant input into improving health outcomes in the future.
- Registered nurses are seen by DHBNZ in the future as working in highly autonomous roles with a range of highly developed skills and competencies.
- Work is already underway to provide systems and structures for appropriate pathways toward specialist registered nursing practice.
- The new enrolled nurse scope of practice provides for a safe, regulated health care workforce.

Weaknesses

- Delays in reviewing the Medicines Act and other legislation continue to impede nurse practitioner and registered nurse practice.
- No national strategy exists for training and monitoring the unregulated health care workforce.
- Limited understanding of the EN scope of practice.
- Lack of aged care workforce development.

Opportunities

- Nursing can provide input into developing a strategy for the use of an unregulated health care workforce.
- Nursing can push to enrich the skill mix by increasing the proportion of enrolled nurses within the nursing team.
- Development of specialty services to the aged care sector including NPs.
- Development of nationally standardised education framework for HCAs.
- Education re scope of EN practice.

- Nursing is in a position to develop a good working relationship with HWNZ – lobby HWNZ to make nursing workforce development a priority.
- Nursing can advocate for the development of the proposed DHBNZ competencies and skills required of nurses in the future by ensuring appropriate education strategies are developed.

Threats

- HWNZ fails to effectively incorporate nursing's position in future health workforce planning
- Uptake of enrolled nurses is slow or limited.
- Changes to legislation and other barriers to nurse practitioner practice do not occur.
- Employment of other unregulated health care workers such as physician's assistants who may take over nursing roles.
- No formal recognition of nursing leadership.

Part 3: Models of Care

The term 'models of care' has seen increasing usage over the past five years. Government rhetoric refers frequently to 'changing models of care' or 'new models of care' for example in many of the policy documents to come out of the Ministry of Health. These new models of care are destined to change the face of health care in Aotearoa New Zealand and provide a means of addressing the changing health needs of New Zealanders. But what are models of care and how are new and changing models of care likely to impact on nursing? 'Models of care' is a multifaceted concept with no one definition. However, Queensland Health (2000) describes 'models of care' as simply a term to describe the way in which health services are delivered. Examples of models of care in nursing include nurse-led clinics, family centred care, the 'Recovery Model', case management, and pre-admission clinics. Broader models of care across the health sector include primary health care as an over-riding approach to health care, general practice, the provision of health care in hospitals or in homes, and the provision of specialist health services in major centres. What is generally agreed in the literature is that existing models of care are unlikely to meet the changing health needs of Aotearoa New Zealand's population into the future and new approaches are needed. This section examines some of the more common models of care currently in existence in nursing and health and some of the proposed models of care. It must be acknowledged that most models of care are interdisciplinary and collaborative and when seeking literature to support this section, the examples given all draw on interdisciplinary team work to achieve improved health outcomes. Although the lead role may be a nurse, doctor or some other health professional, those models of care that overtly utilise interdisciplinary approaches appeared to be the most effective. Interdisciplinary practice improves health outcomes when the essential components of effective interdisciplinary health care including trust and mutual understanding of roles, skills and responsibilities are present (Pecukonis, Doyle, & Bliss, 2008).

Nursing models of care – orienting in time

Broad Models of Care

Nursing is an evidence-based practice discipline. The goal of nursing is to improve health outcomes. Ultimately every nursing relationship, interaction and activity is designed to achieve that goal whether it is at the bedside, in the home, in schools, in research, in policy, in management, or in collaboration with other health and social care providers. Broad models of care in nursing provide a framework for nurses to achieve these improved health outcomes. When considering broad models of care associated with nursing, it is important to consider the broader definition of nursing and the approach that nurses take to providing professional nursing care. As noted in the NZNO definition of nursing (NZNO, 2010d), nursing is an evidence-based practice discipline underpinned by nursing theory and research. Nursing's core focus is people (with or without disease), and the way in which people respond to health, wellbeing, illness, disability, the environment, health care systems, and other people. With this broader definition in mind, nurses bring an effective nursing approach to the provision of health care and utilise the relationships they develop with people to form the basis of effective nursing interventions. This approach to nursing also forms the basis for the development of nursing models of care.

The development of primary health care nursing as an all-encompassing approach to nursing care provided in the primary health care sector in Aotearoa New Zealand is one example of a broad model of care that nursing has led as a response to both international and local developments in health care need. The Expert Advisory Group on Primary Health Care Nursing (2003) provided the framework for subsequent funding of narrower models of care under the primary health care nursing umbrella (discussed below), as well as the development of education programmes in primary health care and eventual expansion of new graduate programmes into the sector.

A further example of nursing leading the development of broad models of care has been the development and adoption of the recovery model in mental health nursing. The recovery model (Barker & Buchanen-Barker, 2005), developed conjointly by mental health nurses and people who have used mental health services, has been recognised as a significant mid-range theory of nursing, and is used as a basis for interdisciplinary mental health care in Aotearoa New Zealand and around the world.

Nurse Practitioner-led care can also be considered a broad model of care. Nurse practitioners have specific skills and qualifications that enable them to work at an advanced level with individuals, families whānau and groups. Although support for the nurse practitioner model of care has been slow, nurse practitioners are now practicing in a variety of settings throughout Aotearoa New Zealand. A nurse practitioner '...combines the best of nursing with some skills of medicine' (Jones as cited in Ministry of Health, Nursing Council of New Zealand, DHBNZ, NPAC-NZ, 2009, p. 3) in order to address health needs.

Narrower models of care

The identification and enactment of broad models of care in nursing opens up opportunities for the development of more specific models of care that may be targeted at particular groups of people, at identified health need or at how nursing care is provided. Nurse-led clinics are an example of a model of care that has developed as an effective way for nurses to provide care across a range of settings. Examples of nurse-led clinics span the health care continuum from primary to secondary to tertiary settings and include pre-admission clinics, wound care clinics, youth health clinics, diabetes clinics, ophthalmology clinics, and sexual health clinics. There is a significant body of research to support the efficacy of nurse led clinics with overall satisfaction with care received at such clinics generally rated highly along with demonstrable improvements in health outcomes (Crawford & Riley, 2010; Edwall, Hellstrom, Ohrn, & Danielson, 2008; Krothe & Clendon, 2006; Flynn, 2005; Clendon, 2004/5; Miles, Penny, Power, & Mercey, 2003; Wright, Wiles, & Moher, 2001).

Rural nurses are at the forefront of developing new models of care to meet health needs. Nurse-led clinics and nurse practitioner models of care are growing in number in rural settings but other rural nurse led models are also proliferating. For example, a 'standing orders model' developed at the Westland Medical Centre in Hokitika sees nurses undertaking direct patient care under prescribed standing orders. Along with an investment in education and the provision of housing for staff members, recruitment, retention and burnout issues have been effectively addressed (O'Connor, 2009c).

A decrease in the provision of after-hours care in rural settings and attempts to decrease attendance at emergency departments has seen the development of tele-nursing or nurse-led telephone triage. This model of care addresses health need effectively in both rural and urban settings (Pedersen, 2008; Connechan & Walter, 2006; Light, Hupcey & Clarke, 2005; Keatinge & Rawlings, 2005; Kalafatelis et al., 2002). With increasing access to technology, remote forms of communication are likely to become increasingly utilised as either stand alone models of care or integrated within other models of care.

The Safe Staffing/Healthy Workplaces (SSHW) Unit Governance Group (2009) report significant changes in the models of care utilized in ward based environments over the past 5 years. The impetus for the changes appears to be associated with a desire to improve team functioning and collaboration and to address short staffing issues (SSHW Unit Governance Group, 2009). Many of the models have focused on the integration of unregulated health care workers into care teams. The models being implemented are relatively new and there has been little evaluation either internationally or in Aotearoa New Zealand of their efficacy in improving either patient outcomes or nursing outcomes (SSHW Unit Governance Group, 2009).

Nursing models of care – images of the future

One of the most exciting ways in which nursing can improve health outcomes and health and social equity for people is to develop and fund new and innovative models of care which fully utilize nursing's potential within the health care team – many of these approaches will utilise the diverse skills of the inter-disciplinary team. Nursing's focus on the human response to health experiences and the importance of the relationship between nurse and person/people to improving health outcomes has been demonstrated time and again to be cost-effective, appropriate, effective and acceptable to people (Oftedal, Karlsen, & Bru, 2010; White & Vinet, 2010; Sadala et al., 2010; Clendon & Dignam, 2010; Carrucan-Wood, 2009; Yarwood, 2008; Krothe & Clendon, 2006). Nurses are among the leaders in the scholarship of people-centred approaches to health care and others involved in the provision of health care are seeking nursing's input into designing health services, designing and undertaking effective research, and developing policy that utilises person-centred approaches to addressing health need. What is clearly missing from current political rhetoric in Aotearoa New Zealand around models of care is the presence of any emphasis on the growing importance of humanistic models of care in improving health outcomes. While internationally it is clear that models of care that emphasise the relationships between health professional and the person seeking care improve health outcomes (Cassatly, 2010; Conboy et al., 2009; King, 2009), there is still little in the Aotearoa New Zealand based literature that either examines or proposes the use of people-centred models of care.

The major exception to this is the new Whānau Ora approach to health and well being. Whānau Ora is a future focused approach to whānau well being that fosters wellness, health and resilience, and incorporates an inclusive approach to providing services and opportunities for families across Aotearoa New Zealand (Taskforce on Whānau-Centred Initiatives, 2010). The seven principles underpinning Whānau Ora are:

- ngā kaupapa tuku iho (this is the way in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day to day lives);
- whānau opportunity
- best whānau outcomes;
- coherent service delivery;
- whānau integrity;
- effective resourcing;
- competent and innovative provision.

(Taskforce on Whānau-Centred Initiatives, 2010)

The Whānau Ora framework can be interpreted in many different ways by different people but the fundamental premise is to assist whānau to identify and build on their existing strengths to foster wellness, health and resilience. The intention is that health and social service providers work collaboratively with each other and with whānau to achieve improved health and social outcomes.

The importance of Whānau Ora to nursing is in the synergies that exist between the principles of Whānau Ora and the principles of nursing – the emphasis on the people-centred, relational focus on the experiences that people have with their environment, their health, health care systems, illness, and the people around them and how these can be addressed in order to improve health outcomes. There is much to be gained for nurses and for Whānau Ora providers in understanding the synergies that exist between the two and collaborating closely in both developing best practice in Whānau Ora and evaluating future outcomes.

The further development of nurse-led services based around a philosophy of nursing care holds significant potential for future health care provision. For example, the development of a model of step-down facilities has been suggested. This model of care sees patients discharged following an acute episode of illness or injury to a step-down facility run by registered nurses. These nurse-led intermediary care facilities would have a focus on assessment, monitoring and patient education. Anecdotal reports from Christchurch following the February 2011 earthquake suggest that this model has been exceptionally effective in ensuring people receive expert nursing care in challenging circumstances and it is likely the model will continue (Christchurch focus group, personal communication, May 18 2011).

A further intermediary care model is where nurses with advanced practice skills support effective transition between the home and hospital and back again, ensuring optimised case management across the care continuum. The District Nurses Section of NZNO (now part of the NZ College of Primary Health Care Nurses NZNO) suggest that the intermediary position occupied by district nurses on the health continuum enables district nurses to support the transitional health needs of people as they move between hospital and the home (NZNO, 2008a). While models such as hospital-in-the-home will become increasingly utilised in the future, Duke and Street (2005) warn that shifting services to primary health care and home settings should not be undertaken simply to reduce costs. They note that such services will not be appropriate for all people and nurses may struggle to provide the holistic care they strive for. These issues must be carefully considered as existing models of care are enhanced and new models are developed.

Nurse practitioner models of care will also increase as knowledge around the benefits of the NP model increase. NPs will continue to work collaboratively with medical practitioners and registered nurses to improve accessibility and continuity of care across the primary, secondary and tertiary sectors. This will enhance the integration of care across the sectors with NPs working closely with RNs to provide case management for people presenting with complex issues.

International perspectives on future models of care in nursing suggest that nurses will be skilled and respected frontline practitioners, vital and valued partners in the multidisciplinary and inter-disciplinary team, and confident and effective leaders and champions of care quality with a powerful voice at all levels of the health care system (Prime Ministers Commission on the Future of Nursing and Midwifery in England, 2010; Canadian Nurses Association, 2009). Nursing models of care, while still retaining a focus on illness care, will increasingly shift toward an emphasis on health promotion and disease prevention and the collaborative development of care pathways based on maintaining health and wellness (Prime Ministers Commission on the Future of Nursing and Midwifery in England, 2010; Canadian Nurses Association, 2009). Traditional barriers between the hospital and the home and health and social care will vanish and communities will be served by integrated local networks of services driven by community engagement. Electronic media and communications will support these networks providing multiple entry points into the system for practitioners and community members – gate-keeping will become a relic of the past (Prime Ministers Commission on the Future of Nursing and Midwifery in England, 2010). An example of a future model of care from the Prime Ministers Commission on the Future of Nursing and Midwifery in England (2010) provides an exemplar of how future care may be provided by nurses:

Mary's care in 2020

Mary is an 87-year-old widow who lives in a self-contained bungalow in a retirement complex. She has severe osteoarthritis, Type II diabetes controlled by tablets, and Grade III heart failure. She has decided to hold the budget for her care, which gives her more control and choices. She has chosen to use a local care provider, a social enterprise joint venture by the neighbourhood Age Concern branch and the NHS community nursing service. Mary accesses remote care via her digital television system. Every day she enters information about her pain levels, blood sugar and weight. The nurses who monitor the system then contact her or her care worker to advise on any changes needed in her care. These nurses have rapid and immediate access to advice from specialist nurses and other professionals. As a result of using this system, Mary has not needed a hospital admission for over two years. The integrated team visits the retirement complex twice a week so that residents have quick and easy access to comprehensive care, and receive education on health and wellbeing and advice on income and benefits. Every few months Mary visits her sister, who lives over 200 miles away. The team helps her arrange this and provides her with a mobile monitoring device so they can continue to care for her wherever she is, funded by her personal budget.
(Prime Ministers Commission on the Future of Nursing and Midwifery in England, 2010, p.31).

An Aotearoa New Zealand model may include the above and also look like this:

Whānau ora services for William and his whānau in 2020

William is 9 years old and lives with his whānau: his whaea Aroha, his matua Bill, his nani, Elsa and his two younger brothers in Tamaki Makaurau Auckland. Whāea Mere, a nurse at the local whānau ora health centre has known William since he was a baby. She is part of a team who provide a "one

stop shop" for health and social services. William's asthma is now well controlled thanks to Whāea Mere and the new housing standards that have seen the World Health Organisation's minimum home heating standard of 18˚ Celsius become a mandatory standard in all Aotearoa New Zealand homes, achieved through a fully funded government programme. William's father Bill was injured in a workplace accident some 15 years ago and works part-time as his disability allows. He also has diabetes. William's nani Elsa has recently had bilateral hip replacements using new bioengineering technology to facilitate healing and is recovering well. William's mother Aroha is the primary income earner for the whānau and enjoys her job as a registered nurse working in a local step down unit where she has responsibility for managing the care of people discharged from a large tertiary hospital prior to their return home. Fully funded child care and healthy workplace policies that provide flexible working hours allow Aroha and Bill to spend quality time with their whānau. Whāea Mere supports the entire whānau to manage William, Bill's and Elsa's health issues, co-ordinating the varying health and social care practitioners involved with the whānau. Mere has supported Aroha to quit smoking. The health centre nurse practitioner Kiri works with whāea Mere to help Bill manage his diabetes and William's asthma where required. Neither Bill nor William have required secondary intervention for their health conditions for some years due to the effective Whānau Ora team co-ordinated by Mere. The team includes a nurse practitioner, general practitioner, occupational therapist and social services advocate who all work together managing the family's care over this time.

Health sector models of care – orienting in time

Broad models of care

Broader models of care in the wider health sector include examples such as primary health care, secondary services provided in hospitals, and specialist services provided in tertiary or main centres. The National Health Board (2010) for example, describes the current model of care in the primary care sector in Aotearoa New Zealand as one where consumers are exposed to a number of different service models. These range from the solo general practitioner through to the 10 partner practice in a multi-service purpose-built location that co-locates with pharmacy, radiology, laboratory, physiotherapy, and midwifery, and everything in between. The National Health Board does not articulate the nursing contribution to primary health care or primary care models of care in their example. The National Health Board's broader examination of models of care across the health care sector can be seen in Figure 2.

Home settings		Primary Care		Secondary Hospital		Specialist Tertiary Hospital
	Crossover services		Crossover services		Crossover services	
Supported housing. Aged residential care	Services accessed from home and work. Health protection (e.g. clean water). Health Promotion (e.g. social marketing). District Nursing. Home-based support	Community based population health and health promotion services General practice services	Lower intensity hospitals and ambulatory care centres (e.g. smaller hospitals providing GP beds and/or aged residential care)	Typical provincial 'base' or district hospital providing core secondary services	Infrequent model where hospitals provide core secondary services and a small number of specialist services	Hospitals providing highly specialized services on a regional or national basis

Figure 2. Current models of care in Aotearoa New Zealand (adapted from National Health Board, 2010)

Aotearoa New Zealand has a history of funding innovations some of which have been successful but which have not been promulgated nationally. Those models that demonstrate improved health outcomes for people that are appropriate, equitable, accessible and affordable must be made available nationally and the onus is on funders and providers to utilise the best available evidence to support implementation of models of care.

Narrower models of care

Narrower models of care that can be seen in the health sector include examples such as Care Plus (a model of care that provides targeted funding for people experiencing two or more long term conditions or other specific criteria), virtual first specialist assessments (assessment and development of a written plan of care by a Medical or Nurse Practitioner following referral by a GP or NP to specialist services), and rural after hours models of care.

Care plus is a primary health care initiative aimed at improving long term conditions management, reducing inequalities in health, improving primary health care teamwork and reducing the cost of services to high-need primary health care users (Ministry of Health, 2004). People who meet specific eligibility criteria (people experiencing two or more long term conditions, a person with a terminal illness, a person who has had two acute medical or mental health admissions to hospital in the past year, a person who has had six or more visits to primary health care in the past year, and/or someone who is on active review for elective surgery) have low or reduced cost access to a nurse and/or doctor, receive a comprehensive assessment and care plan, receive advice on improving health outcomes through better self-management, and receive support to meet their health goals (Ministry of Health, 2004). Evaluation of care plus demonstrated that people on the care plus programme believed their care had improved and that it was more structured. People also appreciated dedicated time to talk about their condition with a health professional (CBG Health Research Limited, 2006). However, evaluation also showed that admissions to hospital for those on a care plus programme had increased 40% in the following year although this may have been due to improved care and early intervention as a result of the programme (CBG Health Research Limited, 2006). More recent evaluation of the programme is required as is the need to address the variability

in the way the program is provided. In some areas nurses take on the bulk of care plus work, in others it is doctors. It is unclear which approach is most effective.

Virtual first specialist assessments are a means of improving access to specialist advice and earlier commencement of specialist care for those referred to secondary services for treatment. On referral from a GP or NP to secondary services, a virtual assessment of the referral and any associated tests and/or diagnostic interventions (e.g. X-Rays) is undertaken by a specialist medical practitioner or nurse practitioner. Following virtual assessment, a written plan of care is developed for the patient and the plan and any other advice is given to the referring GP or NP to implement. The virtual specialist assessment reduces travel costs and time spent attending outpatient appointments, reduces waiting times from referral to diagnosis, assessment or treatment, and improves communication between primary and secondary care (Ministry of Health, 2009c).

Rural after hours care has been an area of concern for a number of years as numbers of general practitioners in rural areas fall. Among the various interventions to address this issue, a collaborative model of after-hours care was developed in a rural east coast community. First contact for people seeking care is with a community nursing team operating from the local health centre. This is complemented by on-call advice from GPs and GP clinics twice daily at weekends. The model has been shown to be sustainable and reduce the burden on rural GPs (Scott-Jones, Lawrenson & Maxwell, 2008). Many rural nurses and general practitioners complete primary response in medical emergency (PRIME) training in order to support their ability to be first responders in rural communities. PRIME training was established as a jointly funded venture by St Johns and ACC to provide both the coordinated response and appropriate management of emergencies in rural locations.

The models of care outlined here provide a snapshot of the broader health care sector in Aotearoa New Zealand as well as a number of examples of innovative models of care in the narrower sense. There are a wide range of examples that have not been included but those that have demonstrate that innovative models have been and are continuing to be developed across the health sector to meet health needs. The next section examines some of the proposed models of care that government agencies intend should develop.

Health Sector models of care – exploring images of the future

In line with the models of care proposed above by the Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010), Aotearoa New Zealand's proposed future health system looks very similar, exemplifying the reliance Aotearoa New Zealand has on international models of care – possibly at the risk of failing to develop Aotearoa New Zealand based models of care that may be significantly more appropriate and effective in the Aotearoa New Zealand context. The National Health Board (2010) identifies four trends in models of care. The first of these is an increase in prevention, self-management and home-based services. The emphasis on technology and more efficient communication outlined in the exemplar above are also identified by the National Health Board as key factors in the Aotearoa New Zealand health care sector. Greater health professional mobility is a part of this.

The second trend identified by the National Health Board is the development of integrated family health centres, partnerships and teams. Integrated family health centres are one of the key policy platforms of the current government and are health centres that would provide a full range of services in the community, including some services (like outpatient clinics) currently provided in hospitals; specialist assessments; minor surgery; walk-in access; chronic care management; increased nursing and allied health services; as well as selected social services (New Zealand Medical Association, 2010). The integrated family health centre is similar to the 'medical home' (USA), 'polyclinic' (UK) 'superclinic' (Australia) and 'family medical clinics' (Canada) internationally. The intention of these clinics is to improve service integration and increase access to specialist, allied and community services (National Health Board, 2010). The devolution of a range of secondary care services such as minor elective surgery and endoscopy to integrated family health centres is also a driver behind the model. Of significant concern is a lack of information on the cost of this model of care, a lack of broader consultation around the acceptance of the approach, and a lack of clarity around how such an approach will be evaluated.

The third trend identified by the National Health Board is the development of hospital clusters and regional services. Smaller secondary hospitals will form partnerships with neighbours in order to be able to provide a more comprehensive and cost effective set of services with a further emphasis on the devolution of services to community settings. The final trend noted by the National Health Board is the consolidation of specialist diagnostics, care and intervention into regional and national services – possibly from only one location with the use of technology and efficient means of transportation to shift patients around centres. However attempts in 2010 to shift neurological services from Dunedin to Christchurch saw vocal community protests as people from Otago and Southland saw access to services potentially decreased as a result of consolidation of specialist services. Any consolidation of services must be tempered in light of community need. The National Health Board's overall vision for future models of care sees increased integration of services with people experiencing health care as a single system rather than a 'setting' (National Health Board, 2010).

One of the key strategies intended to assist with the development and implementation of new models of care is the development of clinical leadership across the health sector (Ministerial Review Group, 2009). Clinical leadership is defined as leadership by clinicians of clinicians - clinician meaning any health professional involved in actual clinical care of patients – this includes nurses, allied health professionals and doctors (Wright, Barnett & Hendry, 2001). It is well documented that good clinical leadership improves patient safety and quality across a range of sectors (Ministerial Review Group, 2009; Murphy, Quillinan & Carolan, 2009; Wright, Barnett & Hendry, 2001) but that existing health infrastructure in Aotearoa New Zealand has not been conducive to developing effective clinical leadership. Health Workforce New Zealand intends to make the development of clinical leadership a priority (Trim, 2010b).

Increased blurring between the roles and responsibilities of differing health professionals and substitution of regulated health care professionals with non-regulated workers e.g. physician's assistants, mental health support workers, requires substantial consideration in the development of new models of care. As noted earlier, a joint health professions statement issued by the World Health Professionals Alliance comprising ICN, the International Hospital Federation, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental

Federation and the World Medical Association indicates that task shifting and adding new cadres of worker results in fragmented and inefficient health services and that '...whatever the strategy selected, task-shifting should not replace the development of sustainable, fully functioning health care systems. It is not the answer to ensuring comprehensive care, including secondary care, is accessible to all' (ICN, 2010a, p. 14).

Internationally, significant calls have been made for a re-orientation of health care from a focus on acute care to a focus on primary health care. As outlined earlier in the document, there is a growing pool of evidence to support approaches that focus on cross-sectoral collaboration to address the social determinants of health as the most effective means of meeting health need. New models of care need to ensure there is clear articulation of the pathways from the provision of care to identified health outcomes.

Trends, issues and developments

The future findings in this section have been analysed below to identify the key trends, issues and developments that will impact on nursing in relation to models of care.

- Nursing's focus on people's health experiences and the importance of the relationship between nurse and person on health outcomes will be one of the most effective approaches to future models of care in the health sector.
- The synergies between Whānau Ora and nursing will provide opportunities for future collaborative work in addressing health need.
- Expanded nurse-led services will be an appropriate means of providing cost-effective and acceptable health care.
- Nurse practitioner models of care will continue to develop.
- New inpatient and residential models of care implemented to address staffing issues and the integration of unregulated health care workers are largely unevaluated.
- Integration of a broader expanded scope of EN practice and HCA contribution to health care is unevaluated.
- International literature supports the development of nurse leadership in developing new models of care.
- Future models of care are likely to emphasise prevention, self-management and home-based care.
- Telephone consultations and triage, IT, and virtual consultations and communication between patients and health professionals will become commonplace.
- Integrated family health centres have been proposed as a new model of care but a lack of information on cost, poor consultation around acceptability of the approach and a lack of clarity around evaluation are significant concerns.
- Amalgamation and partnerships will likely occur among smaller hospitals in an attempt to provide more cost effective and comprehensive services, and specialist services are likely to become more centralised with increasing use of technology and transportation.

- International literature supports a primary health care approach and a focus on addressing the social determinants of health as the most effective means of addressing health need.
- Pathways from service provision to health outcomes must be clearly identified in any model of care.
- Clinical leadership is intended to improve quality of care and lead the development of new models of care.
- Blurring of boundaries between regulated and unregulated health care professionals requires substantial consideration in the development of new models of care.

Analyzing trends and issues for implications – SWOT analysis

Developing new models of care to meet changing health needs and demands provide opportunities for nurses to showcase the impact that nursing care has on health outcomes. Robust evaluation of new models of care will be imperative. The following SWOT analysis identifies those areas that NZNO can utilise to support the development of new models of care and ensure they are involved in the development of sector wide models of care.

Strengths

- Nursing's relational focus on people will become increasingly important in achieving improved health outcomes.
- International literature supports nurses future role in the development of new and emerging models of care
- New models of care such as Whānau Ora provide opportunities to work collaboratively with others to improve health outcomes.
- Nurse-led services are cost-effective, appropriate, acceptable and improve health outcomes.

Weaknesses

- Continuing lack of consultation around the development of broader models of care in the health sector marginalises the input of nurses and the public.
- A lack of robust, evaluative, Aotearoa New Zealand based research on nursing's impact on health outcomes.
- Poorly defined pathways from models of care to improved health outcomes – there is no blueprint for how new and emerging models of care will be developed nor how they will improve health outcomes.
- Disorganized adoption of models of care that have not been evaluated.
- Health practitioner protectionism around boundaries of practice and income streams.

Opportunities

- Nurses can use international literature to demonstrate the impact of a nursing approach on health outcomes.
- A strong case can be made for funding for future research into nursing approaches to health care.
- Nursing's person-centred and relational approach to the provision of care can provide the basis for developing strong collaborative relationships with other health care professionals to improve models of care.

- Nursing's person-centred and relational approach to the provision of care can provide the basis for developing strong collaborative relationships with other health care professionals to undertake robust research into future models of care.
- Nurses need to be at the forefront of clinical leadership opportunities.

Threats

- Lack of understanding by other health professionals, funders and policy makers on the effectiveness of the nursing approach in improving health outcomes.
- Lack of consultation in developing models of care.
- Poor development of collaborative relationships due to poor understanding of the role of nurses in the provision of health care.
- Lack of nursing involvement in clinical leadership opportunities.

Part 4: Education

Changing demands on the profession of nursing has seen registered nurse education move from an apprenticeship style of education, to a diploma programme, to a degree programme. Enrolled nurses complete an 18 month diploma programme. Nursing education in Aotearoa New Zealand is now at another cross road. New challenges exist to ensure that nursing education programmes meet the changing demands of the health system, and the people it serves. Significant consideration needs to be given to the appropriateness and efficacy of the existing provision of nursing education in this country given these new and evolving challenges. It is timely to consider the position of NZNO on nursing education and continue to move forward in order to improve the nation's health outcomes. This section outlines current nursing education provision in Aotearoa New Zealand and explores a range of existing challenges and some future options for addressing these.

Orienting in time

Background

Nurses in early Aotearoa New Zealand were largely uneducated and untrained – nursing was a role that was often intertwined with homemaking and the care of children (Sargison, 2001). By the late 19th century, however, nursing as an occupation was becoming increasingly popular and hospital-trained nurses began to take over from independent and untrained nurses (Gage & Hornblow, 2007). Political and professional pressure throughout the latter stages of the 19th century saw nurses (and a number of other health professionals) become subordinate to doctors for a variety of reasons. Although the 1901 *Nurses Registration Act* resulted in improved standards of training and practice as well as rapid growth in the number of trained nurses, nursing remained firmly under the control of the medical profession well into the 1960s (Gage & Hornblow, 2007). Nurses were not geared to counter medical dominance, reflecting the place of women in NZ society. Nursing was firmly established as a 'women's profession' – men had not been permitted to register as nurses until an amendment to the 1925 *Nurses and Midwives Act* was passed in 1935 (Gage & Hornblow, 2007).

Education of nurses throughout this time was through an apprenticeship system in secondary hospitals – students of nursing were rapidly absorbed into a system of hierarchical relationships, distinct dress codes, and strict protocols in which access to skills and knowledge was controlled by those above (Gage & Hornblow, 2007). Rapid technological change and developments in medicine in the post World War II period saw an increasing need for nurses to advance their nursing knowledge base in order to keep pace with a rapidly changing environment. In the early 1970s the New Zealand Nurses Association (NZNA), the Department of Health, the Nursing Council of New Zealand, and the medical profession worked to shift nursing education from the hospital apprenticeship scheme into the tertiary education sector (Adlam, Dotchkin & Hayward, 2009). The 1971 Carpenter Report (Carpenter, 1971) had recommended shifting nursing education from hospitals to the university with second level nursing in polytechnics, however pressure from parts of

the education sector saw the government choose to place the three year programme in the polytechnic sector (Adlam, Dotchkin & Hayward, 2009). Some hospital boards were more reluctant to support the transition but by 1990 all hospital nursing schools were closed and completion of a diploma level course of study in nursing was established as the only internal means of gaining entry to the register of nurses in Aotearoa New Zealand (Nurse Educators in the Tertiary Sector [NETS], 2010).

The shift of nursing education from an apprenticeship scheme to the tertiary sector represented a fundamental shift in nursing education, philosophy and policy (Hornblow & Gage, 2007). The shift opened up the first opportunities for the integration of nursing knowledge with clinical practice – education became a vehicle through which nurses could pass on specific nursing knowledge about the impact of nursing practice on health outcomes to students, as well as the clinical aspects of nursing practice. By the late 1980s a further change in nursing education saw the development of the first pre-registration bachelor degrees in nursing (the first three began in 1992) and by the mid-1990s the last diploma courses were phased out with the bachelors degree becoming the standard qualification required to apply for entry to the register of nurses for nurses educated in Aotearoa New Zealand. Two of the first pre-registration bachelor degrees were four year degrees but were soon changed to three year degrees as the Ministry of Education would not fund a four year degree (NETS, 2010).

One of the significant factors in an undergraduate bachelor's degree becoming the standard entry qualification towards registered nursing practice was in the standardising of nursing education with other tertiary education pathways. Traditional tertiary education sees a continuum from bachelor to masters through to doctoral degrees, if pursued. Prior to the development of the undergraduate bachelor's degree, pathways for nurses wanting to pursue higher education were complex and lengthy with limited local access.

A further important factor in nursing shifting to a traditional academic structure of education has been the significant opportunities that have arisen for the development of research and other scholarly activities specific to the profession of nursing in Aotearoa New Zealand. In as much as the scholarly activities of nursing internationally inform nursing practice in Aotearoa New Zealand, Aotearoa New Zealand's unique cultural context requires the development of research and knowledge specific to Aotearoa New Zealand nursing. The development of an academic structure in nursing education has seen a steady increase in nursing research that is leading to new knowledge that specifically reflects the Aotearoa New Zealand context. While there is still more work to do, the structure is in place for the continued development of this specific nursing knowledge.

Higher education for nurses in Aotearoa New Zealand has been available in universities since the 1970s and in polytechnics since the mid 1980s through a mixture of graduate qualifications, post-registration bachelor's degrees and post graduate certificate, diploma, master's and doctoral programmes. Courses of study may be clinically or research focused. A large push in the early 2000s saw the establishment of clinical master's of nursing programmes in a number of tertiary education institutions. Anecdotally, enrolment in clinically focused courses in the past 10 years has been higher than enrolment in research focused courses (S. Neville, personal communication, November 16th, 2010). While this has had significant positive spin-offs for the development of advanced nursing practice, the nursing profession needs to remain mindful that robust nursing research is vital

to demonstrating the impact of nursing care on patient health outcomes. Health Workforce New Zealand (previously the Clinical Training Agency [CTA]) has provided some funding for post-graduate education. Historically, the bulk of this funding has gone toward courses with a focus on clinical practice. This has likely also contributed to the evolving shift from research based degrees to clinically focused degrees as the preferred option for nurses.

Bachelor of Nursing Māori programmes and the Bachelor of Nursing Pacific programme as cultural alternatives to existing nursing programmes have been developed to meet the needs of Māori and Pacific students in Aotearoa New Zealand. These programmes are designed specifically for Māori and Pacific students with a particular focus on the health needs of Māori or Pacific communities within the New Zealand context.

A staircase approach to nursing qualifications has the potential to enhance the recruitment of Māori and Pacific students into nursing (Cook, 2009). Anecdotally, it is understood that about half of all Māori and Pacific enrolled nurses eventually qualified as registered nurses (Cook, 2009). While stair-casing may be impractical, clear pathways from HCA to enrolled nursing to registered nursing will ensure improved access to education for Māori and Pacific students and others who may not immediately manage bachelor's level study.

How smoothly the new level five enrolled nurses' diploma will staircase into the bachelor's level qualification is still to be determined. The potential exists to create an appropriate process that will ensure enrolled nurses will not have to repeat education points if choosing to continue on to bachelor level education.

In conclusion, there are three scopes of nursing practice in Aotearoa New Zealand – registered nurses, enrolled nurses and nurse practitioners. To qualify as a registered nurse in Aotearoa New Zealand, a student undertakes an undergraduate degree at an approved institution – currently a university, polytechnic or wananga – prior to applying for registration. To qualify as an enrolled nurse, a student will undertake a diploma (level 5) qualification – likely to be offered only at polytechnics or wananga – prior to applying to be enrolled. To qualify as a nurse practitioner a person must already be a registered nurse and have completed a clinical master's degree prior to completing the approval process for entry to the scope of practice for nurse practitioners.

Issues in nursing education

Nursing in Aotearoa New Zealand faces a range of issues across undergraduate, post-registration and postgraduate education. Underpinning these are significant issues associated with the funding of nursing education. In this section, analysis starts by examining issues associated with funding of nursing education in general, then moves on to explore issues specific to undergraduate education, followed by post graduate education. It is worth noting that a number of the issues are common across undergraduate, post-registration and postgraduate sectors and these are elaborated on in the undergraduate section.

Funding of nursing education

Funding of nursing education - particularly at the post graduate level – continues to be a significant issue. The funding structures for nursing education are complex with funding and policy decisions coming from both the Ministry of Health and the Ministry of Education. The following points

summarise the funding sources for undergraduate, post-registration and postgraduate nursing education:

- Ministry of Education (through the Tertiary Education Commission [TEC]).
    - The majority of funding for nursing education is from this source.
    - Components of this funding of particular significance to nursing education include the Public Provider Base Grant (PPBG), and the Student Achievement Component (SAC), and Performance Based Research Funding (PBRF).
- Ministry of Health (through Health Workforce New Zealand [previously CTA])
    - Provides the bulk of funding for post graduate clinical programmes e.g. Master of Nursing programmes, NEt-P.
    - Some DHBs have made funding available through their own resources augmenting nurses' access to higher education.

The range of sources of funding for nursing education have the potential to be detrimental to the development of the profession of nursing, potentially limiting the ability of nurses to maximise their contribution to improving health outcomes for New Zealanders (Brinkman, 2010). One of the greatest concerns is the inequity in funding that exists between the medical and nursing professions. For example, HWNZ fund 100% of education for house surgeons during their probationary year but only a half share with the DHBs of the $14,400 that is put towards nurses undertaking a NEt-P consolidating year. While HWNZ has agreed to fund the equivalent number of new graduate positions in 2011 as they did in 2010, there is no guarantee that this will continue, particularly in the current economic climate where job opportunities are limited, for example, through significantly low staff turnover. The pie chart below demonstrates the inequities in post graduate health workforce training funding that currently exist:

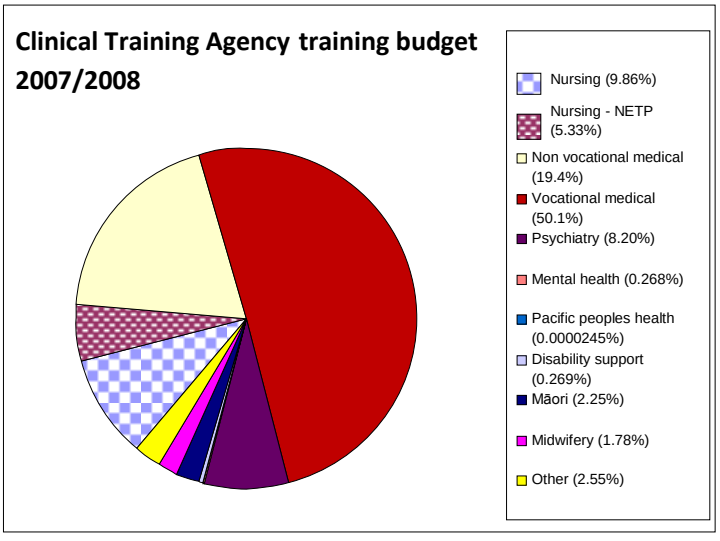

Figure 3. Clinical Training Agency training budget 2007/2008 (Brinkman, 2010)

Some disparities also exist in the funding of undergraduate education. Tertiary Education Commission funding for undergraduate nursing education is considerably lower in comparison with some other clinical practice health professional programmes (for example, medicine).

Further concerns include different priorities between DHBs and HWNZ in terms of workforce development, a lack of supportive literature regarding successful models of care delivery, and a lack of evaluative criteria surrounding the provision of nursing education funding (Brinkman, 2010).

There have been significant shifts in funding foci in recent years from a 'bums-on-seats' approach to more recently the number of people graduating with a particular qualification. This has significant implications for the connection between the quality of nursing education and the available funding. Recent focus on 'bums-on-seats' has seen the dilution of student entry criteria to some nursing programmes of study, and an ongoing struggle for nursing programmes to maintain the quality educational standards required for entry into the profession of nursing by the Nursing Council of New Zealand. With a refocusing on completion, quality education that incorporates effective pastoral support along with a standardising of entry criteria may facilitate improved educational outcomes for students of nursing.

While we know that 98% of students that sit the State examinations pass (Nursing Council of New Zealand, 2009a), actual nursing student attrition rates in Aotearoa New Zealand are more difficult to ascertain – estimates indicate that 20-25% of nursing students do not complete their studies, with up to 45% in some centres (Cook, 2009). Figures are higher for more mature students and for Māori and Pacific Island enrolments (Cook, 2009). Internationally, the figures are comparable. In the United Kingdom, up to 25% of nursing students fail to complete their studies (While, 2010) and in parts of Australia it is up to 40% (Dragon, 2009). Across all disciplines, approximately 19% of students enrolling in a bachelor's degree of any type in Aotearoa New Zealand fail to complete the qualification (Ministry of Education, 2010). While New Zealand research on reasons for student attrition from nursing programmes is limited, international research suggests that attrition rates can be attributed to a range of factors with findings indicating that male students, those with the minimum required entry criteria, those who are younger, and those who already hold a first degree are less likely to complete (Pryjmachuk, Easton, & Littlewood, 2009; Mulholland et al., 2008). It has also been found that the clinical placement experiences of students may also influence student completion (Pryjmachuk, et al., 2009). Recommendations for improving student attrition rates include increasing the level of qualification required to gain entry to the programme, improving the flexibility of programme structures, improving student support, exploring the specific educational needs of male students, younger students and those who already have a first degree, as well as examining the overall cohesion between workforce needs and those assumptions that inform nursing education (Pryjmachuk, et al., 2009; Mulholland et al., 2008). Recent research in Aotearoa New Zealand suggests that improving education and support for younger students around the emotional challenges of nursing may assist with reducing attrition (Clendon & Walker, 2011). Further New Zealand based research is desirable.

The advent of Performance Based Research Funding (PBRF) in the early 2000s has also had a significant impact on both the funding resources available to tertiary education providers and the culture of tertiary education in Aotearoa New Zealand. PBRF allocates research funds to tertiary education providers based on excellence in research. Since introduction of PBRF, there have been notable changes in the distribution of research funding in the sector, the research reputations of education providers, and a number of human resources shifts (Brinkman, Wilson-Salt, & Walker,

2008). PBRF has held two assessment rounds (2003 and 2006) and nursing has ranked at the bottom of both rounds out of 42 subject areas. Reasons for this are said to include:

- Large numbers of part-time staff – mostly women;
- Substantial numbers of staff at non-university education providers (where staff contracts usually do not reflect the time and resources required to undertake research);
- Large numbers of academics and postgraduate students whose primary degree was not a research-intensive one.

(Brinkman, Wilson-Salt, & Walker, 2008; Phibbs & Curtis, 2006).

While the PBRF component of funding for nursing education remains relatively small, it is intended to increase. The low ranking of nursing raises two significant concerns. Firstly, nursing's low rankings limit the amount of funding available for research in nursing. This is of considerable concern if nursing in Aotearoa New Zealand is to grow as an evidence-based practice discipline and be in a position to clearly demonstrate its impact on improving health outcomes. Secondly, the low ranking diminishes nursing's reputation as an evidence-based practice discipline and serves to marginalise nursing in the health and education sectors – further limiting opportunities for nursing research as well as collaborative research. While there have been a number of initiatives designed to address nursing's low PBRF ranking (including the STAR Project – a $2.7million fund to improve research capability in nursing), several fundamental issues continue to impact on nursing's research capability: a lack of time and support allocated to academic staff at non-university education providers; continued expectations on academic staff to maintain clinical competency; and a lack of understanding of the importance of undertaking nursing research matched with the ability/motivation to do it among the nursing profession. The need for strategically aimed research to improve nursing's position in the health sector cannot be underestimated.

NZNO's framework for post-registration nursing education outlines seven principles for realising nursing capability that could equally apply to undergraduate education (see figure four below). These are:

- Appropriate (based on health needs and the consequent learning needs for developing competent and confident nursing care).
- Acceptable (nursing care is culturally appropriate to the recipients of care and nurses develop political competence to enhance their advocacy skills).
- Affordable.
- Accessible (flexible delivery and adequately resourced).
- Relevant.
- Supported (workplaces provide release time for nurses to attend post-registration education).

(Brinkman, 2010)

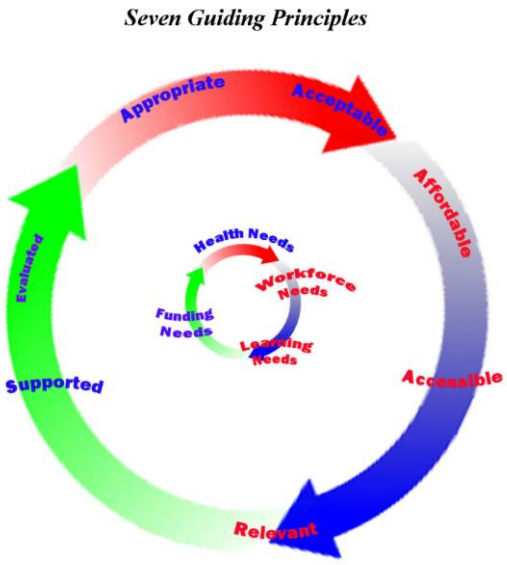

Figure 4. Seven Guiding Principles of nursing education

The seven principles provide the basis from which nursing education in New Zealand can and should develop. Addressing issues of equity in funding with other health professionals and based on individual and population health needs must be a priority for nursing into the future.

Undergraduate education

While the shift in registered nurse education from apprenticeship to polytechnic diploma to bachelor's degree has had significant positive benefits for the profession of nursing, there are also a number of limiting issues that have persisted. While many of these issues are identified verbally through discussions with advisory groups, anecdotally through discussions with those in the sector, and in the international literature, there is little in the way of Aotearoa New Zealand research exploring those issues that have been identified. Despite the lack of research, it is important that these issues are examined in light of the potential impact they may have on the education of nurses in Aotearoa New Zealand.

Issues that have been identified include those associated with the funding of nursing education (see above); issues associated with academic/teaching workforce development including an ageing teaching workforce, remuneration that has failed to keep up with the clinical sector, and the need for academics to maintain a balance between teaching, research and clinical practice; a perceived gap between theory and practice; variable relationships between District Health Boards and education providers; interprofessional/interdisciplinary education; 17 different institutions providing a Bachelor of Nursing degree on 22 different sites across a country of only 4 million people; and poor recruitment of some groups of students into education – particularly men and students of Māori and Pasifika descent. Further issues that have been identified and are discussed later in the document include: poor resourcing of smaller education programmes; significant pressure on clinical placement availability for students of nursing; and poor understanding nationally of how current nursing education provision intends to meet the future health needs of Aotearoa New Zealand.

Academic/teaching workforce

There is a significant clinical component to the education of nurses with academic staff being expected to maintain some clinical competency in order to be able to teach effectively. This factor combined with the expectation of also maintaining research activity along with everyday teaching demands means that academic staff are expected to be expert teachers, expert researchers and expert clinicians without appropriate remuneration or support to achieve the desired outcome (particularly in smaller polytechnics). While this combination of expertise may be ideal, it is very difficult to attain and without remuneration that is parallel with clinical settings, limits the number of nurses interested in taking up faculty positions. An ageing teaching workforce compounds the problem. As a result, there is a tangible dearth of succession planning in nursing education. Since the advent of PBRF, some nursing education providers have encouraged selected staff to focus on research and others on clinical expertise. Increasing numbers of joint clinical appointments are evolving although this is often dependent on funding from district health boards and/or the ability of the individual nurse to establish or drive such an appointment. (See below for models of clinical faculty.) Fundamental to moves to focus individual staff on research or clinical practice is the importance of ensuring that this does not contribute to any perceived theory-practice gap.

The theory-practice gap

The theory-practice gap has been an issue of concern in broader nursing education circles since the shift of education away from an apprenticeship scheme. Some argue that it has always existed and probably always will (Scherer & Scherer, 2007). Simply stated, the theory-practice gap is a perceived disjunction between the 'thinking' (the theory) of nursing and the 'doing' (the practice) of nursing (Andrew, et al., 2009). While there is little New Zealand based research exploring the issue of a theory-practice gap, the NZNO student survey in 2010 (Walker, 2010) did find that while most students felt the integration of theory and practice was 'good' (51.2%) or 'excellent' (21.3%) there remained a number of students who found integration 'poor' (22.2%) or 'very poor' (5.3%). Comments from students suggested that some felt there was too much time spent on the theory of nursing and not enough time spent learning and practicing 'nursing' skills. While some argue that student nurses are not necessarily in a good position to recognise what is important and what is not in terms of education needs, their opinions are still important. It does appear that some students of nursing still struggle to grasp the integration of nursing knowledge and theory with nursing practice suggesting that there is still work to be done in this area. Again, further Aotearoa New Zealand research is required.

Despite the lack of Aotearoa New Zealand based research evidence, there have been some efforts both in this country and internationally to address the theory-practice gap. The employment of clinical lecturers (Auckland University), professional clinicians (Massey University), sessional teachers (Australia), and lecturer practitioners (UK) has been one way that some nurse education providers have attempted to address the theory-practice gap. Clinical lecturers and lecturer practitioners are employed primarily to teach but are also expected to be in clinical practice. Whereas, sessional teachers and professional clinicians are nurses who are in clinical practice the majority of time and come in temporarily to teach in clinical areas specific to their area of practice. Research from Australia, however, questions the effectiveness of sessional teachers in bridging the theory-practice

gap and argues that while sessional teachers emphasise clinical experiences in their teaching, this may be due to a lack of awareness of the importance of the theoretical components of nursing education. This lack of integration, in turn, actually widened the theory-practice gap (Andrew, et al., 2009). While further research is needed into the roles of clinical lecturers, professional clinicians and joint clinical appointments in Aotearoa New Zealand, research from the UK shows the lecturer practitioner model has had some success at addressing the perceived theory-practice gap (Hartigan, et al., 2009; Noonan, et al., 2009; Fairbrother & Mathers, 2003). Two further models that have proven to be successful at integrating education, practice and research are joint academic-clinical partnerships (Hawley, et al., 2007; Jackson & Marley, 2007) and Dedicated Education Units (DEU) (Ranse & Grealish, 2007; Jamieson, et al., 2008; http://akoaotearoa.ac.nz/projects/dedicated-education-unit-enhancing-clinical-teaching-and-learning). A number of District Health Boards have established DEUs in partnership with local education providers and are reporting considerable success with this model locally (Kivell, 2011; Casey, et al., 2008). DEUs may also help increase the availability of clinical practice placements for students that has been identified by a number of providers as problematic. Increasing available student practice hours to 24 hours per day, seven days per week may also be required to ensure students grasp the realities of nursing practice.

Relationships between education providers and clinical providers

Aotearoa New Zealand models of nursing education are dependent on good relationships between nursing education providers and district health boards. Unfortunately, these relationships can vary widely (Cook, 2009). This relationship spectrum may impact on the quality and availability of clinical placements for students, and the ability of education providers and health providers to effectively address any perceived theory-practice gap while providing a supportive environment for students of nursing. As noted above the quality of clinical placements available to students can impact on whether a student of nursing remains in nursing education (Pryjmachuk, et al., 2009). Preceptorship or buddying are the most common approaches to supporting students in clinical practice in Aotearoa New Zealand. However the success of preceptorship type models is dependent on the relationships that form between the health care provider, the individual practitioner and the educational institution, and between the individual practitioner and the student of nursing (Happell, 2009; Ingwerson, 2009). Student experiences of preceptorship in Aotearoa New Zealand and internationally are variable, suggesting that some preceptors do not have the skills necessary to be able to provide the support that students need, resulting in poor experiences for students (Vallant & Neville, 2006; Charleston & Happell, 2005). The profession must work to address this issue and ensure that the relationships between district health boards and nursing education providers, and between students and preceptors, are mutually beneficial in order to produce high quality graduates able to meet the changing demands of the health sector.

Interprofessional/interdisciplinary education

The importance of collaborative approaches to health care provision cannot be underestimated and this extends to relationships between health care professionals. One of the fundamental causes of patient errors in health care is communication problems between health professionals (Dillon,

Noble, & Kaplan, 2009). Interdisciplinary or interprofessional education as a means of improving interdisciplinary health care has been mooted as one method of addressing this issue (Pecukonis, et al., 2008). Interprofessional or interdisciplinary education '...occurs when one or more professionals learn with, from and about each other to improve collaboration and the quality of care' (UK Centre for the Advancement of Interprofessional Education, 2002). Interdisciplinary healthcare involves different health professionals contributing to patient care with a common goal (Dillon, et al., 2009). Interdisciplinary practice improves health outcomes when the essential components of effective interdisciplinary health care including trust and mutual understanding of roles, skills and responsibilities are present (Pecukonis, et al., 2008).

The new United Kingdom standards of pre-registration nursing education released in September 2010 require the inclusion of interprofessional education in all nursing education programmes. The Royal College of Nursing in Australia also supports the incorporation of interprofessional education at all levels of nursing education including undergraduate (Royal College of Nursing Australia, 2006). A number of nursing education providers in Aotearoa New Zealand offer interprofessional education at the undergraduate level including the University of Auckland and the Auckland University of Technology, however, these programmes are the exception rather than the rule.

Interprofessional education at post graduate level is more common with nurses having access to a range of post graduate qualifications that are not necessarily specifically nursing focused (though limited by HWNZ funding due to the required NCNZ course approval). Increasing the provision of undergraduate interprofessional education across the professions in Aotearoa New Zealand will be essential to improving health outcomes through the provision of interdisciplinary health care in this country.

17 schools of nursing on 22 sites

Aotearoa New Zealand has 17 different institutions providing a Bachelor of Nursing degree on 22 different sites. While some schools are collaborating around curriculum content, most offer different curricula. While regional differences and demands are important, it is also important to ensure that the outcomes of each programme are reviewed periodically to ensure quality education provision (Cook, 2009). The Nursing Council of New Zealand requires accredited programmes to be monitored five-yearly (Nursing Council of New Zealand, 2010d). While all undergraduate nursing programmes meet minimum standards as set by the Nursing Council of New Zealand, some appear to struggle to maintain consistent quality. A number of smaller polytechnics are subject to nearly yearly Nursing Council review (Nursing Council of New Zealand, 2009a; 2008b; 2007; 2006), suggesting that greater challenges exist for smaller polytechnics to meet the required standards.

The NZNO national student survey in 2009 showed overwhelming support for a national curriculum (77.9% of all respondents) as a means of increasing the portability of studies across institutions and ensuring that all students access an equitable level of education (Walker, 2009b). Although the national curriculum question was not asked in 2010, student comments again reflected support for the concept. General feedback given to the Nursing Council of New Zealand on their review into undergraduate nursing programme standards also supported a national curriculum although feedback from education providers did not (Nursing Council of New Zealand, 2010d).

Benefits of a national curriculum may include a nationally consistent approach for BN programmes on cultural safety and how it is taught, equitable programme provision across providers, resource support for smaller polytechnic providers, improved provision of interprofessional education, and improved relationships between nursing education providers and district health boards – particularly in those areas where multiple education providers use one DHB. The potential for developing collaborative partnerships between universities, polytechnics and health care providers to ensure the best possible education provision needs further development. Past competitive models have done a disservice to nursing education. Ideally, education providers need to move beyond competing for students to working together to ensure equitable provision of nursing education regardless of setting.

The risks associated with developing a national curriculum may include a loss of autonomy for individual providers and a reduced ability to meet local need. Education providers offering the new level 5 enrolled nurse education programme have agreed on national processes to apply the programme and descriptors demonstrating a collaborative approach to nursing curriculum development in today's environment.

While a standard national nursing curriculum may address some of the issues facing nursing education, any curriculum must be developed in light of the population it serves as well as the particular learning needs of the cohorts the nursing profession wishes to attract. In reflecting society's demographics, nursing needs to attract Māori, Pacific, younger people, and men to nursing, and nursing curricula must recognise the diverse needs of these groups. Access to education for Māori and other students outside of the main centres is also important and needs to be considered in any future education strategy. The future role of electronic communication will, no doubt, underwrite the development of flexible teaching strategies in meeting a variety of needs. An alternative may be the development of a fundamental framework for preparation of the new practitioner as discussed at a recent NZNO-hosted education forum. Further work is required to determine how this model may address some of the issues identified.

Attracting people to nursing as a profession

The importance of attracting new students to nursing cannot be underestimated. At present nursing intakes do not reflect population characteristics nor are sufficient in number to effectively replace the current nursing workforce or meet the growing demands for nurses in the future. As the current nursing population retires over the coming years, the number of nurses able to replace them is insufficient (Cook, 2009). In particular men and Māori and Pacific students are less likely to enter a programme of study and even less likely to complete (Cook, 2009). An effective recruitment programme must be developed that promotes the nursing profession as an attractive choice for young people. Videos of nurses talking about their experiences and the realities of nursing practice including shift work may be useful for school guidance counsellors working with young people.

Nursing is an exciting and dynamic profession with multiple opportunities for every member of the profession to contribute toward achieving optimal health outcomes for individuals, families whānau, communities and populations. These elements must be marketed in order to attract a range of capable and effective applicants to nursing. Nursing must consider a range of marketing approaches

that represent the varied elements of nursing including the technical, academic, and emotional aspects. Nursing is an evidence-based practice discipline with the goal of achieving significantly improved health outcomes for our most vulnerable citizens as a result of expert nursing input supported by quality research and must be marketed as such (Gordon, 2009). Nursing should also be marketed as a profession that takes account of the vulnerability of the various populations that it serves and as such should pay close attention to the development of professional values about roles and relationships that inform models of relational practice in nursing (Birks, 2011).

Efforts to recruit Māori and Pacific students to the health sector have shown some success and include the development of the BN Māori and Pacific programmes, a Ministry of Health programme to encourage Māori into health science subjects (Kia ora Hauora) and the new Māori Leadership nursing group – Ngā Manukura o Āpōpō. Learning from these initiatives may assist in the development of appropriate recruitment strategies for young people and men.

Post-graduate and post-registration education

Issues facing the post-graduate nursing education sector include many of the issues outlined above. In particular, they centre around: an ageing faculty; poor funding systems for both research and clinically focused courses; a lack of clarity across the sector for potential students in terms of the courses that are available; and how portable (or not) courses and qualifications are. Health Workforce New Zealand has a significant focus on the funding of medical education over the next two years, and as already outlined, nursing receives a small share of the large pot of money to which access is further restricted at a local level in a number of different ways. It is important that access to funding is equitable. Courses with significant clinical components tend to win DHB favour. Although selection criteria vary across DHBs (according to their District Annual Plans), many of these elements effectively limit nurses' access to courses such as the newly proposed clinical research programme at Otago University and other research based degrees.

The NEt-P, entry to mental health and addiction nursing, and PDRP programmes have been mentioned previously but it is important to note that these are important components of nursing education and any discussion on the future of nursing education must include analysis of how effective these models are and if they are achieving what they are designed to achieve. Differing PDRP programmes limit the ability of nurses to easily transfer their practice between DHBs and some streamlining of programmes may be appropriate. Evaluation of Net-P indicates that the programme has been successful in developing the confidence and competence of new graduate nurses, and that it has had a positive impact on the recruitment and retention of new graduate nurses into DHBs (Haggerty, McEldowney, Wilson, & Holloway, 2009). Clear integration pathways between NEt-P and PDRP and traditional education structures are still required however (Haggerty, et al., 2009). It is also important to consider how the new enrolled nurses may have access to similar structures.

A further, complex debate that exists in nursing education is the varying opinions (without measured outcomes beyond the anecdotal) on the value of level 7 post-registration courses. These courses sit at the same level on the New Zealand Qualifications (NZQA) Framework as the third year of a bachelor's degree. Some argue that all courses beyond registration should be at the post-graduate level (level 8 and above on the NZQA Framework) whereas others argue that much of the nursing workforce are not prepared to study at a post-graduate level due to competing commitments and/or

an inability to afford study, and that specialty focused level 7 programmes enable these nurses to contribute to improved patient outcomes. This debate has yet to be resolved. The practical, clinical orientation of the courses currently meets nurses' needs, however, as nurses who entered the profession under the apprenticeship scheme or with diploma level qualifications retire, it is suggested that bachelor's qualified nurses will increasingly seek post-graduate qualifications as a 'natural' progression. The place of clinically focussed specialist short courses and other complementary programmes of study at level 7 needs to be considered in light of available funding and the preparation of a workforce that is suitably educated to meet individual and population health needs. Preliminary results from a survey of younger nurses aged under 30 currently practicing in Aotearoa New Zealand suggests they gained useful practice knowledge from the completion of level 8 study during their first year of practice (Clendon & Walker, 2011), yet research by Brinkman, Wilson-Salt and Walker (2008) suggests many nurses prefer work-based options and continuing education at level 7. Further evaluative research on this level of education is required.

The new enrolled nurse scope of practice and associated post-enrolment education opportunities have not been discussed in the sector and significant work on this is yet to be done. How enrolled nurses will be supported to maintain and develop competency and how this links with registered nurse education will need to be explored.

Exploring images of the future

Nursing education in Aotearoa New Zealand is facing significant challenges and work must be undertaken to address these. Currently, the focus of the Ministry of Health is on medical practitioners (Ministry of Health, 2010a) and although this is not helpful to immediately addressing current issues, it does give the nursing profession in Aotearoa New Zealand the opportunity to undertake some strategic and cohesive planning into where the profession wants to take nursing education. Already work has been undertaken on the need for a nurse education and training board (Cook, 2009). The 'Cook Report' as it is known, outlines a number of ways in which the nursing workforce in Aotearoa New Zealand can be developed and in particular how better decisions can be made about the appropriate number and mix of nurses that will be needed in the future. In particular, the Cook Report (2009) suggests the following areas need to be addressed:

- How to affirm the place and significance of nursing as a significant career choice.
- How to address the current attrition rates across the undergraduate sector and how to retain nurses who are qualified.
- How to consider the national consequences of each education provider's decisions regarding the size of the student intake each year.
- How to ensure the availability of clinical placements does not limit nurse education.
- How to develop the leadership capacity of nurses at an appropriate time in their careers.

While Cook does not propose any solutions to the above problems, he does support developing high level governance of the current system of nurse education and training, that is, a nurse education and training board. While many of the issues outlined above are recognised as needing to be addressed, there has been limited broader discussion on how this may occur.

Health Workforce New Zealand has indicated that it intends to promote a more cohesive approach to workforce planning and decision-making through:

- Working with the Tertiary Education Commission to ensure policies and systems for funding undergraduate education are aligned with future service needs;
- Introducing career planning for postgraduate education funding (from 2012);
- Developing regional training hubs for planning postgraduate education and training;
- Undertaking workforce service reviews in clinical areas to identify future workforce needs and needed changes; and
- Implementing innovations to unlock the potential of the workforce and develop new roles and models of care.

(Wraight, 2011)

These approaches are not specific to any one health workforce grouping and there has been little analysis of the impact of these on nursing and nursing education.

NZNO proposed a national focus on nursing education for 2011 and sponsored two days looking specifically at nursing education options and priorities, with the option for more meetings as needed.

The first day explored issues associated with undergraduate education, asking essential questions that need resolution in order to meet the demands of current and future environments. The questions posed centred around the following:

- Delivery for future need:
    - What is the graduate profile of 2020?
    - What fundamental knowledge and skills are required?
    - How can nurses be appropriately prepared in a three year generalist programme?
- Relationships:
    - What will be the key relationships in 2020 and beyond?
- Curriculum options:
    - What curriculum structure will best meet the needs of the future?

Consensus was reached in a number of areas suggesting that:

- undergraduate education is currently meeting needs;
- both university and polytechnic nursing education provision should continue;
- collaborative partnerships between clinical and education providers and between education providers need to be strengthened and best practice needs to be shared;
- a national curriculum is not supported;

- faculty development is a significant issue;
- more cognisance of the student experience is required;
- a three year generalist bachelor's programme should continue; and
- smaller providers need significant support.

Further work was identified as being needed including:

- development and evaluation of models of collaborative partnerships;
- further work on the idea of a fundamental framework for preparation of the new practitioner – what is this, what would it look like and would it be useful;
- further consideration of consolidation and alignment of curricula;
- exploration of the advantages and/or disadvantages of a national graduate profile;
- research into faculty development needs;
- further examination of models of interdisciplinary education and the implications of this for nursing;
- further examination of the perspective of student nurses;
- examination of the structure of the first year of practice;
- exploration of how smaller providers can be supported.

Written submissions on earlier drafts of this document identified clear agreement with many aspects of the consensus reached at the education forum. There was agreement that while current undergraduate structures are working well, there should be a greater focus on developing collaborative relationships between education providers and clinical providers and between education providers. Such collaborative partnerships were suggested to result in a range of benefits including research collaboration, resource sharing, joint curriculum development, improved clinical experiences for students and identification of future workforce requirements.

A point of difference between the forum and the written submissions was around a national curriculum. While 12 written submissions supported the idea of a national curriculum, discussions at the forum suggested a national curriculum was not supported. It is clear that further work on curricula is required. Development of a fundamental framework as mentioned above is one approach that may assist in providing clarity around curricula issues.

The second day focused on post-registration education and explored a number of topics including national perspectives on nursing education, support following entry to practice, continuing education, post graduate education and post-enrolment education for ENs.

The key issues identified by the group included:

- strong support for improved workforce planning as a means for ensuring effective education planning;
- further examination of the needs of Māori and Pacific nurses;
- information technology is a priority education need;
- recognition of the importance of collaborative relationships between education and service providers but no clear plan for how this can be achieved;
- the need to address barriers to practice;
- strong support for career planning;

- recognition that professional development sits on a continuum of which qualification is only one component;
- strong support for a stair-casing approach to qualifications but the significant difficulties associated with a blanket approach make this particularly challenging. Individual student approaches are more likely;
- the importance of supporting enrolled nurses to maintain competency in a structured manner;
- mixed support for continued investment in level 700 education provision with a clear swing in favour of this;
- the importance of improving the flexibility of funding for post registration education – in particular examination of the need for NCNZ approval processes for post graduate funding;
- the need to identify and manage new graduate placements more effectively;
- the need to extend funding for entry to practice programmes to all new graduates;
- the need to find employment for nurse practitioners;
- significant support for a model or framework of funded education that also supports nursing leadership, research and management development.

The next step in the process is to discuss the findings from the two forums with the nine member groups of the National Nursing Consortium and develop a strategy for addressing some of the issues identified.

Internationally, nursing education is facing similar challenges. While international proposals must always be viewed in light of the different context of nursing and education, it is helpful to review where the future of nursing education is positioned internationally. The Robert Wood Johnson Foundation (RWJF) is a philanthropic organisation based in the United States that seeks to improve health and health care in America. The RWJF has been very supportive of nursing and has provided significant funding for research and development in nursing for a number of years. The RWJF initiative on the future of nursing is a two year programme designed to find solutions to the challenges facing the nursing profession in America and build upon nursing-based solutions to improve quality and models of care (RWJF, 2010). Nursing education was one of the areas examined and a range of forums and discussions were held to discuss the future of nursing education. The findings from the discussions are framed around three simple headings: what to teach; how to teach; and where to teach. The report provides a range of examples of how nursing education may be framed to meet future needs.

A number of proposals to address the challenges facing nursing education have been made by nurses involved in the RWJF initiative. These include increasing academic and practice partnerships, significant emphasis on developing interdisciplinary and interprofessional models of education, increasing use of nurse-led clinics as sites for academic and practice partnerships and student placements, increasing use of simulation blended with e-learning to enhance interprofessional education and ensure nurses have the capacity to lead health care, increasing access to online courses, the need to break down the silos between medical education and nursing education, and increased use of Dedicated Education Units (Institute of Medicine, 2010). Table one outlines the key messages that came from the forums.

- The new basics in nursing education are collaboration within the profession and across other health professions, communication, and systems thinking;
- Nurses, particularly nurse educators, need to keep up with a rapidly changing knowledge base and new technologies throughout their careers to ensure a well-educated workforce;
- Care for older adults, increasingly occurring outside of acute care settings, will be a large and growing component of nursing in the future, and the nursing education system needs to prepare educators and practitioners for that reality;
- The nation [USA] will face serious consequences if the number of nursing educators is not adequate to develop a more diverse nursing workforce adequate in both number and competencies to meet the needs of diverse populations across the lifespan;
- Technology—such as that used in high-fidelity simulations—that fosters problem-solving and critical-thinking skills in nurses will be essential for nursing education to produce sufficient numbers of competent, well-educated nurses;
- Resources and partnerships available in the community should be used to prepare nurses who can serve their communities;
- Articulation agreements and education consortiums among different kinds of institutions can provide multiple entry points and continued opportunities for progression through an educational and career ladder; and
- In addition to necessary skill sets, nursing education needs to provide students with the ability to mature as professionals and to continue learning throughout their careers.

Table 2. Key messages from the Robert Wood Johnson Foundation Future of Nursing: Education Forums (Institute of Medicine, 2010)

Other international perspectives include the call for international standards of nursing education as a means of addressing the nursing shortage while remaining mindful of the impact of nurse migration on developing countries (Little & Buchan, 2007). The Prime Ministers Commission on the Future of Nursing and Midwifery in England (2010) proposes a number of approaches to nursing education in the future. For example, the Prime Ministers Commission suggests that: all registered nursing qualifications in England will be at the bachelor's level (already the point of entry for RN courses in Aotearoa New Zealand); that nursing as a career must be effectively marketed to quality school leavers, mature people and men as a challenging, exciting and rewarding career; and that health innovation and education clusters be established to strengthen partnerships between the National Health Service, universities and other agencies in order to rebalance the priority usually given to medical education and research. The Commission also argues for the development of clinical academic roles and joint clinical appointments in order to facilitate the ability of students to understand and manage the tensions between theory and practice, and the further development of nursing research capacity (Prime Ministers Commission, 2010).

The international proposals for the future of nursing education recognise many of the same issues facing Aotearoa New Zealand. Aotearoa New Zealand is in an advantageous position given our relatively small size, clearly defined process of nursing regulation and defined competency standards, and effective relationships between existing professional nursing bodies. Internationally it has been found that better nursing education leads to better health outcomes (Aiken, et al., 2003) and now is an ideal time to consider how Aotearoa New Zealand wants to lead the development of nursing education into the future.

Brinkman's (2010) principles for post-registration nursing education outlined earlier provide a basis for future discussions on nursing education in New Zealand. In particular, addressing issues of equity in funding must be a priority for nursing education into the future. The variability of criteria for accessing HWNZ funding is an area of significant concern. Streamlined and equitable approaches to post-graduate nursing education are required and individual career pathways may provide an effective basis for securing funding for post-graduate education in the future. Professional development programmes for all nurses across all sectors must be included as part of any employment agreement and funded accordingly.

Trends, issues and developments

The future findings in this section have been analysed below to identify the key trends, issues and developments that will impact on nursing in relation to nursing education.

- The shift from nursing education from an apprenticeship scheme to a clearly defined tertiary pathway has clarified pathways for nurses seeking higher education and improved opportunities for the development of nursing research and other scholarly activities in nursing.
- There are currently 17 different institutions providing a Bachelor of Nursing degree on 22 different sites and 13 providers of postgraduate education in Aotearoa New Zealand.
- Enrolment in clinically focused post-graduate qualifications has predominated in the past 10 years as a result of the development of the nurse practitioner scope of practice and increased availability of funding – while having significant positive spin-offs for clinical practice development, this may have been at the cost of increasing nursing research.
- Funding structures for nursing education (particularly post-graduate education) are complex and do not meet the needs of the profession.
- Student attrition rates are of concern – particularly for mature students, Māori and Pacific students, and men - clinical placement experiences of students may influence student completion.
- A recent change of policy around education funding opens up opportunities to address high student attrition rates by improving the quality and consistency of nursing education, providing effective pastoral support and tightening entry criteria to bachelor level programmes of study.
- Attracting new cohorts of students to nursing must be addressed.
- Nursing has ranked bottom in two rounds of performance based research funding allocation limiting opportunities for nursing and collaborative research.
- Academic staff are ageing and are expected to be expert clinicians, researchers and teachers without appropriate remuneration or time, limiting the number of nurses who are interested in taking up faculty positions.
- Research into models of nursing faculty practice in the Aotearoa New Zealand context is required – international research suggests mixed results but that academic-practice partnerships and dedicated education units may be an appropriate way forward.

- Nursing models of education are dependent on good relationships between nurse education providers and health service providers and at present many of these relationships vary.
- Interprofessional education as a means of improving interdisciplinary practice (which is known to improve health outcomes) is growing internationally and must become a focus for nursing education in Aotearoa New Zealand.
- A nurse education and training board has been suggested as a means of providing high level governance and strategic oversight of nursing education but this has yet to be established.
- There is no planning for post enrolment education (enrolled nurses).

Analyzing trends and issues for implications – SWOT analysis

Aotearoa New Zealand nurses are in a strong position to address many of the issues facing nursing education. Aotearoa New Zealand's small size, clearly defined process of nursing regulation and competency standards, and effective relationships between existing professional nursing bodies provides us with the opportunity to initiate discussions over the future of nursing education in Aotearoa New Zealand. The following analysis outlines the strengths, weaknesses, opportunities and threats facing nurses as we seek to develop a consensus on the future of nursing education.

Strengths

- Clear pathways for nurses through tertiary education.
- Existing structures for growing and developing nursing research.
- Increasing numbers of nurses with post-graduate qualifications who may be encouraged to develop quality clinical nursing and collaborative research.

Weaknesses

- Insufficient funding for all nurses to develop the post graduate clinical and research skills required to meet the health needs of New Zealanders into the future.
- An ageing faculty with poor succession planning as a result of remuneration that has failed to keep up with the clinical sector and increasing demands to be a clinical, research and teaching expert.
- Complex funding structures for post-graduate nursing education.
- Concerning student attrition rates.
- Insufficient numbers of students being attracted to nursing – in particular young people, men, Māori, Pacific and other ethnic groups.
- Limited planning for post registration enrolled nurse education.
- Numerous curricula that may or may not be sustainable in the current economic climate.

Opportunities

- Development of collaborative partnerships between education and service providers and between education providers to enhance research collaboration, resource sharing, joint curriculum development, improved clinical experiences for students and identify future workforce requirements.
- Refocusing of education funding policy on completion rates and graduation outcomes enables nursing education providers to standardise entry criteria to undergraduate nursing

programmes, and develop and provide effective pastoral support for students in order to address attrition rates.

- Development of an effective marketing programme to attract younger and more diverse groups of students to nursing as a profession.
- Opportunity for the nursing sector to work together to develop a framework for future nursing education.

Threats

- Continued poor PBRF rankings of nursing.
- Continued priority focus of Ministry of Health and HWNZ on medical education.
- Inability to market nursing to younger and more diverse student groups.
- Protracted processes of nursing sector leaders in reaching agreement on a future framework.

Part 5: Employment

People need nurses. We know that quality nursing care improves the health outcomes of people, but that quality nursing care cannot be provided without the systems and structures to support it. Nurses have a right to practice in an environment that is conducive to quality care and to receive fair salaries and wages (International Council of Nurses, 2004). Nursing interventions are cognisant of the impact of the social, economic, cultural and other determinants of health on people's ability to manage their own health and nurses work to address these determinants through their work with groups and communities, through collaborative work with other health professionals, and across the social, health, and economic sectors. The relationships that nurses form with the people they work with are the basis from which successful nursing interventions occur. However nurses are also subject to the impact of the social, economic and cultural determinants of health and employers have a responsibility to ensure that nurses are not subject to the very things nurses seek to address in their practice.

Attracting people to nursing and retaining the nurses that are currently employed is vital to a sustainable health care system in Aotearoa New Zealand. Efforts to address the environment in which nurses work are a key element of ensuring Aotearoa New Zealand has a quality health workforce into the future. This section outlines current employment issues facing Aotearoa New Zealand nurses and some of the initiatives intended to ensure nurses have equal access to good health.

Orienting in time

Nurses are the largest health workforce group in Aotearoa New Zealand. Nurses work in a range of employment settings although patterns of employment are changing. In the mid-1980s, 80% of nurses worked in hospital settings, whereas today that has fallen to 62% with the remaining nurses working in a mixture of mental health, primary health care and continuing care (DHBNZ Future Workforce, 2009a; Cook, 2009). As mentioned earlier, inconsistencies in the definitions of the areas where nurses work make comparisons difficult. However, it is clear that there is a growing trend of nurses shifting from hospital settings to primary health care and community settings for their workplaces. It is likely that this mix will continue to alter as health needs change and increasing emphasis is placed on a primary health care approach to health care. The variety of settings in which nurses practice produce a range of challenges to ensure quality work places and equitable income for all. This section is arbitrarily divided into two, the first section covering issues associated with employment agreements and negotiations, and the second section covering issues and initiatives associated with creating workplace environments conducive to the provision of quality care. The split is artificial as the two are inextricably intertwined and it is impossible to achieve one without the other, however the split has been made to ensure that there is clarity surrounding the varying concepts that are covered.

Employment agreements and negotiations

The exploitation of nurses was common place prior to establishment of a strong union for nurses. Considerable work has been done over the last 100 years to address the health and safety needs of nurses and achieve pay parity with other, equitable occupations. The achievement of a national multi employer collective agreement (MECA) with district health boards in 2004 set the benchmark for wage and salary levels for nurses working for these organisations. Since then, the remaining sectors have struggled to attain equity with district health board employed nurses, and Māori and iwi health nurses, some primary health care nurses, nurses and health care assistants working in the aged care sector, and others are still seeking to achieve an equivalent agreement. The NZNO has significant employment campaigns currently underway to develop multi employer collective agreements or national single employer agreements for large numbers of nurses and health care workers in these sectors including Fair Share for Aged Care, Te Rau Kōkiri (for Māori and iwi health providers), and Pay Parity for Primary Health Care. While this campaign work is underway, many nurses working for smaller health care organisations and some private organisations continue to practice in environments where quality nursing practice is difficult to achieve, poorly recognized, and undervalued if and when it is achieved. This places our most vulnerable citizens at increased risk of poor health outcomes as nurses struggle to provide high quality nursing care.

The achievement of pay parity through an effective multi employer collective agreement with DHBs not only achieved fair pay for nurses working in the DHB sector, it has also been a catalyst for promoting nursing as a professional practice discipline within the health care sector and for those considering nursing as a career. Improved pay and conditions obtained through campaigns and bargaining have been a strong enabler for the nursing profession. While ensuring pay improvements keep up with inflation and other, equitable professions, the DHB MECA also provides opportunities to incorporate principles of safe staffing and healthy workplaces (see below) that contribute to improving health outcomes. In other words, the integration of industrial and professional issues within employment agreements provides a strong basis for achieving improved health outcomes for people.

The union movement internationally, aside from the Scandinavian countries where unionism and collective bargaining remain strong, is faced with decreasing membership as a result of a new, more individualised world of work and there is strong support for a partnership approach to employment relations (Taylor, 2001). Nursing as a profession both in Aotearoa New Zealand and internationally uses its strong union basis for addressing employment issues. In Aotearoa New Zealand, this incorporates traditional bargaining approaches and an issues-based negotiation and collaborative approach. In this document the collaborative approach utilised by NZNO is similar to the partnership approach outlined by Taylor.

The Employment Relations Act (2000) set the scene for the development of a collaborative approach to employment relations and aimed to make the employment environment less adversarial (O'Connor, M., 2010). The Act had a significant focus on collective rather than individual bargaining, as well as an emphasis on mediation rather than litigation. Most significantly for NZNO, strike action in support of a MECA was prohibited under the previous Employment Contracts Act (O'Connor, M., 2010).

The Health Sector Relationship Agreement (2007) between the government (Minister and Ministry of Health), District Health Boards and union parties (Council of Trade Unions including the NZNO) developed as a result of the collaborative approach to employment relationships in the health sector in Aotearoa New Zealand. The Agreement outlines a set of common goals and interests that the signatories agree must underpin employment relations in the health sector. These include:

1. A goal of improving health outcomes for the Aotearoa New Zealand population, and in reducing health inequalities.
2. A shared commitment to delivering a productive, sustainable, responsive, high-performing affordable public health and disability service, in line with the New Zealand Public Health and Disability Act 2000 and the range of health and disability strategies.
3. A mutual interest in the provision of good jobs and working environments for all who work in the health and disability sectors.
4. Respect for each others' different roles and the respective responsibilities that go with those roles.
5. A mutual interest in meeting the objectives of the Employment Relations Act 2000 (ERA) through the promotion of collective bargaining and union representation.

The Joint Action Committee (JAC) Partnership Agreement (Joint Action Committee, nd) was established as an outcome of negotiation between DHBs and NZNO in the 2007 MECA and is a further example of the partnership or collaborative approach to employment relations in nursing. The Partnership Agreement outlines the commitment to partnership between the NZNO and the District Health Board parties and recognizes the value of working more cooperatively and constructively to maintain and advance the nursing and midwifery workforce who take shared responsibility for providing high quality health care on a sustainable basis (Joint Action Committee, nd). Achieving a partnership approach to create an environment in which quality nursing practice can occur requires commitment from all parties. Nurses must be appropriately qualified, skilled and experienced to meet the changing health needs of people, have the support of an effective professional body to achieve this, and continue their commitment to providing quality nursing care. Employers must acknowledge the importance of providing a healthy workplace and appropriate working conditions for nurses, along with the positive impact that nurses have on health outcomes and commit to this.

Changes to the 2000 Employment Relations Act in late 2010 will have a profound impact on employment relations in this country. Union representatives are now required to seek consent from the employer prior to visiting union members on worksites, employees must present a medical certificate if absent from work for more than one day, and the 90 day trial period for new employees has been extended to all businesses regardless of size (Employment Relations Amendment Bill (No 2) 196-3, 2010). Although many employers of NZNO members have chosen to waive the requirement for NZNO organisers to seek consent prior to visiting a workplace, this may change quickly and without notice. The ability of a union to maintain close relationships with members will be threatened by the legislation as it runs contrary to provisions under the DHB MECA. The strength of any union lies in its ability to work with all employees and build capacity within a worksite. Where access to members is restricted, this may have a significant impact on the ability of representatives to assist employees to advocate for the safely staffed and healthy workplaces that improve health

outcomes for everybody including recipients of nursing care as well as nurses. Issues including the ability to transfer accumulated benefits such as long service leave between employers and the impact of the devolution of secondary services to primary health care on employees will also impact significantly on nurses' working conditions.

These ongoing challenges to employee rights come in light of the neo-liberalist perspectives of the current National government. The arguments surrounding economic growth to improve health (neo-liberalism) versus investing in health now to improve economic growth have been discussed earlier. While change in political perspectives is likely to always be a feature of the Aotearoa New Zealand political system, the fundamental values of the nursing profession around health and social equity and improving health outcomes are challenged by the neo-liberalist approach. Nursing's fundamental values form the basis of a cohesive industrial and professional policy platform that can challenge such policies.

While the political and fiscal context create numerous challenges to employment relations, achieving effective employment agreements are fundamental to creating workplaces that are conducive to the provision of quality care.

Creating workplace environments that are conducive to the provision of quality care

The creation of workplace environments that are conducive to the provision of quality care is fundamental to improving health outcomes for New Zealanders. The approaches to employment relations outlined above are supported by initiatives that demonstrate the importance of safe staffing and healthy workplaces to improving health outcomes and provide a basis for arguing for the value of nursing to people, to the health sector, and to government.

The Safe Staffing Healthy Workplaces (SSHW) Unit was established to research and develop a set of tools that would address safe staffing and healthy workplace issues along with how a culture conducive to achieving these could be realized. The SSHW Unit is funded by the Ministry of Health, is part of a collaborative agreement between NZNO and District Health Boards New Zealand (DHBNZ), and responds to issues identified by the Safe Staffing Healthy Workplaces Committee of Inquiry through their report released in 2006 (Safe Staffing/Healthy Workplaces Committee of Inquiry, 2006). The Committee of Inquiry recommendations drew on the Magnet Hospital recognition principles (outlined later in the document) in its analysis of safe staffing and healthy workplaces in Aotearoa New Zealand and identified a number of core elements essential to achieving safe nursing and midwifery staffing for an effective healthcare environment. The seven core elements include:

- The requirement for nursing and midwifery care – including appropriate staffing levels.
- 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.
- The physical environment, technology, equipment and work design.

Collectively, these elements describe a health care environment that is well resourced and well organized and achieves planned health outcomes for people who are the recipients of nursing care (Safe Staffing/Healthy Workplaces Unit Governance Group, 2009). The elements are interdependent with no single element having priority over any other. The SSHW Unit undertakes work to ensure the elements are appropriately addressed in DHBs and has focused on working with three DHB demonstration sites to implement activities that address the elements. Implied in the model of safe staffing/healthy workplaces is that there is an optimum number and configuration of nurses and midwives to deliver high quality health care (Safe Staffing/Healthy Workplaces Unit Governance Group, 2009).

To this end the SSHW Unit has been working on a system of managing care called care capacity demand management. Care capacity demand management is about ensuring that the requirement or demand for patient care is appropriately resourced (Safe Staffing Healthy Workplaces Unit Governance Group, 2009). The goals of care capacity demand management are to:

- Ensure safe, quality care for people.
- Ensure a safe, quality working environment.
- Ensure organizational efficiency.

Figure five shows how the elements of care capacity demand management interact to create safe staffing and a healthy workplace:

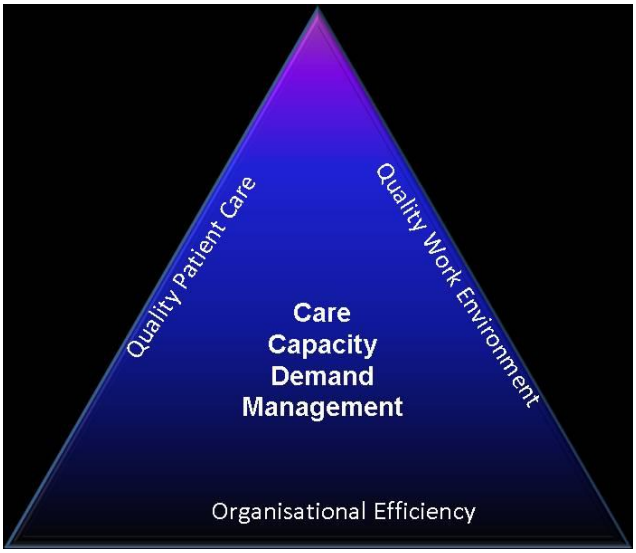

Figure 5. Care capacity demand management

While overall progress on addressing the elements of safe staffing and healthy workplaces in DHBs has been slow (Safe Staffing/Healthy Workplaces Unit Governance Group, 2009), care capacity demand management is showing some success in achieving safe staffing and healthy workplaces in the three demonstration sites where it is being trialed (Lawless, 2010).

While care capacity demand management and the partnership agreement between DHBNZ and NZNO are significant in terms of improving employment frameworks, these approaches do not yet extend substantially beyond the DHB sector to address the issues facing nurses in the primary health

and aged care sectors. As noted above, there are significant employment campaigns currently underway to develop multi employer collective agreements for large numbers of nurses in these sectors. While the focus of these campaigns must be achieving pay parity with their DHB colleagues for nurses working in these settings, the work of the SSHW Unit will provide the basis for future employment agreements focusing on safe staffing and healthy workplaces once initial pay parity has been achieved. The diversity of employers in these sectors creates significant challenges for achieving safe staffing and healthy workplace outcomes and will need to be worked through.

Internationally, a significant focus on achieving healthy workplaces and safe staffing for nurses has been on patient to nurse ratios. Work by Linda Aiken, Director of the Centre for Health Outcomes and Policy Research at the University of Pennsylvania and others over the past 10 years have demonstrated significant links between high patient to nurse ratios and increased mortality, high patient to nurse ratios and nurse burnout and job dissatisfaction, and some relationship between higher nurse education levels and lower patient mortality (Van den Heede, et al., 2009; Kane, et al., 2007; Sasichay-Akkadechanunt, Scalzi, & Jawad, 2003; Aiken et al., 2002). California introduced mandated patient to nurse ratios in 2004 and recent research has found that these mandated ratios have resulted in lower mortality rates and nurse outcomes predictive of better nurse retention (Aiken, et al., 2010).

While this research contributes significantly to our understanding of the impact of nursing on health outcomes and the importance of safe staffing levels and healthy workplaces, focusing solely on mandated patient nurse ratios does not account for the complexity of the health care system (Safe Staffing/Healthy Workplaces Committee of Inquiry, 2006). Further work is required into how such approaches to health outcomes can be made applicable to nursing in the primary health care sector where addressing the social, cultural and economic determinants of health through collaborative activity is a significant part of nursing practice. Further consideration of how to utilize both international and local research into safe staffing and healthy workplaces in advocating for effective employment agreements and approaches to bargaining is also required.

One of the initiatives resulting from the research into patient to nurse ratios and mortality has been the development of the Magnet Recognition Program. This is an American initiative designed to recognise health care organisations that provide excellence in nursing care. Characteristics of a Magnet hospital include nurse participation in hospital affairs, nursing foundations for care, nursing management ability, support and leadership, adequate staff and resources, and collaborative nurse-doctor relationships (Armstrong, Laschinger, & Wong, 2009). Hospitals achieving Magnet hospital recognition clearly demonstrate better patient outcomes than non-Magnet hospitals (Aiken, et al., 2009), and a number of Australasian hospitals have sought and achieved Magnet recognition including Hutt Hospital in Aotearoa New Zealand and Princess Alexandra Hospital in Queensland, Australia.

The Positive Practice Environments: Quality Workplaces for Quality Care campaign is a further example of an internationally based campaign that recognizes the benefits of creating healthy workplaces. The campaign is supported by the World Health Professionals Alliance comprising ICN, the International Hospital Federation, the International Pharmaceutical Federation, the World

Confederation for Physical Therapy, the World Dental Federation and the World Medical Association and over the course of the 5 year campaign intends to:

- Make the case for healthy, supportive work environments through evidence or their positive impact on staff recruitment and retention, patient outcomes and health sector performance.
- Build a global platform to catalogue good practices in healthy, supportive workplaces.
- Drive the establishment and application of principles of positive practice environments across the health sector.
- Celebrate successes that support effective strategies that promote sustainable health systems.

(ICN, 2010b)

There is significant international literature indicating that in general work is good for you, a healthy workforce is a more productive workforce, and that there is a need for collaboration and engagement to create healthy workplaces (WHO, 2010a; Ontario Health Quality Council, 2010; Secretaries of State of the Department for Work and Pensions and the Department of Health, 2008). Effective use of this literature will support the arguments being made by nurses to address workplace issues and will provide a useful source of information for New Zealand's campaigns in this area. We must continue to emphasise the link back to the patient – unless healthy workplaces and safe staffing are developed and sustained through initiatives such as care capacity demand management and Magnet hospitals, patient safety will be significantly compromised.

Exploring images of the future

In the health policy section outlined earlier in this document, it was noted that ministerial health policy is focused significantly on fiscal restraint as the government seeks to contain health care costs. This is not a situation that is unique to Aotearoa New Zealand and internationally most countries are faced with spiraling health care costs in tightening economies. What is significant is that this situation means that in order for nurses to be able to optimise their contribution to improving the health outcomes of New Zealanders, we need to refocus policy makers and funders away from the cost of nursing to the value of nursing (International Council of Nurses, 2010a). This has significant implications for nursing's approach to the development of effective employment frameworks in the future. The work of the SSHW Unit in identifying and defining those factors that contribute to safe and healthy workplaces along with a focus on health and social equity provide a common platform for both industrial and professional approaches to policy.

In addition, nursing is in the unique position of being able to use a wide range of evidence to support their value to employers and their value to people. A range of literature has been presented throughout this document that demonstrates nursing's input into improving health outcomes, nurse's ability to undertake quality research into the human experience of health, illness, and disability, and the value of nurses in addressing the social, economic and cultural determinants of health. The professional practice of nurses provides the basis for arguments to improve employment relations and also provides a position of strength from which to initiate the bargaining process. Kurtzman (2010) argues that policy makers must be persuaded of the value of nursing by arguments derived from scientific advancements, the social benefit that is gained, the business

insights that are offered, and the political sense that they make. However this must be supported by better legislation to facilitate the development of MECAs and a national bargaining approach across the health care sector. Mandatory staffing levels in aged care will also support nurses to provide effective nursing care.

The regional council structure of NZNO could provide an effective structure for developing the integrated voice of NZNO. The structure could be utilised to encourage delegates to emphasise both the professional and industrial strength of nurses to continue the conversations required to improve working environments and subsequently health outcomes. Nurses themselves must take responsibility for integrating the arguments for advancing professional nursing practice.

As nursing workforce and population demographics change, it will be imperative that strategies designed to meet the needs of older and more diverse groups of nurses and people are developed. Traditional shift work patterns may no longer be appropriate in the changing health care environment. While hours of availability of health care professionals may need to be altered to meet the needs of people, flexible working hours, shift times and rosters for nurses also need to be developed to meet the needs of nurses. Technological developments in communication will assist the health care sector to meet the accessibility demands of people, but little thought has yet been given to how technology and other approaches may help the nursing workforce meet their needs. Family demands on nurses such as caring for children have always been present, but increasingly nurses are also being called upon to care for ageing family members. It is vital that flexible working hours, accessible child care and supportive processes for caring for older family members continue to be developed in order to retain these nurses in the workplace. Research into the challenges faced by mid-life nurses found that the demands of home life conflicted with the demands of shift work leaving them with feelings of regret, guilt and the inability to cope (West, Boughton, & Byrnes, 2009). Many of these nurses chose to work part-time in order to cope with the impact of shift work on their lives. West et al. suggest the use of a 'time map' to enable mid-life nurses to discuss their needs with management. The 'time map' outlines the particular demands on the individual nurse that can then be used in discussions with management.

Older nurses are valuable to the health workforce and flexible working hours will also be required to facilitate the retention of these nurses. Some of the reasons that older nurses give for remaining in the workforce include reduced working hours as retirement gets closer, more flexible working hours, and reduced workloads/caseloads (Storey, Cheater, Ford, & Leese, 2009). Low morale in the workplace, poor work-life balance, high workload and staff shortages were seen as barriers to continuing to work, and feeling valued and being consulted about change were considered key factors in assisting nurses to stay in work (Storey, et al., 2009; Boumans, De Jong, & Vanderlinden, 2008). Strategies designed to facilitate older nurses remaining in the workplace need to be developed including providing appropriate information on retirement planning, individual workplans that clearly outline a career pathway leading to retirement that recognises and values the contribution of the older nurse to the workforce, and ensuring that older nurses are consulted in ways that are appropriate to their needs about intended change.

Of equal importance is the growing number of internationally educated and trained nurses in New Zealand and the impact these nurses have on the culture of nursing into the future. New Zealand has

one of the highest proportions of foreign-born and overseas-trained nurses among OECD countries (DHBNZ Future Workforce, 2009a). These nurses face difficulties caused by differing cultural, linguistic and professional backgrounds (Walker, 2009c). In some hospitals in New Zealand up to 80% of the nursing workforce on any given ward may hold internationally obtained qualifications (Wright, 2009). Anecdotal evidence suggests that the key issues causing concern among employers of internationally trained nurses include communication due to English as a second language, poor infection control practices, difficulties with relationships with authority figures, religious beliefs and practices, inability to practice autonomously, and limited knowledge surrounding customer service and the provision of basic care due to practices in their home countries (Wright, 2009). In addition, many internationally trained nurses are unaware of their right to good working conditions and the support available to them through professional and industrial representation as a member of NZNO or any other professional body. Union membership in some countries may cause nurses to lose their jobs (Manchester, 2009). As the numbers of internationally trained nurses increase in proportion to the nursing workforce as a whole, poor understanding of the benefits of belonging to a professional body may impact on membership numbers of NZNO. This may decrease the ability of the organisation to support nurses to gain the healthy working environments they are entitled to. New Zealand trained nurses also need education about how best to work with overseas trained nurses and the benefits they can bring to a workplace. Provisional registration for overseas trained nurses alongside workplace assessment and remediation may assist these nurses to assimilate into the Aotearoa New Zealand workplace culture.

As noted earlier, while change will always be a feature of the New Zealand political environment, policies that challenge the fundamental values of nursing must be confronted. Changes to employment relations are an immediate threat, while in the long term it is important that nursing works proactively to identify and pre-empt potential risks to the health of New Zealanders – in particular those at greatest risk of poor health outcomes including Māori , Pacific, those people on low incomes and children. These risks are not solely within the domain of health policy but exist in employment and labour policy, housing policy, and social policy to name a few. Applying the principles of health impact assessment to all policies is vital and provides a framework for policy analysis that may be useful.

Trends, issues and developments

The future findings in this section have been analysed below to identify the key trends, issues and developments that will impact on nursing in relation to employment frameworks.

- Nurses have a right to practice in an environment that is conducive to quality care and to receive competitive salaries and wages.
- Nurses are subject to the impact of the social, economic and cultural determinants of health and employers have a responsibility to ensure that nurses are not subject to the very things they seek to address in their practice.
- Attracting people to nursing and retaining the nurses that are currently employed is vital to a sustainable health care system in Aotearoa New Zealand and efforts to address the

environment in which nurses work are a key element of ensuring Aotearoa New Zealand has a quality health workforce into the future.

- The variety of settings in which nurses practice produce a range of challenges to ensure quality work places and equitable income for all.
- While significant progress has been made to achieve pay parity with other, equitable occupations, Māori and Iwi health nurses, some primary health care nurses, most nurses and health care workers in the aged care sector, and others are still seeking to achieve an equivalent agreement.
- The SSHW Unit has made significant progress in identifying and addressing barriers to achieving safe staffing and healthy workplaces.
- More work needs to be done on extending the benefits of a partnership approach and the work of the SSHW Unit to the primary health care, aged care and other sectors.
- Internationally, significant research has demonstrated links between high patient to nurse ratios and increased mortality, high patient to nurse ratios and nurse burnout and job dissatisfaction, and some relationship between higher nurse education levels and lower patient mortality – in other words there are not enough nurses and too many patients.
- Further work is required into how such approaches to health outcomes can be made applicable to nursing in the primary health care sector where addressing the social, cultural and economic determinants of health through collaborative activity is a significant part of nursing practice.
- A reorientation from the cost of nursing to the value of nursing is required – value to people and value to employers.
- Current government focus on fiscal restraint presents challenges and opportunities for traditional union approaches to employment relations.
- The professional practice of nurses provides the basis for arguments to improve employment relations and also provides a position of strength from which to initiate the bargaining process.

Analyzing trends and issues for implications – SWOT analysis

Strengths

- The significant research that supports the value of nursing to people can be used as a basis for developing effective employment frameworks and as an argument in the bargaining process.
- The regional council structure can be utilised to strengthen the professional voice of nursing
- The use of a collaborative approach to employment relations

Weaknesses

- Continued reliance on partnership and collaboration when government sees a diminished place for unions.
- Poor integration of overseas trained nurses.

Opportunities

- Build on the success of the SSHW Unit by continuing Aotearoa New Zealand specific research into safe staffing and healthy workplaces and extend this to look at primary health care and other settings.
- Consider the possibilities of developing a new approach to collectivism (union collectivism has been vital but strengthening professional collectivism may be a new approach to ensure gains can continue to be made).
- Development of appropriate workplans for retaining older nurses in the sector.
- Utilise existing research and literature that supports the development of healthy workplaces as a means to improving the health of populations and productivity of the nation.

Threats

- Inability to retain older nurses in the workplace.
- Inability to successfully utilise overseas trained nurses.
- New approaches to employment relations are not considered.
- Government fails to recognise the legitimate role for workers in workplace decision-making.

Identity

Identity examines what the profession of nursing believes about the world and about themselves as nurses and what nursing can contribute to this world. Identity is one of the most important determinants of the future we can create (Rhea, 2005). At the start of this document, a number of key values and assumptions were listed that members of NZNO have identified as underpinning their nursing practice. These values and assumptions help define the profession of nursing in New Zealand and provide the basis from which nurses identify themselves as nurses. Work has also been done recently within the NZNO on a definition of nursing. A definition of nursing assists nurses in being able to describe the focus of their practice and their contribution to health care and improving health outcomes in New Zealand. As nurses increasingly seek to demonstrate their value to people, having a good understanding of what nursing is and how it contributes to improving health outcomes enables nurses to articulate their contribution clearly. The definition reads as follows:

NZNO Definition of Nursing

Nursing in Aotearoa New Zealand is an evidence-based practice discipline underpinned by nursing theory and research. Nursing's core focus is people (he tangata) – with or without disease. Professional nursing practice attends to the differing ways in which people experience health, well-being, illness, disability, the environment, health care systems, and other people, and brings coherence to all that contributes to positive health outcomes. It is the relational processes, knowledge and skills of nursing that enable people to get on with their lives, whatever their health circumstance. Nursing assures a human face in health care. The discipline of nursing in Aotearoa New Zealand addresses the uniqueness of our cultural experience: professional nursing practice is founded on whakawhanaungatanga, manaakitanga, rangatiratanga, and wairuatanga.

Nurses assume various and evolving roles in the health workforce, spanning the settings of the health sector – in institutions, homes and mobile through communities – reaching across boundaries of all public and private service sectors. Nurses work collaboratively with others to address health need and provide professional, equitable, effective, and empathetic nursing care for individuals, families whānau, hapū, iwi, communities, and the wider society. Nurses have education and regulation through which they develop nursing practice, and the fiscal consciousness required for them to practise in roles that are complementary to, facilitative and integrative of the roles of medical practitioners and other health care workers. As such, they are key to the quality and cost of health care provision and innovation in service design and delivery that aims to advance the health of the nation.

A definition of nursing offers us an opportunity to develop a reference point – something that we can refer to when we talk in interdisciplinary forums about the particular contribution that nurses make to health, something that we can discuss 'in house' about nursing practice, nursing research and nursing policy, something that we can refer to when we talk to the Ministry of Health, funding bodies and service providers about the most appropriate models of service delivery for improving health outcomes (Litchfield, 2010). The definition of nursing differentiates nursing practice from the practices of other health care workers in terms of its significance for health, health care, and the

delivery of services, and is a statement about the focus of the discipline. It is not a list of the things that nurses do – these must be defined by nurses themselves practising in their particular time, place and context.

The values, beliefs, ethics, emotions and intelligence of the profession of nursing and how we teach these to new comers to nursing shape the identity of nursing and the subsequent strength of the profession to achieve a future that contributes to improving health outcomes for all New Zealanders. Incorporating nursing knowledge, theory and research into undergraduate and postgraduate education programmes provides the foundation for nurses to be able to develop and lead the nursing profession as an evidence-based practice discipline into the future. It is the knowledge that nurses develop through research and practice about nursing and its unique contribution to improving health outcomes that underpins the development of nursing as a profession in Aotearoa New Zealand.

Direction setting

In this section, I summarise the key findings from the strengths, weaknesses, opportunities and threats analysis of each of the sections in the document.

Strengths

There are a number of key strengths that currently exist in the nursing profession that can be drawn on as we develop the profession into the future. Nursing's core focus is people and the goal of improving health and social equity and improving health outcomes through the provision of effective nursing care provides the basis for the future development of nursing. The clear and robust pathways to health that have been identified – that is, addressing the social determinants of health through effective primary health care – provide a strong argument for how nursing can best have an impact on improving health outcomes. The New Zealand government's acknowledgement of persisting inequalities in health and clear international support for the role of nurses in addressing these through nursing interventions also enable nurses to advocate for a growing role in addressing health need through a primary health care approach.

Registered and enrolled nurses and nurse practitioners are a regulated health care workforce with accountability under the HPCA Act (2003). They provide safe and effective nursing care and we know that nurse-led services are cost-effective, appropriate, acceptable, and improve health outcomes. Nurse practitioners in particular, are seen by DHBNZ, the Nursing Council, the Ministry of Health and NPAC-NZ to be in a position to provide significant input into improving health outcomes in the future. Registered nurses of the future are seen as working in highly autonomous roles with a range of highly developed skills and competencies. Work is already underway to provide systems and structures for appropriate pathways toward specialist registered nursing practice. The new enrolled nurse scope of practice provides for a safe, regulated health care workforce that can support all health professionals to provide safe and effective care.

Nursing's humanistic and relational focus on people will become increasingly important in achieving improved health outcomes and international literature supports nurse's future role in the development of new and emerging models of care focused on these identified strengths of nursing practice. New models of care such as Whānau Ora provide opportunities to work collaboratively with others to improve health outcomes. There is also significant potential for nurses to be involved in clinical leadership positions, and pathways for nurses through tertiary education now exist to support both clinical and leadership education.

There are good existing structures for growing nursing research and increasing numbers of nurses with post-graduate qualifications now exist who may be encouraged to develop and become involved in quality clinical nursing and collaborative research. The significant research that supports the value of nursing to people can be used as a basis for developing effective employment frameworks and as an argument in the bargaining process.

Weaknesses

Despite the existing strengths of nursing, there are also a number of weaknesses that impede nurse's ability to practice in a manner conducive to achieving improved health outcomes. There is currently poor recognition by the Aotearoa New Zealand government of nursing capability and/or poor enactment of nursing models of care. The humanistic and relational approach to health care that is a strength of nursing practice is neither well-articulated nor understood by those outside of nursing.

There is significant disagreement over the need for investment in health versus investment in the economy to improve health outcomes and there is usually one perspective dominating health policy at any given time. There is a need to strengthen arguments around the importance of investing in health in appropriate and effective ways in order to address this issue. The existence of restrictive purchasing, funding and contracting models for both registered nurses and nurse practitioners and delays in updating the Medicines Act and other legislation continue to impede the development of nursing practice.

Clear standards of practice for the unregulated health care workforce at level 4 on the NZQA framework that staircase into enrolled nurse (level 5) and subsequently registered nursing practice (level 7) must be developed and implemented. Limited understanding of the enrolled nurse scope of practice continues to limit the effective use of this workforce. The lack of workforce development in the aged care sector is a particular problem and remuneration in the sector does not support recruitment and retention of health care workers, enrolled nurses or registered nurses. If employers choose to employ HCAs, then they should take responsibility for their practice, not RNs, ENs or NPs. HCAs should not be replacing the EN or RN workforce.

Poorly defined pathways from models of care to improved health outcomes with no blueprint of how new and emerging models of care will be developed, nor how they will improve health outcomes, limits the potential for improving health. There has been disorganized adoption of models of care that have been poorly evaluated or not evaluated at all. Lack of involvement of communities in the development and evaluation of models of care is a significant concern as is the continued lack of consultation with nurses.

Nursing lacks robust, evaluative, Aotearoa New Zealand based research on nursing's impact on health outcomes and this further limits nurse's ability to demonstrate how they improve health outcomes through the use of nursing-based models of care. Health practitioner protectionism around boundaries of practice and income streams further limits nurse's ability to develop new models of care and evaluate these.

Complex funding structures of nursing education limits the ability of nurses to provide appropriate education – particularly at the postgraduate level – to meet the health needs of New Zealanders into the future. An ageing faculty with poor succession planning as a result of remuneration that has failed to keep up with the clinical sector and increasing demands to be a clinical, research and teaching expert compounds the problem. Concerning student attrition rates and insufficient numbers of students being attracted to nursing – in particular young people, men, Māori, Pacific and other ethnic groups – will challenge the development of the nursing profession into the future and

must be addressed. A large number of undergraduate curricula – some with poor entry criteria – little pastoral support, and variable standards of delivery are significant issues. There is also no planning for post enrolment education for enrolled nurses.

A continued reliance on a partnership approach to achieving effective employment agreements when government sees a diminished place for unions requires consideration in the context of the professional development of nursing.

Opportunities

Despite concerns regarding a lack of New Zealand based research on nursing's contribution to improving health outcomes, we can use existing international frameworks and research to continue to argue for nursing capability in improving health outcomes as we continue to develop our own research capability. A strong case can be made for funding for future research into nursing approaches to health care based on international research.

The professional and industrial arguments in nursing can be addressed by using a social determinants and primary health care philosophy to explain the link between the two – a primary health care approach to addressing health inequities and improving health outcomes ensures the impact of the social determinants of health will also be addressed for nurses.

Nursing has the opportunity to provide input into developing a strategy for the use of an unregulated health care workforce and into development of a nationally standardised education framework for HCAs. Nurses should be leading this work. We can simultaneously push to enrich the skill mix by increasing the proportion of enrolled nurses within the nursing team and undertaking significant work in educating registered nurses, nurse practitioners and other health professionals regarding the enrolled nurse scope of practice and how enrolled nurses can have effective input into interdisciplinary teams. The development of specialty services to the aged care sector and in particular the use of nurse practitioners to deliver effective, collaborative care to older people can be significantly developed.

Nursing is in a position to develop a good working relationship with Health Workforce New Zealand (HWNZ) and it is important that we continue to lobby HWNZ to make nursing workforce development a priority. Nursing must ensure it continues to lead the development of frameworks for specialty and advanced practice. Nursing's humanistic and relational approach to the provision of care can provide the basis for developing strong collaborative relationships with other health care professionals to improve models of care and undertake robust research into future models. Nurses need to be at the forefront of clinical leadership opportunities and the profession must develop a clear framework for developing leadership capacity among younger nurses.

The development of more collaborative relationships in education making better use of the opportunities provided by the university sector for the development of research is vital. Closer collaboration and partnership between education providers and clinical environments must be considered if nursing is to develop in a manner that will meet future population health needs. Work to develop and implement any model must begin now and must include close discussions with

clinicians and academics to ensure any new model will be relevant in all settings. Refocusing of education funding policy on graduation outcomes provides the opportunity to develop a national graduate profile, standardised course entry criteria, effective pastoral support and appropriate funding in order to help address student attrition rates. We must also develop an effective marketing programme to attract younger and more diverse groups of students to nursing as a profession.

The Safe Staffing Healthy Workplaces (SSHW) Unit has made considerable progress on identifying and addressing those elements required to achieve safe staffing levels and healthy workplaces and we must now build on these successes and extend them to look at primary health care and other settings. Funding and time for undertaking robust research into the efficacy of newly developed models of safe staffing and healthy workplaces must be advocated for strongly.

Threats

The continued lack of recognition of nursing capabilities by government and the wider health sector poses a significant threat to the development of the nursing profession. This underlines the need to ensure robust nursing research into health outcomes is undertaken and strategically utilized in arguments to demonstrate nursing's importance in the health sector. Although HWNZ has made encouraging noises around nursing workforce development, we must ensure that they follow through with any promises or proposed work and that nursing has a cohesive voice in this area. If HWNZ fails to effectively incorporate nursing's position in future health workforce planning this will be a significant issue.

The new enrolled nurse scope of practice offers significant opportunities for the development of an effective health care workforce but if uptake of enrolled nurses is slow or limited then the opportunity to maximise the potential of this group will be lost. Further research into interdisciplinary team work and the place and efficacy of the enrolled nurse in the interdisciplinary team may mitigate this threat.

The inaction of government to address funding, contractual and legislative barriers to nurse practitioner and registered nurse practice poses a significant threat. Until many of these areas are addressed, again, nurses and nurse practitioners will be unable to realise their considerable potential in improving health outcomes. A lack of understanding by other health professionals, funders and policy makers on the effectiveness of the nursing approach to improving health outcomes poses a further threat and also contributes to the poor development of collaborative relationships. As noted above, the profession of nursing must continue to undertake and utilise robust research to support their arguments around the impact of a nursing approach to improving health outcomes and improving understanding of nursing as a profession. We need to speak the language that other health professionals, funders and policy makers understand and we must ensure that nurses are consulted widely and appropriately in all issues associated with health care. Workers have a legitimate role in workplace decision-making but if government fails to recognise this role through changes in legislation, the health of all New Zealanders will be affected.

Continued poor PBRF rankings of nursing pose a significant threat and despite increased funding to address this issue, further analysis of the causes and means of addressing this issue needs to be undertaken. We know we must develop better research outcomes if we are to improve nursing's PBRF ranking but until nurses become more overtly involved in all levels of research and move to understand the culture of publishing research, this is unlikely to occur. The continued emphasis on medical education funding is unequal and unfair and must be addressed.

If nursing continues to be unable to market nursing to younger and more diverse student groups, we are at significant risk of perpetuating the greying of nursing. Again, this is a significant risk for the future of nursing as a profession in New Zealand and work must begin now to develop marketing campaigns that are appropriate to these groups. Nursing must emphasise both the academic and clinical nature of nursing practice to potential students and ensure that students coming into nursing understand both these facets.

The opportunity for nursing to develop a new collaborative approach to nursing education currently exists but if nursing as a profession is unable to progress discussions and development of this then the opportunity will be lost. NZNO has lead discussions on nursing education in 2011 and it is vital that all nursing groups play a significant role in developing the future of nursing education.

Funding is the fundamental barrier to the development of the nursing profession in all areas, be it developing new models of care, undertaking research, or undertaking education. Specific immediate threats include limited funding for the Safe Staffing Healthy Workplaces Unit, failure of government to provide funding for Te Rau Kōkiri (the collective employment agreement for Māori and iwi health care professionals seeking pay parity), and failure to adequately fund the aged care sector. The nursing profession must continue to advocate strongly for funding to address the social determinants of health – if the SSHW Unit does not continue or its capacity is limited then both improved health outcomes for people and unsafe work environments for nurses will be the result, if Te Rau Kōkiri is not funded, inequities in Māori health are perpetuated, and if funding is not increased in the aged care sector then our most vulnerable and frail elders will suffer.

It is the above factors that provide the background for development of the vision that is found at the start of this document. How we achieve the vision is the next question.

Innovation

Having set the vision, we need to consider in detail the approach to achieving the vision. Nursing as a profession must work together to develop the approaches we need to ensure nurses remain at the forefront of improving health outcomes and addressing health inequalities. We must consider what innovations we might require to achieve the vision.

The vision provides a basis for the development of practice, policy and research agendas over the coming years, and nursing's professional bodies will work collaboratively and with other health professionals and members of the public to ensure nursing practice continues to meet the needs of New Zealanders in the most appropriate, effective, and accessible manner.

It is recommended that the next stage of the vision project is to establish a working group to develop a comprehensive strategy for NZNO to advance the vision and incorporate it into their annual planning process.

Conclusion

Nursing in Aotearoa New Zealand is poised to move into the future in one of two directions. We can sit back and let others dictate what they believe is nursing's role in the future or we can move forward and articulate our contribution to addressing health inequalities and improving health outcomes for the people of Aotearoa New Zealand. This document has examined a number of the trends, issues and developments both within and external to nursing that will shape the provision of nursing care in Aotearoa New Zealand over the next twenty to thirty years. It has also identified the strengths, weaknesses, opportunities and threats that will continue to challenge nursing but also provide us with a direction for the future. Many of the identified issues are the same things that nursing has been grappling with for the past twenty years and we need to consider new directions for addressing these. Strong leadership, a focus on primary health care and addressing the social determinants of health in all areas of practice, undertaking and utilising nursing research to demonstrate nursing's contribution to improving health outcomes, staying true to nursing's core values, strengthening nursing education, and working together as a profession will guide us as a group into the future.

Every nurse has a sphere of influence which can be used to build the capacity of individuals, families whānau, communities, and society to shape its future.

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