New Zealand Nurses Organisation
Manifesto
Election 2011
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The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing more than 46,000 nurses, midwives, students, kaimahi hauora and health care assistants on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and well-being of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

This manifesto for nursing and health is based on current NZNO policies, priorities and campaigns. It sets out what we see as the key challenges for the next New Zealand Government and the actions necessary to ensure an equitable and sustainable health system.
In Aotearoa New Zealand there is increasing evidence of the development of a two-tier system where access to care is increasingly determined by location, financial resources and ethnicity. Despite this, fears that our aging population will cause public health spending to blow out of control, have fuelled an agenda which includes cuts in funding for public health, privatisation of services, and increased reliance on health insurance as the ‘only way’ of keeping the lid on costs. NZNO does not subscribe to this view, which ignores evidence that projected future health care costs can be mitigated by keeping people in good health, nor that the longer, healthier life all New Zealanders are enjoying should, ironically, be characterised as a burden. Certainly there are predictable and serious population and health workforce challenges, but these can best be met by maintaining and improving sound investment in health, not rationing services.

The priority given to public funding for health care over other spending is a political decision. New Zealanders are faced with an increasingly stark choice between a system that offers selective funding for some public health services and relies on individuals privately funding the rest; and one based on the principles of equity, disease prevention and health promotion, which focuses on providing the highest level of universal health care possible. There are also significant disparities in access to all levels of care, including the most basic primary health care.

Managing the continuum of care, from investment in early life to security of care at the end of life, sustainably and equitably, so all New Zealanders have timely access to the health care they need, will largely depend on the effective utilisation of a flexible, integrated health workforce – ensuring the right level and mix of skills in all health settings. Equitable employment conditions and healthy, safe work environments are integral to maintaining a motivated and stable healthy workforce, while universal access to primary health care is fundamental to maintaining and improving population health.

The nursing team, which comprises regulated health professionals – nurse practitioners, registered and enrolled nurses – supported by unregulated health care assistants (HCAs), constitutes the largest group of health workers, who work at the front line of almost all health care in both hospitals and the community. In hospitals, nurses are present 24 hours a day, providing round-the-clock physical, clinical, emotional and technical care, constant surveillance and emergency response; in community settings they care for the elderly, run specialist clinics and deliver primary health care. Nationally, nursing is intrinsic to the delivery of a wide range of government and non-government services from Plunket, Māori and iwi providers and Family Planning to accident compensation, rehabilitation, and prison services.

**“The development of a society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum and the degree of protection provided from disadvantage as a result of ill-health.”**

Despite multiple health system reforms, there are significant disparities in access to all levels of care, including the most basic primary health care.
Nurses also undertake high quality health research, manage the majority of health services, including health promotion and education, and provide timely and effective policy advice at all levels of the health and social service sectors.
Nurses are clinicians who are educated to recognise when medical intervention and referral is necessary; they work with doctors and other health practitioners to ensure seamless delivery of appropriate care. Nurses are also educators and health consumer advocates.

Aotearoa New Zealand’s health system, and the health of all New Zealanders, is closely linked to the quality and effectiveness of its nursing services. Having publicly funded nurses as the entry point to the primary health care team would optimise the use of funding and health workforce resources, increase people’s choices and improve health equity.

The past decade has seen the introduction of a number of significant government health initiatives, briefly described below, which, in view of their outcomes, provide both the context and rationale for the action NZNO advocates. While primary health care, integrated service delivery and provision for an increasing range of complex, specialised diagnostic and acute care services are consistent and expected themes, there are extraordinary omissions. These include the failure to update obsolete medicines legislation and regulations, or address significant issues concerning the heavy reliance on overseas trained health practitioners.

The introduction of the New Zealand Public Health and Disability Act (2000) signalled a fundamental change in direction, from both the competitive health service model of the 1990s and a predominantly medical focus, towards a more collaborative health system, focused on improving the health status of New Zealanders and reducing health inequalities. These included a range of initiatives to:

- promote healthy living;
- reduce the incidence of cancer, obesity, diabetes, and cardiovascular disease;
- upgrade mental health; and
- upgrade child health care services.

Successful achievement of health strategies is largely dependent upon an efficient interface between all aspects of community and hospital care. The nursing workforce provides that interface.

District health board (DHB) funding was tied to the provision of health and disability services for the total regional population. However, funding for primary health care services was tagged to enrolment with a primary health organisation (PHO), generally a private GP practice, and this
remains the access point for most health care, regardless of the availability of GPs to provide it, or the health care needed.

The Primary Health Care Strategy (2001) articulated an evolutionary approach to achieving better population health and health equity, emphasising the need to develop the primary healthcare workforce, co-ordinate services, and support the development of services by Māori and Pacific providers. The extensive contribution nursing could make to primary health care had been anticipated by the 1998 Ministerial Taskforce on Nursing, which introduced the nurse practitioner model, and in 2003 a framework to activate primary health care nursing was proposed by an expert advisory group.

Substantially broadened priorities for mental health to include community-based primary services were envisioned in Moving Forward (Ministry of Health, 1994) and a separate funding stream was established with the Blueprint for Mental Health Services: How things need to be (1998) to achieve the urgently needed improvement in the quality and range of mental health services to accommodate the shift from institutional to community-based care.

He Korowai Oranga: the Māori Health Strategy (2002) challenged the health system to ensure Māori access to appropriate and affordable health care based on the empowering principles of whānau ora – supporting Māori families to achieve their maximum health and well-being. It also identified mental health as a priority area for Māori. Consequently, culturally appropriate primary mental health services were a key feature of the second New Zealand Mental Health and Addiction Plan, Te Tāhuhu: Improving Mental Health 2005-2015 (2005).

Aotearoa New Zealand’s health system, and the health of all New Zealanders, is closely linked to the quality and effectiveness of its nursing services.

The Disability Strategy (2001) recognised that, in addition to the 20 percent of New Zealanders who report some disability, there are specific challenges in meeting the needs of an aging population, namely ensuring the provision of:

- co-ordinated home-based and residential support services for people with disabilities of all ages and ethnicities; and
- hospitals with increased specialist and diagnostic services, able to cater for a higher turnover of more acutely sick people.

The Accident Compensation Corporation (ACC) has been the primary provider of no-fault personal injury cover for all work and non-work injuries for all Aotearoa New Zealand residents and visitors since 1974. Its position as sole provider, as consistent with the social contract it was based on, was restored in 2001.

Advances in medicine and biotechnologies opened up opportunities for new professional and technical roles and the transitioning of some workforce activities. These factors prompted new legislation to meet increased expectations for public safety, accountability and transparency in the health sector, notably:

- the creation of the Office of the Health and Disability Commissioner (HDC);
- the Code of Health and Disability Services Consumers’ Rights (1996); and

Current Government

In 2008, the incoming National-led government introduced Better, Sooner, More Convenient Health Care, a new initiative in primary care aimed at reconfiguring services to provide a wider range of services closer to home through integrated family health centres, including devolving some secondary services to a reduced number of PHOs. Building on the principles established in He Korowai Oranga: the Māori Health Strategy, the Māori Party successfully ensured support for the whānau ora programme, which provides for community-based management of integrated social and health services for families and whānau.

While primary health care, integrated service delivery and provision for an increasing range of complex, specialised diagnostic and acute care services are consistent and expected themes, there are extraordinary omissions. These include the failure to update obsolete medicines legislation and regulations or address significant issues concerning the heavy reliance on overseas trained health practitioners.

integrate national, regional and local health sector planning and accountability; to enhance clinical input and direction; and to rationalise services and procurement where possible. The NHB incorporates a business unit responsible for information technology (IT) and workforce strategies, administered by the Health IT Board and Health Workforce New Zealand respectively. In acknowledging the persisting inequalities in health in Aotearoa New Zealand, the NHB noted the need for cross-sector collaboration and suggested the development of four models of care to address current health system pressures:

- prevention, self management and home-based services;
- integrated family health centres, partnerships and teams;
• 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; and
• managed specialisation and consolidation into a smaller number of centres/hubs.

These reaffirm the importance of primary care and access to specialist services. The Health Safety and Quality Commission, an independent Crown entity responsible for driving improvement in health and disability services, replaced the Quality Improvement Commission and will also assume mortality review functions.

The role of PHARMAC, Aotearoa New Zealand’s successful pharmaceutical management agency, is being expanded to include management of all hospital medicines and medical devices. However, mooted pharmaceutical concessions in free trade agreements threaten to jeopardise PHARMAC’s unique purchasing position, and ability to deliver a range of subsidised drugs for far less cost than comparable countries.

There has been a significant change in the direction of public health, with a clear refocusing of policy on fiscal restraint and rationing of services. Steps have been taken to:

• reduce ACC coverage and services and prepare it for privatisation;
• reduce the number of health targets (including dropping oral health, mental health, nutrition/physical activity/obesity targets); and
• increase elective surgery, including contracting out to private providers, in spite of the under-use of public hospital theatres17.

Similarly, the abandonment of the Pay and Employment Equity Unit, removal of the requirement for schools to provide only healthy food and beverages, drastic changes to the employment environment through amendments to the Employment Relations and Holidays Acts, and more punitive sentencing legislation and privatised prisons, are incompatible with an evidence-based approach to addressing the determinants of health.

Good progress has been made in the nursing workforce particularly with:

• an ongoing commitment to supporting the safe staffing healthy workplaces agenda; the prompt resolution of the title and scope of practice for enrolled nursing; the initiation of elected nursing positions on Nursing Council;
• changed regulation enabling nurse practitioners to sign sickness benefit medical certificates;
• more flexibility around standing orders for supply or administration medicines; and
• the introduction of a pilot programme for nurse prescribing.

But there remain significant legislative, funding, purchasing and contracting barriers to the effective use of the nursing workforce, in spite of the demonstrable potential it has to improve health equity and reduce the costs of future health needs 18 19 20.

Successful achievement of health strategies is largely dependent on an efficient interface between all aspects of community and hospital care. The nursing workforce provides that interface; thus the degree to which the nursing workforce is nurtured, developed and sustained ultimately affects the health of the nation21.

NZNO is committed to a public health system, universal access to free primary health care, and a publicly funded injury prevention, rehabilitation and accident compensation scheme. The following sets out NZNO’s priorities and identifies the challenges and actions the incoming government must take in order achieve health equity and a high quality sustainable health system.
Universal access to primary health care

- Make publicly funded nursing services the key entry point to primary health care to ensure all New Zealanders have access to comprehensive primary health care, including primary aged and mental health care.
- Support the whānau ora model in principle as an appropriate means of supporting families and communities to address their health and social needs.
- Prioritise wrap-around services for mothers and children to give the best start in life and reduce future health needs.

Invest in the nursing workforce

- Remove legislative and other barriers to advanced and innovative practice to ensure a flexible nursing workforce able to meet population health needs.
- Ensure nurses have equitable access to funding for postgraduate education, clinical training and leadership opportunities; that new-entry-to-practice (NET-P) positions, including appropriate places for Māori and Pacific graduates and ENs are available to all new graduates; and subsidise return-to-work programmes to maximise recruitment.
- Affirm new models of care that are inclusive of the broadened EN scope of practice and protect and enhance employment opportunities for ENs in primary, mental health and aged care, and in DHBs.
- Ensure qualifications for all health workers are consistent with the public safety standards of the HPCAA.

Ensure safe clinical environments

- Ensure that staffing in all nursing environments meets the patient requirement for care by implementing care capacity demand management developed by the SSHW Unit, and ensuring access to nationally consistent acuity assessment tools.
- Recognise that healthy work environments promote productivity, quality and safety, and protect workers’ rights by including a healthy workplaces clause in all employment contracts.
- Facilitate the development of clinical frameworks and guidelines for responsibility of care that clarify the interface between regulated and unregulated workers, particularly in aged care and mental health.
- Ensure that culturally and clinically appropriate care in all settings is provided by the appropriate person in the health care team.
- Establish a single agency for the recruitment of overseas health professionals to minimise exploitation, protect Aotearoa New Zealand employment conditions, and maximise the use of workforce resources, including finding alternative safe clinical pathways for overseas trained Pacific nurses living in Aotearoa New Zealand to gain New Zealand registration to address critical health workforce shortages in Pacific communities here.

Increase equity

- Address the social determinants of health through the co-ordination of social, health, environmental and employment government strategies across all sectors.
- Raise the minimum wage, return the minimum hours defining full-time work to 35 hours per week, reinstate the Pay and Employment Equity Unit, and repeal amendments to ERA and Holidays Act that promote inequitable industrial relations.
- Stop moves to privatise and restrict ACC and health and education services.
- Facilitate union representation and integrative (interest-based) bargaining.
- Develop genuine and nationally consistent indicators of activity, output, quality and health outcomes to facilitate sound planning.
Protect public health

- Protect public health by continuing to fund smoking cessation strategies; implementing the 5+ Solution to the misuse of alcohol; re prioritising oral health and healthy eating/healthy action programmes and removing GST on healthy foods.
- Retain the capacity to deliver co-ordinated public health programmes and services to improve population health, and address the increase in diseases of poverty, such as rheumatic fever and tuberculosis.

Ensure safe aged care

- Set minimum mandatory staffing levels in aged care which take into account the right skill mix, and develop robust measures for acuity assessment, safety and quality in aged care.
- Ensure that access to home support is assessed face-to-face by a regulated health practitioner, and that care is provided by the most appropriate person/team in all settings, ie EN, RN, NP, HCA.

Improve access to mental health services

- Ensure access to primary mental health care, including culturally and clinically appropriate community-based and residential alcohol, drug, and gambling addiction and rehabilitation services, and alternatives to police management of acute care episodes.

Primary health care services encompass not only a broad range of professional health care received in the community, including health education, counselling, screening, disease prevention and management, but also services that contribute to health, such as those centred on employment, community development, environmental protection and voluntary work. Investment in primary health care demonstrably reduces health disparities and future health needs and, because of the lifespan over which the benefits are gained, the greatest benefit in health spending comes from that directed at the young. Universal access to the necessary information, education and clinical care to manage good health, with particular attention to the needs of mothers and young children, must be prioritised to ensure improved population health, health equity and manageable health needs.

Current funding of primary care, based on enrolment with a PHO, does not ensure universal access to healthcare. Moreover, it has the perverse effect of exacerbating health disparities since the most vulnerable and lower socio-economic populations, ie those who are poor, sick, in dysfunctional families/relationships, and who live in rural or remote locations or areas with few GPs, are the least likely to be enrolled. Ironically, those who are not enrolled, attract higher GP fees, if and when they do seek health care, and prescription charges may be a further barrier. Lack of access to 24-hour emergency and after-hours care is also problematic in remote, rural and low socio-economic areas, further entrenching disparities.
A health system which excludes people at entry level is not only unjust, it is demonstrably wasteful of human workforce and financial resources.

Flexible funding streams are necessary to facilitate alternative pathways to primary care and optimise the use of health workforce skills, across the rage of health practitioners, to deliver safe, efficient and equitable health care. Funding is the primary tool for incentivising the changes needed to ensure equitable access to health care. For that reason nurses must be as involved in the planning and funding of services as they are in delivering them.

Alternative purchasing models, having publicly funded nurses as the key entry point to the primary health care team, would optimise the use of funding and health workforce resources, increase people’s choices and improve health equity. A wide range of initiatives including walk-in centres, nurse-led clinics, and nurse partnerships with other health professionals such as pharmacists, GPs, and specialists, could provide safe, cost-effective, primary health care. In this context, it is important to note the fundamental difference in focus and outcomes of nurse-led clinics in the United Kingdom, where nurses are used as substitute GPs25 (with little difference in cost), and those in the

The funding model for PHOs has an inbuilt disincentive to service poorer communities with higher health needs, despite the fact that these are where the most health gains are to be made.

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United States, which are targeted to specific disadvantaged populations to address access issues26. It is the latter model NZNO advocates. It fully utilises nursing’s holistic scope of practice and nurses’ expert knowledge of when to refer to other health professionals, as a complement to, not substitute for, medical care.

This is already occurring with services such as Family Planning, which delivers around 140,000 nurse consultations a year on a range of sexual health issues and trains nurses and doctors in specialised procedures such as intra-uterine device (IUD) insertion and vasectomies, for a fraction of the cost of unplanned pregnancies, abortion, and treatment for sexually transmitted diseases. Bulk funding and direct payment of salaries from the Ministry of Health for all primary health workers, including midwives and GPs, as well as opportunities for self-employment, are other viable alternatives that would reduce costs and improve access to a range of services. Historical precedents should not limit future development.

NZNO supports the whānau ora model in principle as an appropriate means of supporting families to address their health and social needs, providing that those who are providing care are appropriately skilled and qualified for the role. Similarly, integrated family health centres offering a range of health and social services, have the potential to deliver timely, co-ordinated care and enable a smooth transition between maternity and primary health care service and well child provision, including screening and immunisation programmes. Direct funding of centres staffed by a team of salaried health practitioners would deliver safe health outcomes more cheaply than publicly subsidised but privately-owned facilities; a significant reduction in prescription costs, for example, would be expected.

Primary health care must encompass culturally and clinically appropriate aged care and primary mental health care services. The overall impact of exposure to healthy lifestyle messages and new technologies is not yet known27, so the implications of an aging population are not entirely clear. But current trends indicate people are healthier for longer28, requiring more acute care, including complex medication “poly pharmacy”, at a later age. Thus the demand for primary aged care will increase, alongside the need to cater for higher acuities. Safe provision of a range of services, from home-based to residential and acute gerontology and dementia aged care, will largely depend on the nursing workforce. It will require transitioning home-based support services from the predominant ‘per hour, per client’ funding model to a ‘packages of care’ model, as recommended
in the Health Workforce Advisory Committee paper Care and Support in the Community Setting30.

Access to home support must be determined through face-to-face assessment by an appropriately skilled, qualified and regulated health practitioner. In all aged-care settings nursing care must be provided by the appropriate people in the healthcare team – NP, RN, EN and HCA – ensuring the right skill mix for differing levels of care. Levels of care need to be constantly and consistently addressed. NZNO supports the SSSHFW Unit’s urgent recommendation that DHBs purchase a nationally consistent acuity tool such as Trendcare. Since falls are a major cause of preventable injury in older people, ACC’s decision to abandon its falls safety and education programmes is unaccountable and short-sighted; NZNO urges their reinstatement.

Though aged care has been largely privatised over the past two decades, international research recognises the importance of the not-for-profit sector. There is some evidence that the quality and cost-efficiency of not-for-profit services are better than those commercially provided31. In light of the significant transfer of public wealth to the private sector – $800 million per year – the use of which is of public wealth to the private sector – $800 million per annum31 – the use of which is effective for timely access to affordable primary mental health care is strong, the Ministry of Health’s Evaluation of Primary Mental Health Care Initiatives (2009)34 noted that one third of all GP presentations concern a diagnosable mental disorder35, and cautioned “In the complex competing demands of the GP consultation, there is a tension involved in responding to mental health concerns that take increased time... compounded by the part fee-for-service system, which means that from the patient’s perspective there are financial barriers to present to, and continue their engagement with, health professionals for mental health problems”. This report validated the significant role of practice nurses and GPs, and indicated a high degree of success in addressing common, mild to moderate mental health conditions in primary care settings. In Australia, Medicaid funding has been extended to nurses so they can see people presenting with primary mental health issues directly36.

There are considerable gaps and widespread regional disparities in access to community-based mental health care, including a critical lack of alcohol and other drug and gambling addiction and rehabilitation services. Where there is a failure of service provision, police detention and/or management of acute care episodes is common, regardless of the health risks this imposes, particularly where there are co-morbidities. Only a well trained clinician will recognise symptoms caused by diabetes and alcoholism, for example, and inappropriate treatment can be fatal. Similar risks were pointed out by the National Health Committee in a recent report on prison health services37 which noted that the common practice of isolating prisoners expressing suicidal ideation is clinically inappropriate. Incarceration should not be the default alternative to safe primary health care delivered by appropriately trained mental health workers.

It is not acceptable that children suffer lifelong disabilities for want of timely access to primary health care for treatable conditions such as rheumatic fever, that cancer patients suffer continual nausea because they cannot afford to pick up a prescription for an anti-emetic; or that those with untreated mental health problems end up in police cells; or that older New Zealanders, without adequate home support, injure themselves.

In light of the significant transfer of public wealth to the private sector – $800 million per year – and concerns around the quality and safety of care, it may be pertinent to reconsider private contracting of hospital-level aged care. There should be transparency and accountability for all public health care spending in privately owned residential and hospital facilities, where the lines between public and privately provided services are increasingly blurred.

Clearly there is a need to ensure universal access to basic primary health care, aged and mental health care to reduce entrenched and new disparities, and maximise the prevention of ill health so current and future health demands remain within our ability to resource them. Current funding pathways and workforce resources must be reconfigured to ensure that care needed is given by the appropriate practitioner. Universal access to safe quality primary health care can be achieved by having nurses as the entry point to the primary health care team.
The incoming Government should:

1. Make publicly funded nursing services the key entry point to primary health care to ensure all New Zealanders have access to comprehensive primary health care, including primary, aged and mental health care.

2. Realign funding mechanisms for primary health care to remove barriers to the effective use of nursing skills to provide frontline care.

3. Support the whānau ora model in principle as an appropriate means of supporting families and communities to address their health and social needs.

4. Prioritise services for mothers and children, including ensuring a smooth transition between maternity and primary health services, Well Child, and screening and immunisation programmes. Ensure access to home care is determined through face-to-face assessment by an appropriately skilled, qualified and regulated health practitioner, who has access to nationally consistent acuity assessment tools.

5. Ensure culturally and clinically appropriate care in all settings is provided by the appropriate person in the healthcare team.

6. Ensure equitable access to community-based and residential alcohol and other drug and gambling addiction and rehabilitation services.

The key challenges for nursing and midwifery in the delivery of effective services are:

- creating an environment conducive to, quality nursing and midwifery care; and
- achieving and maintaining safe staffing levels.

The nursing profession has a social contract to provide high quality nursing care where and when it is needed. Meeting the obligations of this contract requires that individual practitioners, regulated under the HPCAA, are competent and fit to practise. The context in which nurses and midwives practise, supports them to be successful.

Accessible, effective health services require a nursing and midwifery workforce that is freed to care and proud to nurse. This means having:

- the right skill mix and numbers for the nursing/midwifery work required;
- the right knowledge and competence level;
- the right equipment, technology and health care team;
- the right work environment, creating and sustaining quality and safety;
- nursing authority and leadership over practice;
- regulatory and funding policies which enable nursing and midwifery;
- sound employer and practice policies and procedures; and
- genuine participation in service decisions.

The environment in which nursing is able to deliver care successfully is free from abuse, offers meaningful manageable work, reasonable autonomy, and a culture of respect that acknowledges both the person and the professional.
A key recognition of the right to work in a safe clinical environment is the healthy workplaces clause in the DHB MECA. NZNO advocates this clause be extended to all employment contracts to maximise safety, quality and productivity.

Facilitating innovation in nursing, midwifery and medical practice to meet changing health needs while protecting public safety poses particular challenges for Aotearoa New Zealand. With a small geographically dispersed and demographically diverse population, it is important to ensure education and training is directed to supporting a flexible, trained, generalist health workforce able to be deployed in a wide range of settings to meet all health needs. These range from emergency response to disaster or pandemic, managing chronic care, to assimilating new practices to treat longer living, higher acuity patients.

This requires:

- facilitating higher levels of education and clinical training for extended, advanced and leadership roles, including NP, nurse specialist, clinical nurse educator;
- facilitating broader skill sets, including maintaining dual scopes of practice, eg nurses who are also midwives;
- developing clinical frameworks and guidelines for responsibility of care, that clarify the interface between regulated and unregulated workers, particularly in aged care and mental health; and
- ensuring education and training for all unregulated health workers is nationally consistent and up to level 4 on the New Zealand Qualifications Authority framework, and provides a supportive career path to a regulated nursing role, such as EN, as outlined in NZNO’s position statement on HCA education.

Nursing services are the common denominator for all aspects of health care and are critical to improving population health. Increasingly, nurses are working in environments where they have little control over factors that impact on their ability to deliver quality care; where their autonomy can be limited by bureaucracy and managerial fiat; where they may lack the ability to mobilise resources to support patient care; and where they frequently feel exhausted, overwhelmed and unsafe. Cost-cutting strategies, such as raised thresholds for hospital admissions, shortened lengths of stay, and fewer staff, may lead to rationing nursing care, as nurses use their clinical judgement to prioritise assessments and interventions. Not surprisingly, this has a direct, negative impact on the quality of care and patient outcomes. The environment in which nursing is able to deliver care successfully is free from abuse, offers meaningful manageable work, reasonable autonomy, and a culture of respect that acknowledges both the person and the professional.

There is an urgent need to address the way the nursing workforce is managed and supported to ensure nurses, in partnership with physicians and other health care professionals, lead the design of comprehensive, wrap-around health care services that provide an enabling context within which to practise. Understanding how to support and use the health workforce appropriately, matching skill sets with health need, requires:

- developing genuine indicators of activity, output, quality and, ultimately, health outcomes;
- using standardised measures, including qualitative measures, of health status to provide the fundamental data to improve the effective management of the health sector;
- removing barriers to all regulated health practitioners to ensure they are able to practise to the full extent of their scopes of practice, training and education;
- implementing robust methods for matching the demand for nursing care with the appropriate care capacity; and
- implementing robust methods of determining the resources required by nurses to support effective practice and to monitor the efficacy of the resource supply chain.

A comprehensive and flexible approach is needed to meet the challenge of delivering health care which meets the needs of the Aotearoa New Zealand population and is consistent with global standards of best practice. Processes need to be developed to deliver and monitor the interdependent elements of safe staffing identified by the Safe Staffing/Healthy Workplaces Committee of Inquiry’s Report (2006) and to ensure a high level of care is sustained. NZNO is committed to continuing its collaboration with DHBs in supporting the work of the SSHW Unit in hospitals and extending it to primary health, aged care and mental health.

It is important to ensure education and training is directed to supporting a flexible, trained, generalist health workforce able to be deployed in a wide range of settings to meet health needs.

The privatisation of aged care, separate funding for mental health services, disestablishment of EN positions, and increasing employment of disparately trained, unregulated HCAs have all presented significant and, as yet, unresolved, challenges to public health and safety over the last few decades. In the aged-care sector, where patient numbers and the degree of acuity are relatively constant, (though there is clear evidence that those coming into residential care are older and require more acute care)
even the minimal voluntary standards jointly developed by private, government, community and professional organisations have rarely been achieved. These voluntary standards are outlined in the New Zealand Standards Handbook Indicators for Safe Aged-care and Dementia-care for Consumers.

As HDC and Nursing Council of New Zealand (NCNZ) reports confirm, this poses a risk to regulated nurses in aged care who, under the HPCAA, are accountable for their practice and those they delegate to and provide supervision for. Regulations which currently require only one RN to be ‘on duty’ (not necessarily on the premises), and who may supervise up to four ENs or HCAs, each caring for ten or more residents, are out of step with the increasing demand for more acute rehabilitation and complex dementia care, and impose unrealistic workloads which compromise patient safety. The risks have been heightened with the change to the DHBs services contract for Aged and Residential Care (AARC). This contract which no longer requires the manager of aged-care facilities be a clinician, thus relegating clinical governance of publicly funded health services to a subordinate role in privatised services.

New Zealanders nearing the end of their lives should be confident the fine health care they have helped provide for others will be available to them. Residential aged care needs consistent guidelines to provide an auditable measure not only of staffing numbers, and the right skill mix for differing levels of care.

Urgent and essential requirements for the aged-care sector include:
- Mandatory staffing levels;
- an enhanced skill mix;
- nationally consistent acuity assessment tools;
- a comprehensive, national set of quality and safety indicators; and
- equitable industry standards for wages and conditions.

Safe clinical environments require health care to be given by the appropriate person. HCAs are a growing proportion of the nursing workforce, and work in hospitals, district nursing and mental health services, as well as in aged care where they predominate. Yet the boundaries between their duties and those of regulated ENs, and the lines of responsibility for direction and delegation of tasks, are often poorly understood. There is increasing evidence that EN positions are being disestablished and replaced with HCA positions, in spite of their significantly different roles, training and regulation. Substitution of HCAs for ENs is short-sighted and unsafe. Safe staffing protocols and appropriate education are needed to enable the respective skills of both nurses and HCAs to be used efficiently and safely.

NZNO’s immediate concern has been to ensure public safety by making sure basic training programmes are available. However, it is clear from the proliferation of short training and education programmes offered by industry training organisations (ITOs) and DHBs that HCAs are being used to fill gaps in clinical services and/or replace regulated nursing staff. Individual DHBs may find this cost effective in the short term but, on a national level, such duplication is expensive, unsustainable and unsafe, as other countries have found. Short, limited training courses cannot ensure the quality, consistency and flexibility needed in the nursing workforce and substituting HCAs, particularly in acute care when the work primarily requires an RN, is not a productive deployment of resources. Education resources should be channelled towards ensuring ENs are appropriately supported to transition to the broadened scope of practice, while HCA training should be nationally standardised, transportable and provide a pathway to a regulated nursing role.

The piloted introduction of new unregulated roles such as physician/practice assistant (PA) and operating department practitioner (ODP) rather than using existing regulated nursing roles, invites confusion and potential risk to public safety, secure employment and a stable and assured future workforce. Facilitating advanced practice roles for RNs and NPs, as with HWNZ’s innovation project of the registerednurse first surgical assist role (RNFSAR) and increasing the use of ENs in the peri-operative specialty would lead to a more skilled, flexible and innovative workforce, without the need for costly duplication or unsafe substitution.

Facilitating advanced practice roles for RNs and NPs and increasing the use of ENs in the peri-operative specialty would lead to a more skilled, flexible and innovative workforce without the need for costly duplication or unsafe substitution.

In the aged-care sector, there is clear evidence that those coming into residential care are older and require more acute care – few facilities consistently meet the minimal voluntary standards for safe aged care and dementia care.
While the targeted funding stream for mental health has resulted in improved mental health services over the past decade, it has also precipitated education and training for mental health support workers that, in some cases, is inconsistent with the regulation of health practitioners. The national diploma in mental health (support work) at level 6 on the NZQA framework, for example, is a non-clinical qualification for leading a team of mental health workers. Mental health is intrinsic to health, as illustrated by Professor Sir Durie’s Te Whare Tapa Whā Māori model of the four cornerstones of health – taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health), and taha hinengaro (mental health). The same public safety regulations for health practitioners must apply to those working in mental health, as in any other area of health. It is neither sensible nor safe to qualify non-clinicians to lead regulated clinicians, or to undertake clinical work.

**The incoming Government should:**

1. Develop a comprehensive national set of indicators of activity, output, quality, safety and, ultimately, health outcomes, to target and assess the effectiveness of quality improvement activities.

2. Use standardised measures, including qualitative measures, of health status to provide the fundamental data needed to improve the effective management of the health sector.

3. Ensure that staffing in all nursing environments meets the patient requirement for care. This will require implementing the care capacity demand management approach, developed by the SSHW Unit, and including a validated mechanism for assessing patient acuity.

4. Recognise that healthy work environments promote productivity, quality and safety, and protect workers’ rights by including a healthy workplaces clause in all employment contracts.

5. Set minimum mandatory staffing levels in aged care which take into account the right skill mix, and develop robust measures for acuity assessment, safety and quality in aged care.

6. Facilitate the development of clinical frameworks and guidelines for responsibility of care that clarify the interface between regulated and unregulated workers, particularly in aged care and mental health.

7. Ensure the NZQA level of qualifications and training for all health workers are consistent with public safety and facilitate entry to the regulated health workforce at level 5.
Sound workforce planning, recruitment and retention, nursing leadership and professional development are NZNO’s third priority.

Population aging and technological changes are anticipated to increase the demand for health care services, while feminisation of some sectors, new working patterns and an aging health workforce – 40 percent of the current nursing workforce is aged over 50 – may result in a reduction in the supply of experienced health workers. Ideally, the demography of the nursing workforce should reflect that of the population, but currently men (7.2 percent), Māori (6.3 percent) and Pacific and Asian peoples, are significantly under-represented and about 40 percent of the workforce has come from overseas, increasingly from developing countries.

There are 17 tertiary institutes offering approved nursing programmes on 22 sites throughout Aotearoa New Zealand, including dedicated Māori and Pacific programmes. These incorporate the same competencies but are tailored to the needs of students from these communities and are focused on meeting specific population health needs. NZNO strongly supports these programmes, which aim to improve recruitment and address high attrition rates and should contribute to improving Māori and Pacific peoples’ health status. However, there is considerable variability and duplication across the sector and a significant reduction in the number of different programmes or a national curriculum, with consistent cultural and clinical components, would improve the consistency of outcomes of nursing programmes. An NZNO survey of nursing students indicated that this would be widely supported by students.

**Workforce planning**

The workforce is the health sector’s largest resource and accounts for approximately 70 percent of public health and disability expenditure per year ($10 billion) overseen by the NHB. HWNZ is charged with addressing health workforce issues. While the establishment of a specific body to lead and co-ordinate the planning and development of the health and disability workforce is welcome, the overtly medical rather than health focus, is out of step with current health thinking and underestimates the importance of 50 percent of the health workforce, i.e. nursing.

The rapid increase in the number of HWNZ’s health service reviews, from three to 17 in a few months, illustrates the pitfalls of approaching workforce issues from a specialist, disease-focused perspective, rather than planning for a flexible, well educated workforce, that can work across a wide range of services to meet changing health needs. There is also a significant disconnect between HWNZ’s indication that nursing is “unlikely to be a priority for the next two years” and the models of care the NHB has proposed to help address persistent health disparities, which all point to the need for increased nursing input.

Workforce resources need to be focused on reducing demand for specialist services where there is already a shortfall in capacity, through integrated public and primary health care. Nursing is, in every way, intrinsic to achieving a population-wide improvement in health, and should be central to all health workforce planning.
The continued reliance on recruitment of overseas health practitioners to meet workforce shortages is spectacularly inefficient in terms of assuring a stable health workforce; it can also be highly exploitative and unjust.

Increasing globalisation and demand for health practitioners highlights both the need for sound workforce planning and Aotearoa New Zealand’s susceptibility to policy changes in other countries. Although the net outward migration of nurses is somewhat ‘balanced’ by the inward migration of overseas trained nurses, relying on immigration in such a critical area as health is short-sighted, risky and unethical in the light of global shortages.

It is even more short-sighted not to make use of existing nursing skills, especially where there is a recognised health demand. Requiring overseas nurses trained in English to take an English language test, is an unnecessary barrier to registration, as is using a culturally and clinically irrelevant and discriminatory language test to determine communication competence in health care settings. Burdening nurse/midwives with the full costs and professional development requirements of both scopes of practice is rapidly ensuring a return to a single scope of practice, while patchy provision for nurses to return to or, in the case of new graduates, begin work, means we do not reap the full return on the investment in their education. In addition, several thousand nurses are currently choosing not to practise or to avoid certain health sectors, while OTNs are at risk of exploitation and often unfairly locked into employment as HCAs.

Reasons for the underuse of existing nursing resources include:
- inadequate staffing levels and heavy workloads;
- disparities in pay and conditions, particularly in Māori and iwi providers and aged care facilities;
- financial barriers to re-entry to practice and for dual scopes of practice;
- lack of child care facilities and flexible working hours;
- financial barriers to registration for immigrant nurses; and
- the culturally and occupationally inappropriate academic International English Language Test (IELT).

Subsidised retraining schemes and, for OTNs, the replacement of IELTS with appropriate communication and cultural competence assurance and mentoring programmes, are cost effective means of using, rather than squandering, existing workforce resources. In particular, alternative safe clinical pathways to registering resident overseas trained Pacific nurses to address critical health workforce shortages in Pacific communities can and must be found.

Similarly, nurses should be encouraged to acquire and retain additional scopes of practice, such as midwifery, by collaboration between the relevant regulatory bodies to facilitate rather than create disincentives to maintaining dual registration. The 2010 budget ascribed $3 million to encourage GPs back into maternity services, but ignored the potential of recruiting and retaining highly competent and experienced nurse/midwives with similar incentives. Addressing the safe staffing and healthy workplaces agenda will also improve the retention of nurses and midwives. Professional development and recognition programmes (PDRP) should be standardised across the country to facilitate a flexible, continuously improving health workforce.
Nursing careers and professional development

Nursing is predominantly a female profession and nurses’ careers tend not to follow a linear trajectory in terms of career progression. Many nurses have breaks within their careers or reprioritise their career plans due to family responsibilities including both child rearing and caring for aging parents. However, nursing has a robust history of developing systems that support career planning from the nursing perspective of achieving better patient outcomes, rather than the world view of career progression through a hierarchical organisational structure. These include:

- sound appointment processes, induction and orientation programmes;
- the nurse-entry-to-practice programme (NET-P);
- annual performance appraisal systems many of which include a professional development plan, professional development and recognition programmes (PDRPs); Quality & Leadership Programmes (QLP) for midwives;
- specialty accreditation systems;
- certifications for various activities;
- nurse practitioner regulation; and
- credentialling guidelines for the expanded RN scope of practice.

Nurses must be assured of access to education and training programmes that will support their advancement as health professionals, while maintaining a high level of competence, knowledge, skill and commitment to quality care. Historically, nursing has been highly disadvantaged in comparison with other health professions in funding allocations for post-entry clinical education, and access has proved difficult because of the cost. Performance-based research funding (PBRF) is less accessible for professions like nursing where the research provenance is relatively short, and where there is not the prolonged academic/clinical interface. As there is with medicine, for example.

Nurse practitioners

The extremely low uptake of NP roles, amounting to less than 0.2 percent of the nursing workforce, compared with the USA, where NPs comprise about 7.5 percent of nurses, is indicative of both the threshold for registration and lack of satisfactory employment opportunities. Significant barriers to NPs using the full extent of their scope of practice as authorised prescribers remain. These include legislative, regulatory, contracting/purchasing/funding services, access to diagnostic and investigative tests and lack of employment opportunities. While some progress has been made, eg -NPs are now able to sign some medical certificates, the major obstacle, the obsolete Medicines Act 1981 remains, though its fourth review in just over a decade is underway.

There is abundant evidence that NPs are safe and conservative prescribers, who refer appropriately. With a minimum of eight years’ training, postgraduate education, clinical experience, and a rigorous registration process, it is unnecessary and counterproductive to delay removing the restrictions that prevent these expert practitioners delivering the health care they are trained and qualified to provide. Similarly, standardising educational programmes, reducing the complexity of bureaucratic processes, and providing consistent support for NP candidates, would enhance uptake and ensure a capable and innovative NP workforce.

The NHBC’s review, Trends in service design and new models of care, indicated the need for more NPs in acute care, as hospitals and regional services are aggregated and people travel to receive care. But their potential, and that of RNs, across all services is significant, as we develop new ways of working with people who need care. Using a NP to follow a patient across different levels of acuity rather than transferring them from service to service, delivers better health outcomes and is more cost effective. A review of health needs in the Waikato4 identified three areas, which are also national priorities, where NPs could make a significant difference in this way: gerontology, primary health care / rural, and mental health and addictions. More needs to be done to facilitate employment opportunities for NPs to encourage nurses to take up this valuable role and enable confident planning for the NP workforce. Seventy-five NPs from a total of 50,000 nurses is not a realistic reflection of the capacity of the nursing workforce to fulfil this role.

Registered nurses

The flexibility of the regulated nursing workforce to quickly assimilate new practices and be deployed where most needed, has been critical to improving health care. Recent changes to the RN scope of practice to enable expanded practice ensure nursing’s continued responsiveness to changing health needs, knowledge and treatment opportunities. Credentialing of expanded roles and activities by professional organisations and employers, in accordance with national guidelines, will ensure public safety.

HWNZ’s RNFSFA project and proposal to trial diabetes nurse specialist (DNS) prescribing are both welcome. International evidence strongly indicates that nurse prescribing is safe, improves patient access and health outcomes and reduces doctors’ workloads. However, an incremental disease-based approach to nurse prescribing would be restrictive and time-
Students

Progress has been made in attracting, educating and retaining nurses, including programmes for increased retention and capacity of Māori and Pacific nurses. However, demographic trends indicate the increased need for nursing skills in the future, and it is imperative that nursing education continues to be prioritised to avoid skill shortages in the long term. Multiple factors are involved in attracting intelligent and capable men and women to a nursing career, including pay and employment conditions, continuing education and career advancement opportunities, recognition and portability of qualifications, and job security and satisfaction.

Research presented at NZNO’s Safe Staffing and Healthy Workplaces Symposium (2008) indicates the positive impact of the 2004 DHBs/NZNO multi-employer collective agreement (MECA) in attracting younger people to nursing as a career. However the cost of nursing and midwifery education remains a problem. Research into the impact of student debt on nurses found that:

- 60 percent of respondents had considered going overseas because of their student loan debt;
- 22 percent had considered leaving nursing because of their student loan debt; and
- 69 percent said their loan had influenced their decisions on whether to undertake further study.

The requirement for workplace experience through clinical placements increases the costs for the student, while limiting their opportunities for part-time employment to support their studies. There is also concern about both the variability in quality of clinical placements, and changes in funding and legislation. One such change is the removal of compulsory payment of student union fees, which will reduce academic and social support services for students and almost certainly result in higher drop-out rates.

The introduction of interest-free student loans has been a positive move, though this now looks less assured. NZNO applauds the success of the voluntary incentive payment scheme (‘bonding’) for health professionals who agree to work in hard to staff areas and suggests there may be potential for voluntary bonding to be open to all graduates. However, further action is needed to relieve the burden of fees and debt to avoid the continued loss of new graduates overseas, and encourage advanced level nursing. Several hundred new graduates seek higher paid jobs overseas without having ever practised in Aotearoa, yet more overseas nurses are registered each year than new graduates.

Funding to support NET-P and the midwifery first-year-of-practice programmes has proved beneficial to all parties and must be extended to all midwifery and nursing graduates, including ENs. Similarly, it is essential to ensure designated and appropriately paid employment opportunities for those graduating from targeted Māori and Pacific programmes, if the benefits of increased professional participation and better health outcomes for these communities are to be realised. Stronger collaboration and links between the regulatory, education and employment bodies are needed to facilitate the transition into employment to ensure the cost of innovation and training is not wasted.

Enrolled nurses

Decisive action by Minister of Health Tony Ryall at the beginning of this term of government saw the sensible resolution of a single title and scope for enrolled nursing and elevation of the qualification to level 5. It is thus disappointing and concerning to note the disestablishment of EN positions in many health settings including aged care, hospitals, and mental health services. ENs are a valuable regulated health workforce, with a recognised qualification that employers, patients and fellow health workers can have confidence in. They are an essential part of the nursing continuum, and increase the flexibility with which the nursing skill mix can be adjusted to fit patient groups and the context of care. ENs should be used much more extensively within the health sector, as they are in Australia; employers must be encouraged to retain and increase EN positions and provide opportunities to facilitate their transition to the new scope of practice.

Health care assistants

HCAs now constitute a valued part of the health workforce, yet the boundaries between their responsibilities and those of regulated nurses are blurred. HCAs are increasingly undertaking a variety of complex tasks which are the domain of the RN or EN, frequently with little or no educational support. NZNO does not advocate the regulation of HCAs, but rather a clear understanding that this is an adjunct role, not a nursing role – nurses have a legislated scope of...
practice, HCAs have a job description. HCA work should not be extended beyond supporting patients with activities they would perform for themselves, if able. Employers must be responsible for ensuring HCAs are ‘fit’ for their job description, and training for HCAs should be standardised, employer-funded and nationally accessible.

NZNO does not support the introduction of an “advanced caregiver” role outside the framework for regulated health workers, ie above level four of the NZQA framework. NZNO advocates education which offers opportunities for advancement, and recognition of prior learning61.

Current efforts to raise the status of workers at the lower end of the skill and pay scale, especially in female-dominated occupations such as health care, are directed, almost exclusively, at gaining qualifications. Though appropriate training for HCAs is important, training that is time-consuming and expensive and which results in no tangible benefit to the HCA, is unlikely to prove successful and expectations from a large qualified workforce may pose unrealistic budgetary challenges. It would also be unfortunate if a qualifications framework resulted in the exclusion of some suitable and dedicated people from HCA work. Good pay and conditions and reward for experience would go a long way towards reducing the costs of the current high turnover of HCA staff.

New health professional roles

Precipitate piloting of unregulated roles such as physician/practice assistants and ODPs has been undertaken without adequate consultation or investigation of alternative options, though their introduction has the potential to profoundly affect health and workforce outcomes. Aotearoa New Zealand’s small size precludes its capacity to train, retain or regulate a wide variety of health workers. Introducing new cadres of health workers before establishing safe protocols for their integration with the regulated health workforce risks the same negative health and employment outcomes that occurred as a result of confusion between ENs and HCAs.

A comprehensive assessment of health workforce capacity and needs, encompassing a full range of possible solutions and options for the future, including expanded nursing roles, should be undertaken. New cadres of health professionals should only be considered if other options are inadequate and should only be introduced to a strategic national plan.

Good pay and conditions and reward for experience would go a long way towards reducing the costs of the current high turnover of health care assistants and improving health outcomes.

Nursing has a vital role to play in meeting this challenge but current structures and resourcing are not directed at nursing, in spite of policy frameworks which clearly are.

NZNO welcomes the long-awaited regulation of anaesthetic technicians under the HPCAA, and looks forward to the regulation of paramedics, as urgently recommended by the Health Select Committee in its 2008 Report.

Introducing new cadres of health workers before establishing safe protocols for their integration with the regulated health workforce invites confusion and puts public safety at risk.
The incoming Government should:

1. Plan for self sustainability in the nursing workforce. This requires collection of comprehensive and up-to-date workforce data. This data should be regularly reviewed and maintained across the whole sector and used to inform nationally co-ordinated workforce planning and development strategies across all sectors.

2. Develop a national curriculum, with consistent cultural and clinical components, to improve the consistency of nursing programmes.

3. Value nurses, ensuring funding for NEtP and the midwifery first-year-of-practice programmes is available to all new graduates; subsidising return-to-nursing competence programmes; facilitating postgraduate education, clinical training, and leadership opportunities including NP, nurse specialist, and clinical nurse educator roles for experienced nurses.

4. Remove barriers to advanced and innovative practice to ensure a flexible nursing workforce to meet population health needs.

5. Establish a single public agency to source overseas-trained health professionals, ensure they are ethically sourced and have access to training, assessment and mentoring programmes which are culturally and clinically appropriate in Aotearoa New Zealand.

6. Work with Nursing Council, tertiary education providers and NZNO to find alternative safe clinical pathways to registering resident overseas-trained Pacific nurses to address critical health workforce shortages in Pacific communities here.

7. Provide incentives and co-ordinate continuing education requirements for nurses and midwives to encourage retention of dual scopes of practice, and extended skills, to address the need for increased mother/child care.

8. Affirm new models of care that include ENs, and protect and enhance employment opportunities for ENs in primary and mental health and aged care, and in DHBs.

The principle of equal pay for work of equal value has been accepted both nationally and internationally for more than 50 years. Until 1990, collective awards negotiated by their unions assured most workers of equal pay and conditions within their occupations. But in 1990 the Employment Contracts Act effectively limited union outreach and replaced national awards with individual contracts and smaller collective agreements. Although the Act was repealed in 2000, and pay parity for DHB-employed nurses and midwives eventually regained in 2004, amendments to the Employment Relations Act and the Holidays Act in 2010, widely rejected by employers, workers and the government’s own advisers, is recreating the power imbalance in industrial relations that historically has led to conflict, inequity and low productivity.

Moreover, the implications for the health sector are significant. It is an extraordinary indictment of our health system, and inconsistent with Te Tiriti o Waitangi, that those working for Māori and Iwi providers continue to earn up to 25 percent less than their DHB counterparts.

Challenge four

Employment relations

It is an extraordinary indictment of our health system, and inconsistent with Te Tiriti o Waitangi, that those working for Māori and Iwi providers continue to earn up to 25 percent less than their DHB counterparts.
The 2010 National Terms of Settlement (NToS) jointly proposed by the Ministry of Health, DHBs and health sector unions affiliated to the Council of Trade Unions (CTU) including NZNO, has facilitated the efficient and fair settlement of pay and employment conditions. However, there remains a large discrepancy in wages and conditions for many nurses and HCAs who are not covered by the NZNO/DHB MECA, which, along with inadequate staffing protocols, continues to contribute to chronic MECA, which, along with inadequate staffing

It is a feature of many DHB-contracted services that those working in them are similarly disadvantaged, whether the contractors are private businesses as in aged care, not-for-profit social service organisations, or rural and integrated health services and community trusts. In this context, the increasing tendency of DHBs to shift services to the latter, as with Otaihape Health Trust, is of extreme concern as there is no provision for health care services, or employment, in the event of failure. As primary contractors, DHBs must be responsible, according to Department of Labour guidelines, for ensuring the same health and safety standards apply to all its contractors: “The principal [contractor] cannot distance themselves from what is occurring in the workplace simply because the employer is more directly related to and responsible for the employees carrying out the work.”

The only way this can be assured is for all DHB-contracted services to specify employment terms and conditions consistent with the DHB MECA.

Family Planning nurses directly funded by government are similarly disadvantaged by inferior pay rates, and face increasing recruitment and retention problems. There must be no discrimination between persons within the same profession with the same level of responsibility, educational qualification, experience, and skill requirement. Industry-wide setting of pay and employment conditions, negotiated collaboratively through integrative (interest-based) bargaining between unions and employers, to achieve the best outcomes for all, is essential if Aotearoa New Zealand is to retain its skilled workers and social infrastructure. There is clear evidence linking union density and collective bargaining coverage with higher wage rates, increased productivity and reduced inequity.

Wider pay and employment equity issues also need addressing throughout the health sector which is largely dominated by women who, on average, earn 12 percent less than men and are less likely to reach senior positions, or to be in full-time, permanent employment. There is no legitimate reason for women to be more likely to be in part-time, casual or lower paid work, nor for them to be less independent economically. Childbearing accounts for a small period of time in comparison to the whole of a woman’s working life, yet there is little awareness that time taken off for this purpose guarantees ongoing disparity by substantially reducing women’s career prospects, earnings and ability to plan for retirement. The move towards work/life balance and shared responsibility for childcare is predicated upon the principle of equality: that both men and women have equal access to and responsibility for childcare, and can participate equally in the workforce.

Access to onsite childcare facilities, which would enable breastfeeding and other ‘family friendly’ initiatives such as rostering options, is lacking in most health care environments. Changes in the delivery of health care, especially public and primary health care, including better access, longer surgery hours, and on-call care, can only be met if staff are available to provide such services. Flexible rostering, family friendly environments and paid parental leave are conditions which will not only attract and retain nurses, but also significantly contribute to family health. However, the disestablishment of the Pay and Employment Equity Unit (PaEE) has significantly reduced the capacity to approach such issues constructively and develop coherent effective strategies to ensure full and equal participation in all aspects of employment. Instead, a strong message has been sent that it is acceptable for “women’s work” to be devalued and for discriminatory practices to continue unexamined. NZNO strongly advocates the restoration of the PaEE unit.

Raising the minimum wage and returning the definition of full time work to a minimum of 35 hours is essential to reducing poverty and entrenched disparities.
The most unacceptable and pervasive inequity, however, remains the gap between the rich and poor which Aotearoa New Zealand has shamefully allowed not only to continue, but to widen at a greater rate than most other OECD countries. Though we have a minimum wage, an international benchmark of economic credibility and social responsibility, it is currently set at $13 per hour, well below the level of two thirds the average wage recommended by the International Labour Organisation. In addition, the rise in non-standard and contracting working arrangements which are increasingly casual and low paid, exclude many people from this protection. The surreptitious and unanticipated redefinition of full-time employment as 30 hours per week further locks those on the lowest wages, into an inescapable cycle of poverty, insecurity and stress. Raising the minimum wage and returning the definition of full-time work to a minimum of 35 hours is essential to reduce poverty, the root cause of ill health and entrenched disparities.

Most HCAs working in aged care, a disproportionate number of whom are Māori, Pacific and migrant workers, are on the minimum wage or slightly above. They have generally had to fight for the government-funded increases the sector has been given in the past few years, while significant profits from multinational chains have been sent offshore to overseas shareholders. Public funds are thus being used to enrich overseas investors at the cost of workers in Aotearoa New Zealand: the lower the minimum wage here, the higher the profits there, and the wider the gap between economies.

There is strong evidence that low wages are a barrier to economic development and a significant factor in the increasing outward flow of Aotearoa New Zealand-trained health professionals, and the high turnover of overseas-trained health professionals. Investment, beginning with raising the minimum wage, in increasing human resources and addressing the health brain drain through bilateral agreements to regulate gains and losses, would effect greater equity, reduce health demands, and create a sustainable health workforce.

Changes proposed in the Injury Prevention Compensation and Rehabilitation Bill 2009 disentitle claims from prisoners and for self-inflicted and other mental injury. They also reduce the hours defining vocational independence from 35 to 30, and remove the obligation to have work and income assessments commensurate with pre-injury occupation and earnings. These changes fundamentally undermine the principles of ACC, by ensuring people in these circumstances will never have the means to regain lost health and independence. Nurses, midwives and HCAs – who have a high rate of back and shoulder injuries as transferring, rolling and repositioning patients is integral to quality nursing care – are particularly at risk of sustained loss of income and opportunity for rehabilitation from work-related injury – a poor reward for their care of others.

The incoming Government should:

1. Repeal amendments to the Employment Relations Act and Holidays Act made in 2010 which are unworkable, unfair and set up a combative rather than collaborative industrial relations environment.

2. Promote collective employment bargaining as an essential part of developing and maintaining safer, higher quality and more accountable health and disability support services.

3. Ensure pay parity for all nurses, midwives and HCAs across all sectors.

4. Work with NZNO and Māori and iwi health providers to develop and fund a national Māori and iwi primary health care MECA – Te Rau Kōkiri – that delivers pay parity between primary and secondary providers.

5. Promote industry-wide wage setting through integrative (interest based) bargaining between unions and employers to achieve best outcomes.

6. Ensure all DHB-contracted services specify employment terms and conditions consistent with the DHB MECA.

7. Reinstate the Department of Labour's PaEE Unit.

8. Encourage ‘family friendly’ environments and ensure access to childcare facilities, including those suited to the needs of workers with 24-hour rostering and those who are breastfeeding.

9. Raise the minimum wage to two thirds of the average wage, as recommended by the International Labour Organisation and ensure its comprehensive enforcement.

10. Return the definition of full-time work to a minimum of 35 hours a week to ensure a living wage.
NZNO recognises that health is reliant on an effective health service and on other social, cultural and economic health determinants, such as income and poverty, employment and occupation, housing, education and social support. NZNO advocates implementation of comprehensive and integrated governmental programmes to achieve health equity through action on the social determinants of health. A blueprint for this has been developed by the WHO Social Commission on Health Equity in the Report Closing the Gap in a Generation (2008). The Commission’s overarching recommendations to establish healthy family, community and workplace environments, which sustain equity and prosperity, are entirely consistent with the recommendations in this manifesto.

They are to:
• improve daily living conditions – the circumstances in which people are born, grow, live, work and age;
• tackle the inequitable distribution of power money and resources – the structural drivers of those conditions of daily life; and
• measure, understand and assess the impact of action on the social determinants of health.

Improving daily living conditions requires not only universal access to health care right from the start, but also good housing, healthy food options, quality education, decent work and fair pay, protection from the consequences of injury and disease, and healthy, safe environments. Tackling the inequitable distribution of power, money and resources means putting health and health equity at the heart of all government policy and planning decisions to create a socially inclusive framework for policy making. Understanding the social determinants of health requires health research focused on those determinants, and a workforce trained to recognise and address the root causes of inequity and ill health. The health impact assessment (HIA) tool and the whānau ora impact assessment tool developed by the Ministry of Health, provide robust assistance for such policy development.

The nursing model of health, like the whānau ora model is, essentially, holistic and focused on well-being rather than disease. NZNO supports the integrated approach implicit in the whānau ora programme that focuses on:
• whānau, hapū, and community development;
• Māori participation, including supporting effective Māori health providers and a highly skilled Māori health workforce;
• effective service delivery; and
• working across a range of social sectors such as social development, education and housing to effect change.

However, we caution against funding whānau ora services on the back of cuts to current services.

This country’s very high and increasing rates of ‘diseases of poverty’ such as rheumatic fever and tuberculosis, which are now more commonly found only in developing countries, are indicative of widespread poverty and impose lifelong costs on individuals and the country. Māori and Pacific peoples are disproportionately affected, though these diseases are affecting increasing numbers of Pākeha children too.

The financial burden of injury and disease can severely limit the capacity to sustain the basic necessities of life, or to provide adequately for children. The Woodhouse Principles, on which ACC is based, anticipated its extension to include coverage for disease to ensure the comprehensive universal social protection needed to underpin social and health equity. Recent changes to ACC legislation, regulation and policy, predicated on the flawed objective of full funding by 2019, have reduced and delayed access to ACC-funded health services and imposed barriers to safe clinical practice. Privatisation of ACC, which had a disastrous impact on the health system when it introduced in the 1990s, seems imminent, though the Labour Party has pledged to reverse any such moves. NZNO is opposed to any privatisation of ACC and, as a member of the ACC Futures Coalition, is committed to retaining ACC as a publicly-owned, single provider and to maintaining and improving the provision of injury prevention, treatment, rehabilitation and ‘no fault’ compensation for all New Zealanders.
Family violence, drug and alcohol abuse, smoking, heavy workloads, stress, eating disorders, and suicide are preventable social problems, which exact a heavy toll on the health system. They must be addressed at source through integrated social and public health strategies and education campaigns. NZNO advocates prioritising the provision of wrap-around services for mothers and children, as articulated in the Public Health Advisory Committee’s Report to the Minister of Health The Best Start in Life: Achieving effective action on child health and wellbeing (2010) in view of our abysmal record of child abuse, the provision of consistent national child protection services in health to screen at risk children and support health professionals are essential. The significant success of smoking cessation strategies across most population groups, except Māori women who have the highest smoking prevalence rate of any ethnic group (49 percent), indicates the potential of comprehensive and co-ordinated programmes to improve population health. NZNO is a member of the Smokefree Coalition whose vision for Aotearoa New Zealand by 2020 is to see children of future generations free from exposure to tobacco and enjoying smokefree lives. Accordingly, we strongly support the continuation of smoking cessation strategies.

Alcohol needs to be similarly targeted because of the widespread social, health and economic harm caused by its misuse. Liberalised laws regarding the sale and consumption of alcohol have exposed more people at a younger age to alcohol with disastrous results: 600 babies born with foetal alcohol syndrome, 75 percent of adult presentations at emergency departments on weekends; one third of police apprehensions, and 500 serious and fatal traffic incidents per year, indicate the extent to which the misuse of alcohol is endemic. NZNO is a signatory to the Alcohol Action NZ campaign, which proposes the 5+ solution to:

• raise alcohol prices;
• raise the purchase age;
• reduce alcohol accessibility;
• reduce marketing and advertising; and
• increase drink-driving counter-measures, including lowering the blood alcohol count (BAC) to 0.5 percent, in line with other countries.

Aotearoa New Zealand’s increasing rates of ‘diseases of poverty’ are indicative of widespread poverty, and impose lifelong costs on individuals and the country.

There must also be increased treatment opportunities for heavy drinkers. A recent Australian report, the largest and most rigorous evaluation of the cost effectiveness of preventive strategies for non-communicable disease undertaken anywhere in the world, identified a 30 percent tax on alcohol and a ban on alcohol advertising as the two most cost-effective interventions out of the 150 examined. The report states: “The vast majority of the health gain is achieved by the 30% tax on alcohol. The 30% tax alone could achieve 21% of the population health improvements that would be achieved if all drinkers reduced their daily alcohol consumption to fewer than four standard drinks for men and two standard drinks for women.”

Nurses liaise with and support the work of local, national government and non-government agencies to help consumers with addiction needs access the right services, and provide education and professional support. They are acutely aware of the lack of accessible and appropriate treatment opportunities, including community-based addiction centres, for alcohol and other drug, and gambling addictions. Dedicating alcohol taxation to the provision of services to mediate alcohol harm, offers a rational and equitable solution to current shortages.

Improving oral health was identified as a significant part of overall health and was a key population health objective of the New Zealand Health Strategy (2001). Oral health has, however, been dropped as a priority health target, in spite of the decline in children’s dental health since the 1990s. Only 48 percent of this country’s reticulated water supplies contain fluoride, an essential element lacking in our soils. This means many children are not protected from dental caries, a painful infectious disease that is particularly dangerous for those with rheumatic disease where infection in the oral cavity can have life-threatening sequelae. The higher proportion of Māori living outside main centres, where there is less access to fluoridated water supplies, means Māori have not benefited equally from what is widely accepted as the safest, most effective intervention in reducing the level of dental caries. NZNO strongly recommends reinstatement of improving and funding oral health as a priority health target.

Health promotion, particularly encouraging healthy lifestyles, including the initiatives identified in the Ministry of Health’s Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau Strategy (HEHA) are essential to reduce the consequences of the rapid rise in obesity, diabetes and poor lifestyle choices. Recommendations following the initial the implementation HEHA programme need to be prioritised and resourced. Removing GST on healthy food would be a direct means of encouraging healthy eating, especially among those in most need.

The nursing model of health, like the whānau ora model, is essentially holistic and focused on well-being rather than disease.
Hospices, which provide specialist palliative care to those who are dying, support for their families and professional training, are currently only part funded. Dying is inevitable; dying unsupported is unacceptable. The government’s target of 70 percent funding for all hospices has not yet been achieved, nor are hospices in all areas or accessed by all cultural groups. Everyone who has a life-limiting illness should have access to quality palliative care irrespective of where they live, the illness, their ethnicity or social background. More resourcing, education and promotion is needed to address the significant regional and cultural variations in the availability of and access to quality hospice and palliative care.

Electronic information and communication technologies (ICT) have had a profound effect on health care delivery, yet its potential to deliver innovative and equitable health care has not been realised. There continues to be a disconnect with most systems, eg individual DHB regions are unable to share information or communicate effectively with providers across the sector. Despite the Health Information Strategy and the work of the Health Standards Information Organisation, ICT in the health sector has been too fragmented and uncoordinated to support safe and efficient clinical practice, and optimal patient outcomes. The National Health IT Board has a two-phase plan to consolidate IT systems and then develop a model for shared care to ensure secure patient and health provider access to electronic health information by 2014. This plan offers promise of a coherent national strategy but will require significant investment in both infrastructure and health workforce training. An attitudinal change to move past the barriers and gate-keeping around sensitivity of business information is also necessary. It is imperative that nurses and midwives, as frontline health professionals working across all health settings, are involved in the development of the IT systems they will be using.

As a developed country, Aotearoa New Zealand also has an obligation to contribute to global health by continuing global aid to 0.7 percent of GDP commitment and ensuring aid programmes are targeted at addressing the social determinants of health. Similarly, international and national policy responses to climate change and other environmental degradation should be centred on health equity — ensuring decent work, fair pay and healthy work and living environments for all is not only the right thing to do, it is the only way to sustain a quality health system.

International and national policy responses to climate change and other environmental degradation should be centred on health equity — ensuring decent work, fair pay and healthy work and living environments. It is the only way to sustain a quality health system.

The incoming Government should:

1. Implement the overarching recommendations of the WHO Commission on Social Determinants of Health Report Closing the gap in a generation: health equity through action on the social determinants of health to ensure a comprehensive, consistent, and integrated government approach to reducing disparities and promoting healthy living and working environments.

2. Place health equity at the heart of all local, regional and national planning to ensure decent work, fair pay and healthy work and living environments for all New Zealanders.

3. Ensure the whānau ora programme is properly resourced.

4. Maintain and improve ACC as a publicly-owned single provider of injury prevention, treatment, rehabilitation and ‘no fault’ compensation social insurance system for all New Zealanders.

5. Support equitable funding for the core services of hospices, as per the specialist palliative care service specifications, and facilitate universal access to such services.

6. Protect public health by continuing to fund smoking cessation strategies; implementing the 5+ Solution to the misuse of alcohol; re-prioritising oral health and healthy eating/healthy action programmes, and removing GST on healthy foods.

7. Dedicate alcohol tax to ensure sufficient funding for addiction services.

8. Involve nurses in the development of electronic information systems they will be using and ensure adequate resourcing of equipment and training.
NZNO supports strategies aimed at achieving healthy, safe environments to live and work in and a health system that delivers safe and effective in-patient care and an accessible, affordable system of public and primary health care for all New Zealanders, including protection from the consequences of injury. Underlying the success of both of these goals is the recruitment, retention and development of a stable and well-educated nursing workforce, properly resourced and supported to provide safe effective nursing care.

We have identified the critical need for maintaining and improving investment in health to reduce future demand for health care, and the need for integrated social, health, environmental and employment policy and programmes, to ensure a healthy and productive population. We have also identified the critical challenges facing the nursing workforce, which threaten its sustainability and place the health and safety of the public at risk, particularly:

- barriers to the full and efficient use of all levels of professional nursing skills, including NPs, RNs, and ENs in all health settings;
- under-representation of Māori in the regulated health workforce and in leadership roles;
- inadequate levels of staffing and resources, particularly in aged care and primary health care;
- inconsistent pay and employment conditions between sectors and providers, particularly in the aged-care sector and among Māori and iwi service providers;
- inadequate and fragmented workforce planning, including a narrow focus on specialist workforce needs, poor clinical nursing and midwifery leadership programmes, poor recruitment and retention strategies, and reliance on high levels of overseas-trained nurses and midwives;
- the absence of robust methods to determine the optimal skill mix and number of nurses required across diverse settings;
- replacement of nurses with HCAs, ODPs and practice assistants;
- low participation and leadership of Pacific and other significant ethnic groups;
- high levels of migration; and
- barriers to the effective use of OTNs, particularly Pacific nurses.

NZNO has identified systematic, cost-effective, evidence-based pathways to ensure a sustainable health system that will reduce health disparities and improve health outcomes. We believe that urgent attention to the recommendations of this health manifesto should be given priority by the incoming Government.

Conclusion

Ensuring decent work, fair pay and healthy work and living environments for all is not only the right thing to do, it is the only way to sustain a quality health system.

NZNO has identified systematic, cost-effective, evidence-based pathways to ensure a sustainable health system that will reduce health disparities and improve health outcomes. We believe that urgent attention to the recommendations of this health manifesto should be given priority by the incoming Government.
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References


