NEW ZEALAND NURSES ORGANISATION

# Country Report

## AOTEAROA NEW ZEALAND

## ICN WORKFORCE FORUM 2014

**SYDNEY**

29 SEPTEMBER - 1 OCTOBER

## 1. Environmental Scan

- **Developments in nurses' working conditions**

While nursing employment overall has increased slightly, it has not kept pace with the increase in patient numbers with the consequence that many nurses are carrying increased workloads. This has not been helped with the introduction in district health boards (DHBs) of some unusually obstructive and bureaucratic recruitment rostering policies which leave nurses regularly covering for staff shortages with double and extended shifts and unable to work flexibly e.g. to accommodate the care of children. Overwork and inflexible hours contribute to shortages of experienced nurses, yet the career structure for nurses in New Zealand continues to be very flat, with little incentive and few employment opportunities to develop nursing leadership and skills in a structured way.

The DHB Multi Employer Collective Agreement (MECA) expires on August 31st, 2014 and the prospect for improved pay and conditions look bleak. Analysis of the Health Vote in the 2014 Budget indicate DHBs are underfunded by an estimated $94 million just to cover increased costs and demographic changes, and. When the costs of new services which the DHBs are expected to provide are taken into account, the shortfall is likely to be well over $100 million[1]. 12,000 public service workers, including some community and public nurses are are about to go on strike and reject the 0.7 percent increase offered to their Union, the Public Service Association.

While there has been some increase in the number of primary health organisations (PHOs) that have signed up to NZNO's PHC MECA,

[1] http://union.org.nz/sites/union.org.nz/files/Did-the-Budget-provide-enough-for-Health-2014.pdf

pay parity with DHBs remains an issue and the same is true of nurses working for Māori and iwi health providers.

Aged residential care continues to be a significant area of challenge for nursing both professionally and industrially. Comparatively poorer wages and conditions, heavy workloads, and a disproportionately high number of IQN and migrant workers are characteristic in this largely privatised sector.

There have been significant challenges and delays for new graduates in finding employment with only 60 percent directly employed in nurse entry to practice positions and several hundred graduates still unemployed six months after graduation.The Office of the Chief Nurse has successfully implemented and developed the Nursing Advanced Choice of Employment (ACE) system, a national system utilised by DHBs to recruit new graduate nurses into supported first year of practice programmes including into areas of specialty practice. Voluntary bonding schemes are open to graduates practising in hard to recruit specialties and communities.

Changes to immigration with the removal of most nursing categories from the Essential Skills in Demand Lists last year  may have affected the work and residency prospects of some internationally qualified nurses (IQN).  but without commitment to reduce the risks of NZ's high dependency on IQN, and planning for  a sustainable nursing workforce able to meet the predictable demands of an aging population, NZNO has, for the first time, proposed that all categories of nursing be removed from the ESID Lists, while continuing to call for and support strategies to retain the IQN .

- **Government/governance**

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

There has been little further visible action on the proposed enforced amalgamation of health practitioners' regulatory authorities; the Nursing Council of New Zealand opposes amalgamation, which would lead to increased nursing fees and potential loss of nursing autonomy under the model proposed.  The introduction of the Medicines Amendment Bill in June this year gave Nurse practitioners (NPs) the same 'authorised prescriber' status as medical practitioners, dentists and midwives, but failure to progress ancillary legislation (the Health Practitioners (Statutory Amendments) Bill) to

align other legislation means that there are still significant barriers to nurses being able fully utilise their scopes of practices and to enable the work being done around developing new models of care and service integration.

## 2. Nursing Data

- **Nursing Workforce profile**

In keeping with recent trends, the number of practising nurses in Aotearoa New Zealand increased in 2013 to 50,791 nurses, comprising 107 Nurse Practitioners (NPs); 47,782 Registered Nurses (RNs); and 2,862 Enrolled Nurses (ENs). 3067 nurses were added to the New Zealand register. However the rate of growth continues to slow somewhat with the nursing workforce increasing by just 754, down from around 829 the year before, and 1400 the year before that. The number of new Nurse Practitioners remained constant at 14, and the number of ENs continued to trend down.

IQN continue to be an important part of Aotearoa's nursing workforce. They accounted for nearly half (41 percent) of nurses registered in New Zealand in 2012-2013, and, overall, make up a quarter of the nursing workforce. There has been a change in the country of origin of IQNs over recent years. In 2006 the dominant country of origin was the United Kingdom; in 2012-13, while 177 came from the UK, most of the 1,257 IQNs registered in New Zealand came from Asia, mostly from the Philippines (531) and India (335).

There has been a slight increase to the number of male nurses who make up 8 percent of the workforce. Traditional gender disparities in the nursing workforce are echoed in ethnic disparities with 66 percent of nurses identifying as Pākeha/NZ European, 6.7 percent Māori and 3 percent Pacific, and 14.3 % Asian though the population which comprises ~ 15 percent Māori, 7 percent Pacific and 12 percent Asian.

However, there appears to be an increase in Māori nurse graduates (around 13 percent) but it is not clear whether this has translated into increased employment for Māori nurses. Government strategy is targeted to high school education in health sciences, rather than to career progression for nurses.

The median age of New Zealand's nursing workforce is 46.5 years. 44 percent are aged 50 years or over, with 6.2 percent aged over 65 years old. There is an ethnic component to the aging profile with Pākeha/NZ European RNs having the oldest age profile of any ethnic group: 46 percent are aged 50 or over, and 27 percent are aged

under 40. Most other ethnic groups have significantly younger age profiles.

At 31 March 2013 there were 107 Nurse Practitioners currently practising in New Zealand, representing an increase of 18 on the 89 practising in New Zealand at 31 March 2011. This equals two Nurse Practitioners per 100,000 New Zealanders, or one Nurse Practitioner for every 41,719 New Zealanders.

The largest single practice setting in which nurses are employed is in DHBs and surgical practice. 41.6 percent of all RNs reported working in acute DHB settings i.e. public hospitals. By contrast, less than 0.1 percent of RNs reported working in Pacific Health Service Provider and rural settings and over half of these nurses are aged over 50. 32 percent of RNs aged under 40 are employed by Nursing Agencies. Overall, 46 percent of RNs had at least one post-registration (level 700) qualification.

25 percent of the New Zealand RN workforce received their registration qualification outside New Zealand, most commonly in the UK (40 percent), South East Asia (17percent), or India (11percent). The practice area with the highest proportion of IQN is Intensive Care/Cardiac Care (38 percent). 28 percent (706) of nurses from the Philippines work as RNs in aged care facilities. IQN who fail to get registration in Aotearoa are often employed in private aged care facilities as health care assistants (HCAs), though their nursing skills are a considerable asset to these providers.

Only 61 percent of the most recent cohort of nursing graduates (November 2013) is currently employed under the preferred advanced choice of employment (ACE) scheme according to the Ministry of Health (O'Connor, Teresa, 2014) and slightly more, 69 percent (i.e. 920/1339) in total, according to the Report of New Graduate Destinations from graduates November 13 (Nursing Education in the Tertiary Sector (Aotearoa NZ), March 2014).

## 3. Labour Conditions

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

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

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

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

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

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

The standard age of retirement in Aotearoa is 65 years and most nurses have 'Kiwisaver', an earnings related saving scheme, with some having an additional superannuation savings plan. Little research has been done on nurses' retirement intentions but careful workforce planning could alleviate some predictable shortages from

the large cohort retiring within the next decade. A survey of late career nurses over 50 indicated that while 57 percent intend to retire within the next ten years, a wide range of factors that could affect that decision were identified, including shift work, flexible hours of work, financial resources, health status, relationship status and the location of family.

## 4. Allocation of Resources

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

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

Gaining access to care is a problem for the increasing number of those living beneath the poverty line as they struggle to meet costs, transport issues and/or motivation to improve their health status.

## 5. Scope of Practice

NCNZ consulted on two proposals to extend registered nurse prescribing in March and April of this year: Community nurse prescribing to enable nurses in community and outpatient settings to prescribe medicines for minor ailments and illnesses and Specialist nurse prescribing, to enable nurses working in a collaborative multi-disciplinary team in specialty services or in general practice, to be able to prescribe for common conditions such as diabetes, asthma, hypertension. RNs are eligible to become designated prescribers through a Nursing Council authorisation process.

NCNZ is currently considering a preregistration master’s degree in nursing as an alternative pathway to registration as a registered nurse. Under the current prescribed qualifications a preregistration

master's degree in nursing is not identified as a prescribed qualification for entry to the registered nurse scope of practice.

Two successful demonstrations of Diabetes Nurse Specialist prescribing and Gerontology Nurse Specialist in Primary Care, a nurse-led initiative with a preventative and early intervention, should see wider implementation. Similar advanced nursing practice pilots have been mooted for respiratory nurses and nurses undertaking endoscopy, and colposcopy. A new post graduate training programme for Registered Nurse First Surgical Assistants (RNFSAs) at Auckland University has been established.

The Perioperative Nurses College is currently developing an education framework for anaesthetic assistants training.

## 6. Positive Practice Environments

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

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

- **Occupational health and safety**

Following the Pike River Mine disaster which exposed the significant gaps in health and safety in employment, and the Independent Taskforce on Workplace Health and Safety's Report (2013)[2], new legislation transferring responsibility for workplace health and safety from the Department of Labour to an independent Crown Entity – WorkSafe has been introduced and regulation are being developed to support health and safety in employment reform. Both legislation

[2] http://hstaskforce.govt.nz/documents/report-of-the-independent-taskforce-on-workplace-health-safety.pdf

and regulations are largely modelled on the Australian model Work Health and Safety laws.

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